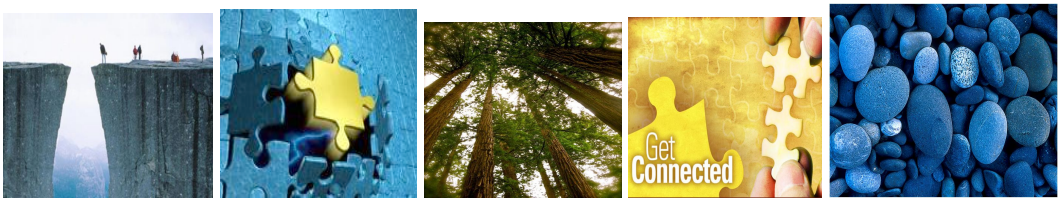

EUREGIO III: lessons learned about improving investment in regional health systems using Structural Funds

EXECUTIVE SUMMARY

HCN, ECHAA, EMK-SU, UM, UL, ULSS10 Veneto
March 2012

Foreword

This report outlines the evidence and learning produced by the EUREGIO III project (2009-2011). It explored and assessed the use of SF for direct health investment in the 2000-2006 and 2007-2013 SF periods. During this time the predominant SF investments focused mainly on capital expenditure for hospital and health facility renewal and eHealth projects. The project therefore aimed to anticipate the mood of change in healthcare as it addresses future flashpoints, demography, chronic disease and an uncertain economic outlook, by concentrating on those areas of spending likely to prove critical to 'improving future healthcare'. It found that the current SF process tends to favour single (monofocus) projects. This is a paradox. The EU Council Conclusions *Towards modern, responsive and sustainable health systems* (6 June 2011) advocates strongly the need to develop a more integrated and pluralistic model of healthcare in place of the hospital-centred default model common across all MS. SF will have a major role to play in supporting this shift. However just as the accent is moving towards integration as a characteristic of structural change, SF projects and spending focus must be similarly integrated, including between ERDF and ESF and Infrastructure and eHealth. This will be a major challenge. In this context, EUREGIO III provided good evidence to inform the Hungarian EU Presidency Programme, which in turn generated comment in the 'Conclusions' about the future 'investment' importance of SF. A further complex issue is the nature of innovation and impact of SF projects. Innovation tends towards the technical element of projects, in particular eHealth, as opposed to achieving innovative and sustainable outcomes. This can be observed in the general weakness in applying lifecycle operational and economic principles to project proposals. Concept planning and decision criteria need particular attention in this respect. However it also important to note a nucleus of innovative projects emerging within the past year or so that capture both the spirit and letter of Europe 2020, for example active and healthy ageing, and which will provide exemplars of good practice on which to build for the future. There is one further important finding, in particular emerging from masterclasses and workshops, if SF investment is to become more effective there will be a need for new concepts to be accompanied by investment in new knowledge, competencies and tool kits to manage the more complex changes ahead.

Professor Jonathan Watson. Executive Director Health ClusterNET ; Project Leader for EUREGIO III
Barrie Dowdeswell. Research Director ECHAA
21 March 2012

Acknowledgements

This project could not have achieved its timely impact without the commitment, expertise, intelligence and insight provided by associate partners, collaborating partners, EAHC and EC line Directorates (SANCO, REGIO and EMPLOY). Barrie Dowdeswell (ECHAA) led the development of incomparable case material with support from the team at Imperial College London. Crucial to this was the full support and contribution of the regions/organisations responsible for the selected case studies. An active dissemination platform was delivered through training workshops (Debbie Stanistreet and Sue Woolf from University of Liverpool) and master classes (Oliver Komma and Szilvia Márfyné Kerekes from EMK Semmelweis University). These events were also informed by a stakeholder analysis and capacity building audits conducted by Margit Ohr (HCN). ULSS10 Veneto guided dissemination activity (through Silvia Mitro and Dario Zanon). The University of Maastricht (Kai Michelsen) led project evaluation. Project coordination relied on the patience, skills and understanding of Edit Sebestyen (HCN). The project also benefited immensely from perspectives provided by reference group members led by Ourania Georgoutsakou (AER). A special mention should also go to Dr. Miklós Szócska, Hungarian Minister of State for Health who invited Barrie Dowdeswell to introduce the project and its interim findings as part of Barrie's keynote presentation to the informal Health Minister's meeting in Godollo during the Hungarian EU Presidency. Ultimately, EUREGIO III and its partners benefited from the thoughtful and stimulating support provided by EAHC Project Manager, Georgios Margetidis.

Key words

Regional; Health systems change; Health Infrastructure; eHealth; Technology; Innovation; Competency

EXECUTIVE SUMMARY

1 Project scope and objectives

The main factor affecting EU regional health systems during this project has been significant change: demographic, epidemiological, technological and economic. The general objective of the project evolved into generating evidence from existing SF projects that can show how to improve the effectiveness, efficiency and sustainability of direct health system investments using Structural Funds in the next cycle 2014-2020.

2 Methods and means

The underlying method & structure for EIII followed the logic of the Policy Action Cycle: Assessment, Policy Development, Assurance and Evaluation. Evidence was generated and shared with stakeholders (SF Managing Authorities, Health Ministries, EC line directorates, regional authorities, SF beneficiaries) through: in depth case studies; stakeholder surveys; capacity building audits; a review of the development and sharing of practical knowledge; training workshops, master classes and other stakeholder events.

Table 1: Relationship of case studies[1] to new priority focus areas identified by EUREGIO III, EU Council Conclusions (6 June 2011) and draft Cohesion Policy 2014-2020 Proposal

Case study	Healthcare reform and masterplanning	Integrated care	eHealth and technology innovation and integration	Healthy ageing	Hospital development / redevelopment
Hungary masterplanning	***	**			
Slovakia masterplanning	***				**
Kymelaasko Finland masterplanning	***	***		**	**
Brandenburg Germany Cardiovascular care	**	***	***		
Sicily • Health needs assessment • Technology assessment • Technology investment	*	*	***		*
Norbottenland, Sweden eHealth		***	***	*	
Greece, Cancer Centre					***
Slovenia eHealth			***		
Poland, Hospital Investment			**		***
Greece, mental Health, Autism Services	***	**			

The challenge for EUREGIO III was how to ensure that case material looks forward to the new challenges affecting the EU, its Member States and regions. This meant a late reshaping of case studies that offer relevant and important precedents and learning experience for the future; where investment strategy must address at minimum:

- The rapidly changing demands on healthcare services in particular an ageing population (healthy ageing) and the rise in chronic illness
- A slow down (and possible reduction) in new resource availability – likely to be particularly acute in the capital sector due to the problems arising from the credit crisis
- The outcomes of the Hungarian Presidency, EU Council Conclusions in calling for reform of health systems to move on from an unsustainable hospital-centred model towards more sustainable and

[1] Information on each case study and how material was collected and analysed can be found at: http://www.euregio3.eu/pages/practical-knowledge-database/

effective integrated care systems
- The reinforcement coming from the new Cohesion Policy draft guidelines underpinned by Europe 2020 which in turn highlight specific areas of concern – and opportunity e.g. healthy ageing / eHealth.
- The need for health investment to make a greater economic related contribution to growth

3 Findings and potential impact

The process of developing modernised care structures and procuring new healthcare services based on use of structural funds is complex. Case study fieldwork, secondary data analysis and feedback from training workshop and master class participants identified specific areas of concern affecting all stakeholders resulting from the SF process and its application in Member States and regions. These include:

- Facing future financial instability and uncertainty the drive for development resources trumps strategy development or sustainability considerations
- Substituting missing strategic policy level directions with project level instruments supports short-term tactical easement of problems rather than transformative change
- Lack of strategic integrative coordination between projects funded from a range of sources and addressing the various levels of care provision undermines service and intersectoral coherence
- Lack of or unclear intervention logic for tactically funded projects undermines ability to select major interventions that are most likely to be effective, and identify the key results that can be monitored to show interventions (and SF investment) work.
- Renewal (or replication) rather than reform/transformation has been the focus of capital investment in the 2000-2006 and current SF period,
- The favouring of high-cost single project infrastructure investment with funded projects not fully assessing longer-term revenue implications is facilitated by a lack of infrastructure strategy and integrated operational planning
- Poorly-timed or ad hoc stakeholder engagement and consensus building delaying key decisions in implementing SF projects
- Organisations seeking to access SF often see themselves as EU funding process illiterate leading them to invest excess resources in grant application, strategic consultancy and/or external project management
- The size of infrastructure investments are often not matched by the necessary development of human capital
- The development of eHealth investments to support integration/continuity of care is significantly under-developed, with little evidence of measurable operational impact.
- Lack of independent guidance and expertise at the level of individual projects, programmes and SF negotiations.

The recent 'Lisbon evaluation' of SF tends to mirror many of these findings. Overcoming such shortcomings will be implicit in the determination of future SF strategy. This is critical if current pressures are to be satisfactorily addressed. In this context, the projects in Table 1 above were selected because they offer good practice pointers for *the future shape of things to come*. For example:

- Measurable contribution to reducing health inequalities;
- Consistency with Europe 2020 aims and objectives;
- Coherence with masterplanning frameworks and regional development plans;
- Planning high risk investment for example capital intensive high technology projects;
- Maximising the potential of ICT in the health sector with particular regard to eHealth;
- Improving workforce competencies and skills;
- Shifting emphasis from short-term tactical response and focus (the on time on budget orientation of much SF evaluation) towards sustainable strategic investment.

4 Strategic relevance and contribution to the 2008-2013 Health Programme

To date, evidence from EUREGIO III has helped shape both the Hungarian EU Presidency programme content and a presentation to the informal meeting of EU health ministers (Godollo, Hungary, April 2011). The EU Council then endorsed the programme recommendations in the EU Council Conclusions of 6th June 2011.

Subsequently, EUREGIO III learning was used as the basis for an introductory guide for DG REGIO desk officers (*Health infrastructure and health service priorities in the post 2013 programming period in convergence regions*).

In looking to the near future, the findings and learning from EUREGIO III will be especially relevant to (i) informing negotiations for the next cycle of Structural Funds and (ii) selected case studies will form part of the evidence for the High Level Reflection Sub-Group 2 led by Hungary and which will address – *Defining success factors for the effective use of Structural Funds for health investments*. Overall, EUREGIO III contributed to priority action 3.3.2 of the Work Plan 2008 that aimed at reducing health inequalities in the EU. It also addressed basic principles of "Together for Health" (e.g. Principle 2 "Health is the Greatest Wealth") and priorities in the pending *Health for Growth* strategy for 2014-2020 and the EIP-AHA Strategic Implementation Plan.

5 Conclusions and recommendations

Future SF investment in health systems should avoid opportunistic or ad-hoc projects. These are inadequate in meeting needs for transformational change to deliver more sustainable healthcare models aligned to regional development plans, national reform programmes and/or health strategies. While not explicitly mentioned in EU2020 health is included twice as an ex ante conditionality (8.4 'active & healthy ageing' and 10.2 'health') in the draft regulation for Cohesion Policy 2014-2020. So, opportunities for SF investment in health care exist but it remains difficult to predict the extent of such ERDF or ESF investment during the next SF period.

SF Managing Authorities, intermediaries (such as MoH) and potential SF beneficiaries should consider the following when preparing health investment priorities for partnership contracts and operational programmes during SF negotiations:

- **Realistic starting points** - taking into consideration the peculiarities of socialised, non-reformed health systems especially in the EU10
- **Commitment to transformational change** – prioritising the shift away from a hospital-centric model of care to more pluralistic community-based and integrated models of care contributing to sustainable health systems
- **Affordable investment priorities** – how SF spending can contribute to structural changes in the delivery of health services. With ERDF this is likely to include e-health, infrastructure and equipment. ESF can compliment this with due attention to workforce development, maintenance and access to employment for people from marginalized social groups
- **Sustainable investment** – the increasing shortage of resources and limited supply of future capital will place a premium on sustainable investment projects that deliver both operational and economic lifecycle value. Adaptability and flexibility will become new critical success factors. This will be essential in a service where rapid and often unpredictable change in clinical technologies and models of care is axiomatic.
- **Address health inequalities** - this will include access to basic health services (GP, outpatient clinic, polyclinic, community based care) by poor and marginalised communities – the unequal distribution of poverty, population, and health infrastructure (NUTS3 targeting and allocation of ERDF, as it is requested in conditionalities, thematic objective 10).

Finally, EUREGIO III has completed its initial stage but there is increasing demand at EU, national and regional levels for knowledge & learning generated by the project (knowledge brokering) as well as guidance & support for translating them into practice (capacity building and technical support).