The Venice Stakeholder Event

Learning lessons about health-related Structural Fund investments

10 April 2010

Content

Key messages

1. ***Many people in the health sector don't know the SF process*** –they do not know how to apply for SF money, what the money can be used for, where the money comes from or how it fits into national health budgets. And beneath all of this, who are the decision makers about health sector investment priorities and what gets funded at national, regional and local levels.

2. EC and national bureaucracy requirements – need ***a more collaborative and supportive approach with beneficiaries*** to assist the develop of programmes and projects

3. There is real need for a support programme to take people by the hand i.e. take regions through a ***peer review process with external/internal experts.*** This should be available as an ***ongoing call of support as and when needed*** in identifying funding priorities and existing financial resources; what Structural Funds are available and what can be done to access it and spend it in ways that are regionally relevant, cost effective, sustainable, flexible and delivers measurable benefit

4. Health-related investment in 2000-2006 and 2007-2013 is mostly based on ***out-of-date thinking and models e.g. continuation of the hospital centric model of care***

5. In generating good practice get behind the description of services to a ***more critical analysis of the process.*** Why does something work or not work? What is the tipping point? We needed a more global approach to the problems faced in the health system: what are the implications of a health-related investment with a view to regional development?

6. It's important to have better knowledge transfer between projects when they are happening e.g. through ***a moderated internet platform – a type of collegiate model of support using something similar to Facebook or Twitter***

7. Prior to the 2008/9 Economic Crisis, health systems across the EU tended towards a culture of cumulative asset growth – avoidance of controversial restructuring – the new emerging emphasis is on the principle of '***disinvest to reinvest'***

8. Managing Authorities should adopt ***conditionality towards evidence-based and integrated projects***. If you can't display this then go away. Needs to be done early enough

9. Within regions, ***SF must not be seen as an add-on investment*** but fully integrated within a regional master plan or strategy that is coherent with national policies. But how does ***regional master planning*** impact on accessing and use of SF? For example, see the best actions and lessons learned from Brandenburg from the 2000-2006 period.

10. Need for a stronger shift to return on investment principles and the contribution of ***health and integrated impact assessment principles*** to achieving this.

11. The strong option for ERDF/ESF beneficiaries is to 'leapfrog' previous (and now unsustainable?) convention – and ***target strategic and structural change*** in line with these principles. These principles can be supra-regional as well as regional.

1 Introduction

The main goal of the EU Cohesion policy 2007-2013 is to reduce social and economic disparities between the regions in the EU and to support achieving the Lisbon objectives for growth and jobs. In the current SF period Cohesion Policy takes a more strategic approach to growth and to socioeconomic and territorial cohesion and there is far stronger involvement of regions and local players in the preparation and implementation of Structural Fund programmes.

Health has been included for a first time as a priority for investment by the Structural Funds (ERDF and ESF) in the Cohesion policy 2007-2013. Health activities became eligible for funding under the three Cohesion policy objectives: a conservative estimate of 5 billion EURO from ERDF in the period 2007-2013 were allocated to finance modernisation of the healthcare system, construction and renovation of healthcare facilities, and the purchase of capital and medical equipment. Complimenting this, ESF provides funding for activities aiming to improve human capacity, to support healthy population and workforce, such as health promotion and disease prevention programmes, training of health workforce, health and safety at work measures.

In the newer Member States and Convergence regions across Europe governments, politicians and policy makers see SF as an important funding source for supporting the modernisation of health services. But, the health sector is starting behind other sectors in using Structural Funds, and also faces the consequences of the post 2008/9 economic climate and financial instability. In this fast evolving and changing operating environment It is likely that Member States will increasingly look to SF as a source of support for health sector investment and health gains.

The Venice Stakeholder event is part of a critical conversation between key stakeholders and EUREGIO III about to respond to these challenges effectively and sustainably. To this end, the event had the following main objectives:

- Building strategic relationships with 'key stakeholders' that enable a coherent approach to maximising health gains from Structural Funds
- Informing the mid-term review about how health gains from SF mainstream OPs can be achieved in the current 2007-2013 period
- Informing planning for the 2014-2020 period between key stakeholders in the SF process
- Facilitating discussion and learning that helps inform planning and implementation of the Technical Platform of the new SANCO/CoR Coordination Mechanism for health and regional development.

The content and conclusions of this report draws on (i) the experiences of SF managing authorities and SF beneficiaries that were shared and discussed at this Stakeholder event (ii) current evidence provided to the EUREGIO III team by MS Managing Authorities, SF beneficiaries and independent evaluators (iii) follow-up detailed investigation of the case material provided to the EUREGIO III.

About EUREGIO III

EUREGIO III project is funded by the EU under the 2007-2013 Health Programme. The purpose of the project is to identify examples of good practice and lessons learnt from planning, seeking funding for, implementing, evaluating and managing health investments in the 2000-2006 Structural Fund period (& 2007-2013 period when available). With this practical knowledge EUREGIO III is designed to inform the use of SF in the 2007-2013 period and planning for the 2014-2020 period. The project has 10 work packages that contribute to identifying, assessing, creating and delivering practical "how-to" knowledge through active dissemination with EC stakeholders (DGs SANCO, REGIO, EMPLOY), national and regional Managing Authorities for mainstream Structural Fund Programmes, current SF projects and potential SF applicants.

The project is run by Health ClusterNET and several Associate Partners (EMK Semmelweis University, Maastricht University, University of Liverpool, Veneto Region and the European Centre for Health Assets and Architecture). Further support is provided by a Reference Group and other Collaborating Partners including AER Public Health Committee (Chair of our Reference Group whose members include national SF Managing Authorities from Hungary, Poland, Slovakia, Bulgaria, Estonia and Greece), EIB, EURADA, EUREGHA, EHMA, EUROHEALTHNET, QeC-ERAN.

2 The economic and financial climate post 2008/9

Until the financial crisis and economic recession in 2008/9, national ministries have comfortably seen Structural Funds as a supplementary (to within country government funding) source for infrastructure development. Since the crash, there has been a marked slow down and in some cases moratorium on routine capital spending. This is likely to last for some considerable time and underlying government debt is clearly a problem. Related problems over bank lending are also highly visible. So, although many governments seek to re-energise their economies with blasts of non-recurrent capital spending this will probably not materialize for health because of revenue affordability reasons and the complexity of capital investment in health projects (capital spending is often difficult to protect in tight revenue budgetary circumstances).

Contributing to this new operating environment for the EC, Member States and regions, the carbon agenda is now beginning to impact on centralised medicine (the hospital centric model), both in terms of the buildings, their technologies and the travel implications for citizens. This is all taking place at a time when new ideas are gaining ground about reshaping models of care to shift treatment into more accessible local community settings thereby reducing reliance on the current high cost (and sometimes slow response) hospital-centric models of care delivery. It also fits well with managing the recurrent resourcing difficulties that most health systems are signaling; breaking down the large critical mass of the workforce concentration in hospitals to more resourceful, adaptable, responsive and potentially lower cost provision in the community. New ICT related dispersal technologies (eHealth) are a major driver underpinning this shift.

These factors are likely to add up to significant competition for future structural funds with demand outstripping supply. In these circumstances a new form of risk assessment will be needed. In addition to assessing the economics of proposals and immediate health need factors a new feature will also emerge; the human capital dimension. This may be summed up in the well know EU maxim of 'health is wealth', in other words will future investment add measurable health status benefit on a population basis; translating meeting need into health improvement. This is an important omission from the current SF and related health

planning processes. Overall this summary shows that the health sector needs to work out how to take advantage of different opportunities for maximising health gains through direct, indirect and non-health sector investments. For example:

- *Innovation, Research & Technology Development* – here it will be possible to identify exemplar projects and strategies that are founded on or contribute to innovative, research and technological advances
- *Entrepreneurship and SMEs* – an emerging model of healthcare delivery is based on Public Private Partnership provision, including different forms of outsourcing. This brings into play the twin features of entrepreneurship and project / service delivery by SMEs
- There is extremely good evidence to show that *the information society* is central to many if not most of these shifts, e.g. eHealth, technology dispersal models etc
- Finally the potential future focus on risk assessing investment to ensure it addresses issues of improving health status brings into play relevance for *employment and human resources.*

Table 1: Challenges for regional health systems in the post 2008/09 economic climate

Key governance issues	
Familiar	Emerging
Governance basics	Systems-wide perspective and commitment
Risk management	Process improvement methods
Productivity	Capacity building
Quality and patient safety	Evidence based decision-making
Increasing demand	Return on investment principles – measurable benefit
Efficiency	Risk assessed sustainability
Changing the mindset	
Understanding the problem	
Making the case for sustainable investments	
Adopting new financial models and ways of measuring success	
Added value from return on investments	
Measurable health gains	

(Adapted from: Ontario Hospital Association (2009) *Health care governance in volatile economic times: Don't waste a crisis)*

The changing financial and economic climate since 2008/9 is starting to be mirrored in the thinking of more leading edge regional health systems. Table 1 (as amended) summarises how the Ontario Hospital Association understands that they need to change the way they think if their services are to remain effective and sustainable in this new climate. To see it as an opportunity and not to retreat into a risk averse comfort zone. There is evidence to show that this changing of mindsets is happening in regions across the EU and that it often pre-dates the financial crisis (examples include but are not limited to: Brandenburg, Hessen, Basque Country, North West, Slovenia, Veneto, Lower Austria, Malapolska, West Sweden).

But as the focus turns to use of Structural Funds there are challenges that are shared among SF Managing Authorities and SF beneficiaries. Among those identified by the EUREGIO III team and others before Venice are the following:

- Financial absorption at national and regional levels is a concern for some SF Managing Authorities
- Health-related investment in 2000-2006 and 2007-2013 is mostly based on increasingly outmoded and obsolete thinking and models
- Risk assessment (economic and sustainability) is emerging as a new critical decision criteria because much of the past two decades of capital investment growth was based on (now unsustainable) debt creation
- Associated rising revenue costs funded largely through increasing public sector debt and previously high, but now unsustainable, GDP growth levels
- Health systems across the EU bought into a culture of cumulative asset growth – avoidance of controversial restructuring; the disinvest to reinvest principle – a new redistributive investment model
- The need for a stronger shift to 'return on investment' principles and the contribution of health (and integrated) impact assessment to this
- The strong option for ERDF/ESF beneficiaries is to 'leapfrog' previous (and now unsustainable?) convention – and target strategic and structural change in line with these principles.

3 Regions have different starting points

Early on in its Interreg IIIC phase, Health ClusterNET and its partner regions realised that regions might share some challenges but they usually have different starting points. In effect a "one-size fits all" approach doesn't work. EUREGIO III and its key stakeholders need to take this into account. Also, EU regions are operating within very different SF processes in which health priorities might be profiled (see the Greek example below) or less obvious. Among the regions represented in the Venice event the following are examples of different starting points while addressing challenges that are common across the EU.

3.1 Malapolska and how to translate a vision into impacts

Change and innovation happened because of one person's vision. Initially, the health sector had one major project planned. But it had to be broken down into several projects to achieve this vision. In essence, it was hard to get a lot of money in one go. The vision became doable when it was translated into addressing priorities in the regional operational plan. Investment comes mainly from structural funds and the rest from national/hospital budget

3.2 The Basque Country: limits and possibilities within a Competitiveness & Employment Region

33% of the regional budget is spent by the health department, which pays hospitals. This proportion of the budget is rather static and in the new economic climate, the health sector needs to compete with other policy sectors for funds. Preceding 2008, the health department had already understood the need to change their health system from acute care and hospitalisation to chronic disease management model due to high demand on hospitals and demographics. This is not simply about identifying and understanding the implications of changing epidemiology but reflects the need for a whole spectrum of services including prevention. The change processes and priorities to achieve this happened because of a new politician. In practical terms, pilots on tele-monitoring are currently underway.

As a Competitiveness & Employment Region, the Basque Country is too developed to ask for more money from European Commission. Back in 2004 work was commissioned to estimate the contribution of health expenditure in the region in terms of GDP, employment and tax contribution. It is suggested that if all regions can demonstrate to the Commission that health contribution is important, then could help get more money for this area. This study was shared with Health ClusterNET partners in its Interreg IIIC phase and informs the current development of a benchmarking tool for HCN member regions.

The Basque example is a shared challenge for all regional health systems. Specifically, there is a need to (i) reorganise the system/change processes if they are to be more efficient with the use of funds (from whatever source) (ii) try to position the health system among other policy areas (iii) accept the need for new processes – don't focus on pathologies but on chronic diseases. To this end, the Health Department is trying to facilitate such changes but are finding it hard to link governments, ideas and people.

3.3 Niederoesterreich: cross-border cooperation

There is real competition to attract funds for health sector investment. Lower Austria is currently undertaking 2 cross-border projects and is looking into further funding possibilities. A fairly radical yet pragmatic proposal suggests moving one hospital closer to border with other MS/regions and achieve cross-border cooperation with EU funding.

3.4 Greece and attempts at health in all policies

The Ministry of Health is responsible for a dedicated SF Operational Programme for health that is rare among EU MS. They started in 90s with mental health inclusion and infrastructure programme funded under EU and then developed projects linked to this and focusing on infrastructure and so moved into ERDF. In the current SF period they seek to finance health infrastructure and mental health/public health/wellbeing

policies. This reflects efforts that have been made for some time to get a full package of structural funds for health. Related to this, they have a national health strategy that is disseminated into other operational programmes. However, putting health in different policy areas is not working. For example, the Ministry wanted to set up an operational programme for ESF but this was not accepted. In consequence they had to integrate their priorities under a designated employment programme and absorption has been very low. It is possible that this reflects a relative lack of experience in the health sector to pursue funds in mainstream SF operational programmes that do not have a health 'label'.

4 Key issues affecting use of Structural Funds for health-related investments

4.1 Relationship between national and regional perspectives

There is a real need for:

- Harmonisation of policy (national policy should provide a framework allowing flexible application based on regional starting points/resources etc)
- Overcoming political and competitive tensions
- Managing expectations. SF has its limits. Who decides final portfolio? How and with what criteria are used (these differ between Member States)
- A much stronger whole systems integration approach to Structural Funds including potential links and complimentary investments between ERDF and ESF.

4.2 Balancing between acute care and primary care

The current SF process seems designed to favour high cost infrastructure investment with scant regard for longer-term revenue implications. Across Europe however, regions are shifting their health system focus from an acute care hospital centric systems to more dispersed chronic disease management and elderly care orientated models. In other words larger but fewer specialized centres and a squeeze on the middle ground general acute hospitals – almost certainly leading to a process of rationalization and mergers. In part this is due to high perceived demand on hospitals and demographics e.g. in the Basque Country that has led to pilots on telemonitoring currently underway. Similar developments were also highlighted by regions at an AER Public Health Committee Conference on Financing Regional Health Care at Lodz in March 2009 with particular attention to appropriate service development in largely rural regions.

4.3 Health in all policies

- How to factor in “Health in all policies”? E.g. In Greece, in current period finance health infrastructure and mental health/public health/wellbeing policies Have been fighting for some time to get a full package of structural funds for health. They now have a national health strategy that is disseminated into other operational programmes. But, putting health into different policy areas is not working.
- There is a need both for more evidence about health and its impacts on economic development and use of currently available evidence.
- Regions need to develop their own capacities to bring health, economic and social development together. Regions will have different starting points for this between and within member states, Relatedly, attention might be needed to review existing funding models.
- There is a need for more clarity about how we can contribute to the future development of EU Cohesion Policy.

4.4 Accessing SF

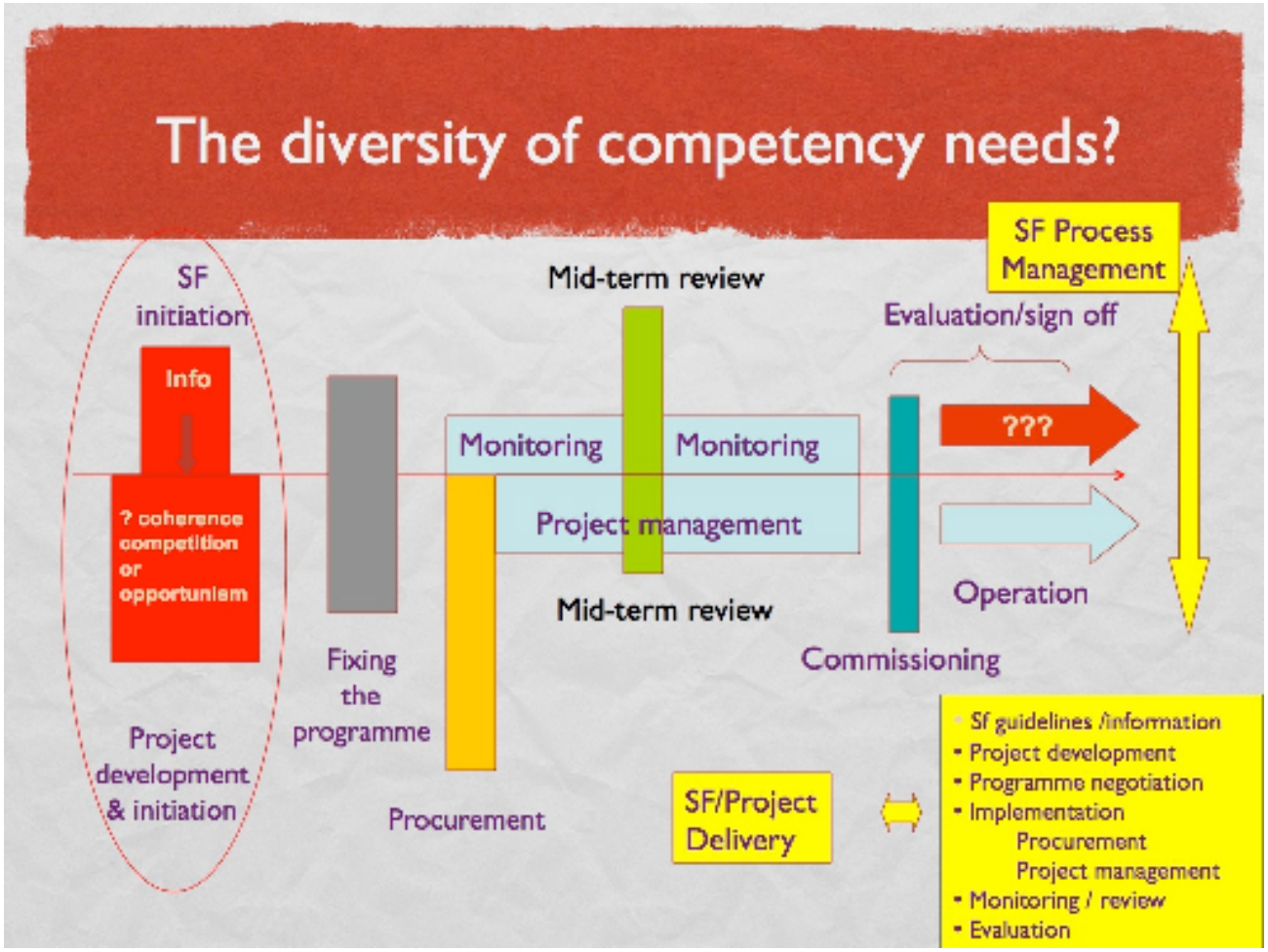
- Competition/cohesion – on which basis to decide allocation of resources between regions? GDP or also quality indicators? In achieving balance will investment plans be sustainable or will they increase debts? Can money be saved – do investments optimise a sector
- In Greece, wanted to do an operational programme for ESF but was not accepted- so had to stick their priorities under the employment programme and absorption is very low
- Programmes seem to based on spending and not strategic planning because of danger of loosing money
- When programme priorities are being agreed there is a need to assess absorption capacity at national and regional levels. What indicators exist that are used by Managing Authorities and Monitoring Committees? Related to this, if investment in competency development is made then how can this be evaluated taking into account short-term vs long-term impact assessment?
- Is it possible to introduce conditionality into ESF/ERDF approval systems and what leverage can be/should be applied?
- Should health needs assessment happen before service planning as it seems to be a fundamental starting point?
- The Basque Country and other regions have estimated the GDP, employment and tax contribution of health expenditure in the region. If all regions demonstrate to Commission that health contribution is important, then could help get more money for this area. Health ClusterNET regions are currently developing a benchmarking pilot project to create comparable assessments.

- Slovenia – for the e-health project was there any broader health and health services strategy defined prior to deciding how to spend the money?

4.5 Good practice

- What is good practice? Is it good practice in process, good practice in project or good practice in final assessment
- How do we know if something labelled good practice is good practice? Proper tools are needed for evaluating projects e.g. are there comparators/benchmarks?
- A new challenge for EUREGIO III has to be if evidence from 2000-2006 projects and SF processes is less relevant now to the new post-2008 operating environment.
- In this sense, many projects are out of date before they start and there is little evidence of projection and forecasting. There is a need for such examples of good practice to inform future projects. WHO Estonian Health system SWOT analysis commissioned. Example of a useful starting point.

Diagram 1: Diversity of competency needs in SF process management and project delivery



4.6 Knowledge and competency

The EUREGIO III project has identified a real range of competency needs across Member States/regions in terms of the SF process and project delivery as summarised in Diagram 1 above. But this understanding leads to a range of new questions and challenges:

- How to know what we need to know?
- How to get to know more (pre-requisites before applying; systems and processes; consultancy)
- Check list of documents showing what do we have to do?
- Evidence about health & impact on economic development needs strengthening
- Regions have to develop own capacities to bring health, economy and social development together
- No clear methods for measuring social and economic impacts (or health ones)
- Lack of knowledge on EU procurement – EC needs to lead on building understanding. But a question of whether the EU procurement process can become more rapid and flexible.

4.7 Cross-border projects

- There is a need to learn from other countries so regions not always competing for SF (some cross boarder projects are happening and provide opportunities to pool resources and not duplicate investment unnecessarily) e.g. the Mental Health project between Zala Region Hungary and Pomurje Region Slovenia; Bordernet HIV/AIDS/STD and the Sialon Project between Veneto region, Slovenia and Fruili Region.
- In next period of SF, co-funding of Danube Strategy or SE Europe strategy and Connections should be used as a support.
- One region is thinking of moving a hospital closer to border and do cross-border cooperation with EU funding.

4.8 Measuring impact

- SF operational programmes are largely impact based (spending based)
- Some outputs are captured but there are questionable outcome measures
- Many investments will need to show demonstrable impact over the longer term. Yet focus is on using inappropriate short-term measures e.g. process not effect

- Need for better/more realistic evidence based correlation between ESF and ERDF aims and objectives in regional policies and projects e.g. employment, few if any bridging measurable links
- There is a need for a toolkit to evaluate health systems and identify the impact of SF on health system indicators.
- EC should define the indicators systems for project evaluation (robust EU structure) before allocating SF. But can this be done in ways that are comparable without being inflexible and therefore not truly showing real outcomes?
- Need for systems of measurement before investment. e.g. How to pre-assess absorption capacity (what are the indictors) if investment in competency is developed then how should this be evaluated? (short-term vs long term)
- Health needs assessments in Portugal, effective project management, BUT has that been evaluated in terms of outcome?
- Not easy to measure impact especially around social and economic change or something so seemingly simple as improving access to care (ehealth Slovenia, scanning in Portugal) are both hard to measure.
- It is easy to talk about health inequalities and projects that make a difference but how to provide evidence given lack of coherence between databases etc. Relatedly, there are problems of reliability and comprehensiveness of current databases. So, a key question is to ask if these are the right databases anyway and more specifically, can the appropriate health indicators be identified and adopted?
- Difference of data systems across Europe and organisation of health systems = a problem for evaluation and follow-up and conditions for use of SF (we recognised that in the first Interreg IIIC phase of HCN. This is why when we looked at the policy implications of identified good practice we did not take a one size fits all approach but enabled regions to develop a menu of recommendations – to cluster policy recommendations based on shared starting points (e.g. EPSON analysis and categories)
- A key next step is to pay more attention to return on investment. Does anyone really know with certainty what we are getting from ERDF/ESF health investments directly or indirectly?

4.9 Achieving added value

The stakeholders at this event were not sure there is much understanding of and tools to assess 'return on investment' and especially how to show added value (health gains) through (i) economic, social and environmental impacts and (ii) economic/social/environmental impacts through health investments

5 Good practice case studies: an emerging critique

Typically when funding processes are reviewed and analysed, although the aims are usually about assessing effectiveness, there is a strong tendency towards an audit based outcome. This is perhaps unsurprising because processes are often viewed in isolation against the background of the views and perspectives of the bureaucracies that have designed and implemented the process and the respondents accessing funds within these process processes and systems. In other words it can end up being a subjective rather than objective outcome.

The needs of the two parties are also not necessarily as convergent as is widely assumed:

- Programme funders are concerned to ensure funds are spent on time, within budget and with due probity as defined by the process; and in accord with overarching strategic aims and objectives
- Potential beneficiaries often (perhaps usually) tend to seek the most effective route to access funds while funders appear to be interested primarily in ensuring that the money is spent; in other words how best to comply with the process to achieve success. This may have a significant price to pay if it avoids focusing on cost effective investments that should include health gains.

Evidence from a major study of capital strategy in Europe run by ECHAA (*Investing in hospitals of the future*. Copenhagen: World Health Organization, on behalf of the European Observatory on Health Systems; 2009. http://www.euro.who.int/observatory/Publications/20090323_1) illustrates the degree to which capital and other investment projects are invariably 'tuned' to fit the processes defined for the particular funding model adopted. In effect, funding models and processes can have a significant and predisposing impact on projects – either at their initial development or subsequent submission stage. This may significantly distort priorities and focus and have unintended consequences.

In the context of Euregio III we are drawing on this learning to analyse representative case studies from the 2000/6 and 2007/13 programmes. This asks three additional questions of the study (one totally unexpected when the project was agreed).

1. Are projects and processes that are over a decade old relevant to the future outlook of European healthcare needs – and the intent of the ERDF / ESF aims and objectives. Health needs and priorities have changed significantly over that time. Has the process kept pace with need and is it sympathetic to the changing and future requirements of a rapidly changing healthcare landscape?
2. To what extent will the 2008/9 financial and economic crisis impact on future ERDF/ESF policy and process and project proposals. It is now only too clear that much of the development of healthcare services and infrastructure has been based on debt creation as opposed to affordable and sustainable financing from assured GDP growth. There is little evidence that this issue of affordability has been tested within the processes adopted. Furthermore many funding agreements are

dependent to large degree on matched funding - with reliance on home government support including the use of public private partnership strategies. The debt crisis changes all. It is already having an influence on the decision criteria for future investment for many of the classic models of capital funding - with the emergence of new risk assessment criteria (slide 5). Some previous match funding strategies have in any event been totally closed off at least for the foreseeable future e.g. some forms of PPP

3. In light of the recent dramatic changes in the future healthcare and economic outlook, to what extent has it been anticipated / or may be envisioned that the process (and the funds allocated) will stimulate progressive change in future healthcare priorities, structures and delivery.

6 Discussion: where to apply practical "how to" knowledge

6.1 The process of decision-making

With National Strategic Reference Frameworks and related SF Operational programmes, funding priorities might seem fairly obvious and transparent. But how these priorities are interpreted and realised as investments can seem less obvious and sustainable if they are driven by a need for short-term political gain e.g. the need to speed up access to and use of SF during and following the post 2008/09 economic crises. In all of this, are needs assessments required and undertaken to inform investment decisions? Are the public consulted about their needs? A stark unknown factor in decision-making for health-related investments is the extent to which available evidence and public participation play a part. In a candidate/pre-accession country such as Albania, the consultancy process is very informal and it is difficult to see a formal process of decision making in health care infrastructure planning and investment. The Albanian representative hopes that Structural Funds financed health investments would institutionalize the process.

6.2 The conditions to deliver change

What is the relationship between national, regional and local perspectives in terms of politics, governance issues (mentioned in Table 1 above) and the above mentioned consultation process. In a sense, a key concern is about how are priorities set regarding which investments are needed and how these are maintained through political changes if they are essential to sustainable development across sectors.

6.3 Leveraging health investments

A whole new area of knowledge and understanding is needed to inform SF applicants and funders about making money available where added value can be predicted or assured e.g. using Structural Funds to leverage added value for health gain?

6.4 Analysing the needs and priorities of health investments

There are two phases for achieving health-related investments through Structural Funds: the planning phase and the implementation phase. Is there a need to separate analyses of the two parts? The planning

phase is more about how do we generate investments ideas and how do we filter them in order to define and describe effective and sustainable projects. The implementation phase has to pay attention not only to the SF process but allow flexibility for project management to adapt objectives, identify and integrate unexpected benefits and review and refine expected outcomes.

6.5 Allocating resources and measuring impact

The European Commission should define a core indicators system for project selection criteria's/evaluation before allocating money. Beyond a core indictors system, Member States and regions should have the flexibility to expand the system to apply locally specific indicators and resource implications. For example, before selecting a healthcare capital investment project for funding attention should be given to ongoing operational costs because there is no need for infrastructure without being able to maintain the cost for 15-25 years. This pre-requisite is important for sustainable development.

7 What EUREGIO III can deliver

The old financial world is gone. Investment can't simply continue on debt creation. EUREGIO III will help stakeholders navigate this new environment by delivering practical knowledge to inform:

- A context framed analysis and recommendations about improving the Structural Fund process for health related investment
- A new approach to competency development through practical knowledge, workshops and master classes
- A starting point for the development of new 'health' and 'generic' indicators

In this sense, EUREGIO III is just the start of an ongoing capacity building process focused on providing practical "how-to" knowledge on health & structural funds to SF Managing Authorities, Intermediary Bodies and SF beneficiaries. As important, this new knowledge is supported by growing understanding of the competencies needed for accessing and using Structural Funds for health-related investments in ways that provide returns on investment that are cost-effective and sustainable. In this sense, the ability to align health sector investments with sustainable development is a key challenge for regional health policy. It will help to identify where investments can be made that are likely to result in sustainable growth and major health gains. This takes regional health policy and health sector investments (where power and political influence is vested in bricks and mortar, as well as service provision) beyond traditional boundaries. This is a particular challenge for the new SANCO/CoR Technical Platform.

ANNEX 1
LIST OF PARTCIPANTS
EUREGIO III project,
Venice Stakeholder Event
25-26 February 2010

N°	Name	Surname	Position	Organization	Address	Country	E-mail
1	Andrea	Frosini	Intellectual Property Manager	Toscana Life Sciences Foundation	Via Torre Fiorentina 1, Siena – 53100	Italy	a.frosini@toscanalifesciences.org
2	Andrea	Horner	EUREGIO III Financial Manager	HEALTH CLUSTERNET	Goldcrest Way Newburn Riverside, Newcastle upon Tyne, NE15 8NY	UK	andrea@healthclusternet.eu
3	Antal	Ling	Consultant	Gress-ing Kft.	Rózsa u. 96 E. lépcsőház G/1, Budapest - H-1064	Hungary	Ling.antal@gmail.com
4	Barrie	Dowdeswell	Director of Research	ECHAA /EUREGIO III	Pinecrest, Longrigg, Riding Mill-Ne446al: Northumberland	UK	barriedowdeswell@aol.com
5	Carina	Kainz		Lower Austria Health and social Fund	Stattersdorfer Hauptstrasse 6 B, St. Pőlten – A-3100	Austria	carina.kainz@noegus.at

N°	Name	Surname	Position	Organization	Address	Country	E-mail
6	Cristina	Pires	Head of Project/ Head of Department	Operational Programme of Health	Av. D. João II, Lote 1.07.2.1-2° andar – 1998-014 Lisbona	Portugal	cristina.pires@povt.qren.pt
7	Dario	Zanon	Director, Litoral District	Health Authority nr. 10, Veneto Region	Piazza de Gasperi, 5 – San Donà di Piave, 30027	Italy	dario.zanon@ulss10.veneto.it
8	Debbie	Stanistreet	Senior Lecturer	University of Liverpool	School of Population, Community and Behavioural Sciences Univ. of Liverpool Whelan Building Liverpool L69 3GB	UK	Debbi@liv.ac.uk
9	Dessi	Dimitrova	Adviser to the Deputy Prime Minister and Minister of Finance	Council of Ministers/ Ministry of Finance	1 Dundukov Street, 1000 – Sofia	Bulgaria	dessi.d.dimitrova@gmail.com

N°	Name	Surname	Position	Organization	Address	Country	E-mail
10	Edit	Sebestyén	EUREGIO III PROJECT COORDINATOR/ HEALTH CLUSTERNET	HEALTH CLUSTERNET	Kutvölgyi u. 2, Budapest – 1125	Hungary	edit@healthclusternet.eu
11	Edmund	Skorvaga	Civil servant	Ministry of Health of the Slovak Republic	Limbová 2 Bratislava – 83752	Slovakia	edmund.skorvaga@health.gov.sk
12	Eleftheria	Lehmann	Director General	NRW Institute of Health and Work	Ulenbergstrasse 127-131, Duesseldorf – D-40225	Germany	eleftheria.lehmann@liga.nrw.de
13	Elisa	Boscolo	Project manager	Office of International Health and Social Services, Veneto Region	2847, Palazzo Cavalli Franchetti, S.Marco – Venezia – 30124	Italy	elisa.boscolo@regione.veneto.it
14	Erio	Ziglio	Head of office	WHO Regional office for Europe, European Office for Investment for Health & Development	San Marco 2847 Venice – 30124	Italy	ezi@ihd.euro.who.int cco@ihd.euro.who.int

N°	Name	Surname	Position	Organization	Address	Country	E-mail
15	Georgios	Margetidis	Scientific Project Officer	Executive Agency for Health and Consumers (EAHC)	DRB/A3-058 Commission Européenne Rue Alcide de Gasperi L-2920	Luxemburg	georgios.margetidis@ec.europa.eu
16	Igor	Krampac	Head of Regional Center for Public Health and Health Promotion	Regional Public Health Institute, Maribor	Prvomajska, 1, Maribor – 2000	Slovenia	Igor.krampac@zzv-mb.si
17	Isabel Mendes	Martins	Head of Department of Internal Audit	Operational Programme of Health	Av. D. João II, Lote 1.07.2.1-2° andar – 1998-014 Lisbona	Portugal	isabel.martins@povt.qren.pt
18	Ivan	Erzen	Ministry of Health	State Secretary	Štefanova 5 Ljubljana – 1000	Slovenia	ivan.erzen@gov.si

N°	Name	Surname	Position	Organization	Address	Country	E-mail
19	Jonathan	Watson	Executive director	HEALTH CLUSTERNET	5 Venlaw Road, Peebles – EH45 8AY Scotland	UK	jonathan@healthclusternet.eu
20	Jonathan	Erskine	Senior Research Associate	European Health Property Network	F119, Wolfson Research Institute, Queen's Campus, Durham University, University Boulevard, Stockton-on-Tees – TS17 6BH	UK	Jonathan.erskine@durham.ac.uk
21	José	Pacheco	Board Member	Regional Health Administration of Algarve	Largo do Carmo, nº 3 Faro – 8000 – 148	Portugal	jpacheco@arsalgarve.min-saude.pt
22	Joyeeta	Guha	Researcher	University of Liverpool	School of Population, Community and Behavioural Sciences University of Liverpool Whelan Building Liverpool L69 3GB	UK	j.guha@liv.ac.uk

N°	Name	Surname	Position	Organization	Address	Country	E-mail
23	Judith	Willert		Lower Austria Health and social Fund	Stattersdorfer Hauptstrasse 6 B, St. Pölten – A-3100	Austria	Judith.Willert@noegus.at
24	Kai	Michelsen	Assistant Professor	Department of International Health, Maastricht University	P.O. Box 616 Maastricht – 6200 MD	The Netherlands	Kai.Michelsen@inthealth.unimaas.nl
25	Klodian	Rjepaj	Chief of Cabinet	Ministry of Health	Bulevardi "Bajram Curri" Nr. 1, Tiranë	Albania	krjepaj@moh.gov.al
26	Kurt J.G.	Schmailzl	Medical Director, Professor for International Health Management	Ruppiner Kliniken GmbH, Brandenburg, Germany	Ruppiner Kliniken GmbH, Medizinische Klinik A, Fehrbelliner Strasse 38.Neuruppin – 16816	Germany	kjgs@gmx.net
27	László	Kornya	Director	St. Stephen Hospital & Municipality of Budapest	Óra út 9, Budapest – H-1125	Hungary	kornya@vitalitas.hu

N°	Name	Surname	Position	Organization	Address	Country	E-mail
28	Ledia	Agolli	Adviser on International Relations	Ministry of Health	Bulevardi "Bajram Curri" Nr. 1, Tiranë	Albania	lagolli@moh.gov.al
29	Luigi	Bertinato	Head of office of International Health and Social Services	Veneto Region	2847, Palazzo Cavalli Franchetti, S.Marco – Venezia - 30124	Italy	luigi.bertinato@regione.veneto.it
30	Manuela	Cocchi	Coordinator of the Operational Unit for Planning and Management of the EU Structural Funds in the Health Sector	Quality Department, General Directorate of Health Planning, Essential Care and Ethical Principles of the health system, Ministry if Health	Viale Giorgio Ribotta, 5 Roma – 00144	Italy	m.cocchi@sanita.it
31	Margit	Ohr	WP Leader, EUREGIO III	HEALTH CLUSTERNET	Kutvolgyi ut 2 Budapest – 1125	Hungary	ohr@policy.hu
32	Marie Astrid	Libert	Project coordinator	COCIR	80 Boulevard Reyers – Brussels 1030	Belgium	office@cocir.org

N°	Name	Surname	Position	Organization	Address	Country	E-mail
33	Mieczyslaw	Pasowicz	Head	The John Paul II Hospital	80, Pradnicka St., Krakow – 31-202	Poland	m.pasowicz@szpitaljp2.krakow.pl
34	Nelly	Barbon	Interreg IVC and MED programme regional officer	Veneto Region	DORSODURO 3494/A, Venice Postcode: 30123	Italy	Nelly.barbon@regione.veneto.it; Interreg@regione.veneto.it
35	Oliver	Komma	Junior fellow	Semmelweis University, Health services Management Training Center	Kútvölgyi út 2., Budapest – 1125	Hungary	komma@emk.sote.hu
36	Ourania	Georgoutsakou	Senior Policy Coordinator, Social Policy and Public Health	Assembly of European Regions	Assembly of European Regions Place Sainctelette, Brussels – 1020	Belgium	g.ourania@aer.eu

N°	Name	Surname	Position	Organization	Address	Country	E-mail
37	Paolo	Stocco	General Director	Health Authority nr. 10, Veneto Region	Piazza de Gasperi, 5 – San Donà di Piave, 30027	Italy	paolo.stocco@ulss10.veneto.it
38	Patricia	Arratibel Ugarte	Insurance and public health contracting officer	Ministry of Health of Basque country Gobierno vasco – Departamento De sanidad y Consumo, Direccion de Aseguramiento y contratacion sanitaria	C/ DONOSTIA-SAN SEBASTIAN, 1-: VITORIA-GASTEIZ - 01010 – VITORIA-GASTEIZ	Spain	p-arratibel@ej-gv.es
39	Peter	Pazitny	Executive Director	Health Policy Institute	Hviezdoslavov o nam. 14, Bratislava – 83102	Slovakia	pazitny@hpi.sk

N°	Name	Surname	Position	Organization	Address	Country	E-mail
40	Rostislava	Dimitrova	Policy Officer	Unit C5. Health Strategy and Health Systems, DG SANCO, European Commission	Rue Breydel, 4 1049-Bruxelles B232, 08/003	EU	Rostislava.DIMITROVA@ec.europa.eu
41	Rui	Lourenço	Head of the Board	Regional Health Administration of Algarve	Largo do Carmo, nº 3 Faro – 8000 – 148	Portugal	rlourenco@arsalgarve.min-saude.pt
42	Sara	Pavoncello	Member of the Operational Unit for Planning and Manageme nt of the EU Structural Funds in the Health Sector	Quality Department, General Directorate of Health Planning, Essential Care and Ethical Principles of the Health Ssystem, Ministry if Health	Viale Giorgio Ribotta, 5 Roma – 00144	Italy	s.pavoncello@sanita.it
43	Silva	Mitro	Project Manager	Health Authority nr. 10, Veneto Region	Piazza de Gasperi , 5 – San Donà di Piave, 30027	Italy	silva.mitro@ulss10.veneto.it
44	Silvia	Boni	FORMEZ Manager	FORMEZ	Formez Viale Marx, 15 Roma – 00137	Italy	sboni@formez.it

N°	Name	Surname	Position	Organization	Address	Country	E-mail
45	Simone	Giotto	Project Manager	Office of International Health and Social Services, Veneto Region	2847- Palazzo Cavalli Franchetti, S.Marco – Venezia – 30124	Italy	simone.giotto@regione.veneto.it
46	Simonetta	Scaramagli	Head of office of Internationa l Care	Health Authority nr. 10, Veneto Region	Piazza de Gasperi ,5 – San Donà di Piave, 30027	Italy	simonetta.scaramagli@ulss10.veneto.it
47	Sira	Bizzotto	Hygiene and preventive medicine resident	Via Venturini, 82, Silea (Tv) – 31057		Italy	Sira.bizzotto@gmail.com
48	Stavros	Divanis	Strategy Programmin g and Evaluation Officer	Special Service Hewalth and Solidarity, Ministry of Health of Greece	1A, Gladstonos str, Athens Postcode: 10677	Greece	sdivanis@mou.gr
49	Sue	Woolf	Researcher	University of Liverpool	School of Population, Community and Behavioural Sciences University of Liverpool Whelan Building Liverpool L69 3GB	UK	suewoolf@liv.ac.uk

N°	Name	Surname	Position	Organization	Address	Country	E-mail
50	Szilvia	Marfyne Kerekes	Project coordinator	Semmelweis University, Health Services Management Training Center	Kútvölgyi út 2, Budapest – 1125	Hungary	kerekes@emk.sote.hu
51	Tiia	Taevere	Project Manager	Ministry of Social Affairs	Gonsiori 29, Tallinn – 15027	Estonia	tiia.taevere@sm.ee
52	Tommaso	Pucci	Officer	Directorate General of Health and Solidarity Policies Tuscany Region	Via Alderotti 26/N, Florence – 50139	Italy	Tommaso.pucci@regione.toscana.it
53	Urmos	Andor	Policy analyst	DG REGIO, European Commission	European Commission – Rue Pere de deken, 23 Office: CSM1 04/67 – 1049 Brussels – Belgium	EU	andor.urmos@ec.europa.eu

	Name	Surname	Position	Organization	Address	Country	E-mail
54	Tamás	Balogh	Head of Department	Development Policy and Strategy Analysing Department, Ministry of Health	1051 Budapest, Arany János u. 6-8.	Hungary	tamas.balogh@eum.gov.hu
55	Jose Agustin	Ozamiz	Chief of Health Insurance, Prof at Deusto University (Bilbao)	Health Department of Basque Government, Ministry of Health	Govierno Vasco,C/ Donostia – Sansebastian Nº 1, 01010 Vitoria-Gasteiz	Spain	jaozamiz@ej-gv.es
56	Merril	Oates	IT manager of Euregio3 web	Health ClusterNET	EMK, Kutvolgyi ut 2 , Budapest 1125 Hungary	Hungary	merrill@healthclusternet.eu

57	Antonella	Biasotto	Program Assistant	WHO Regional office for Europe, European Office for Investment for Health & Development	San Marco 2847 Venice – 30124	Italy	abi@ihd.euro.who.int
58	Valerie	Cogan	Secreteray	WHO Regional office for Europe, European Office for Investment for Health & Development	San Marco 2847 Venice – 30124	Italy	vco@ihd.euro.who.int