# Health and Structural Funds in 2007-2013:

# Country and regional assessment

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Health & Consumers

Summary Report

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## Executive summary

This summary report reflects work regarding health investments and Structural Funds in the 2007-2013 period. Where clear financial figures are used these reflect planned spending of Structural Funds. The mid-term review of the current funding period in 2011should provide a clearer picture of real and probable health spend.

Three main areas of investment are identified. The first two areas of direct and indirect health investment indicated in the National Strategic Reference Frameworks (NSRFs) and Operational Programmes (OPs) for 2007-2013 include: health infrastructure, e-health, inpatient care, access to health care by vulnerable social groups, emergency care, medical equipment, screening, health and safety at work, health promotion and disease prevention, education and training for health professionals. Overall, these investments and the third area "non-health sector investments" with potential health gain address the basic principles of the White Paper "*Together for Health: A Strategic Approach for the EU 2008-2013"* adopted by the European commission in October 2007. Although many Europeans enjoy a longer and healthier life than previous generations, major inequities in health[1] exist between and within Member States and regions, as well as globally. In particular, by using Structural Funds for health, the EU principle of "Health in all Policies" reaches a new dimension that can be systematically pursued within member states and regions.

The identifiable element of planned direct health sector investment (mainly in health infrastructure) at around €5 billion represents just 1.5% of total Structural Funds and draws mainly on available ERDF funding (Figure 1).

Also, indirect health sector investment (Figure 2) does not yet clearly indicate what investments will flow into the health sector as a result of relevant investment priorities. For example, workplace health might be initiated by employers and organisations in the public, private and NGO sectors but will need onward investment into public health services to support development and implementation.

Relatedly, Figure 3 and the associated the EU27 country assessment templates identify a wide range of non-health sector investment where added value in terms of health gain is possible, though difficult to quantify. Instead, attention should be given to extending the impact evaluation of non-health sector investments to assess anticipated and unanticipated health gains related to the wider economic, social and environmental determinants of health.

1 Defined as inequalities in health that are avoidable and unfair.

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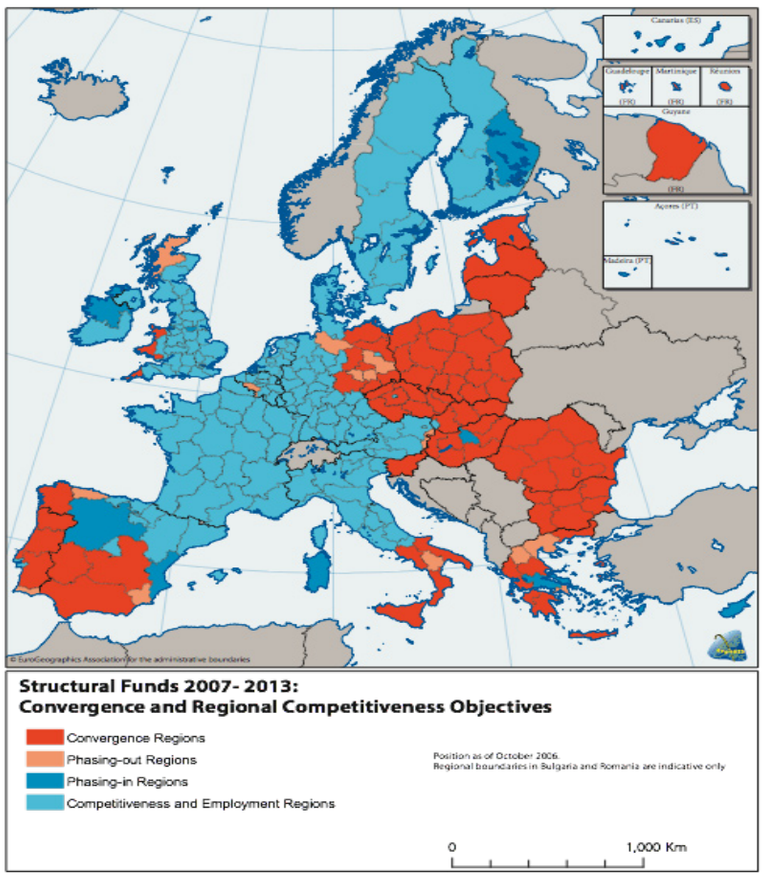
# GLOSSARY

| | |
|---|---|
| CF | Cohesion Fund |
| EBRD | European Bank for Reconstruction and Development |
| EIB | European Investment Bank |
| ERDF | European Regional Development Fund |
| ESF | European Structural Fund |
| EU MS | European Union Member State |
| GDP | Gross Domestic Product |
| NSRF | National Strategic Reference Framework |
| OEM | Original Equipment Manufacturer |
| OP | Operational Programme |
| PMC | Performance Management Group |
| ROP | Regional Operational Programme |
| SME | Small and Medium Size Enterprises |
| SFs | Structural Funds |

**LEGEND FOR COUNTRY ASSESSMENT TEMPLATES:**

| | |
|---|---|
| E | Economic |
| S | Social |
| P | Personal |
| Env | Environment |

# INTRODUCTION




Between EU Member States, total health sector expenditure ranges from 4.9% to over 10.7% of GDP[2]. This is a significant level of economic activity and is likely to be reflected in total health sector expenditure as a percentage of GDP at regional level. However investment in health is not optimized in all regions to contribute to regional development agendas.

The use of Structural Funds (SFs) in the 2000-2006 period and especially in the current period provide a clear opportunity to maximise direct and indirect health gains. The role of health in generating economic wealth and prosperity has been recognised in the cohesion priorities for investment, identified by the European Union for 2007-2013[3]. The present report and the associated EU-27 country assessment templates are intended to inform the reader about the allocated resources and potential health gain to be achieved through the use of SFs in the current period.

The main areas of direct and indirect health investment indicated in the NSRFs and OPs for 2007-2013 include: health infrastructure, e-health, inpatient care, access to health care, emergency care, medical equipment, screening, health and safety at work, health promotion and disease prevention, education and training for health professionals.

2 France (10.7%) Estonia (4.9%): EUROSTAT 2005.

3 Council Decision on Community Strategic Guidelines on Cohesion, (2006/702/EC) - http://ec.europa.eu/regional_policy/sources/docoffic/2007/osc/l_29120061021en00110032.pdf

# BACKGROUND

## A. Cohesion Policy

The new 27 NSRFs agreed between the Member States and the European Commission in 2007 and applied through thematic and regional Operational Programmes identify the investment priorities, which also include health.. These priorities comply with the objectives of the *Community Strategic Guidelines for Cohesion* (2006), which include a specific chapter on "help maintain a healthy labour force"[4]. European cohesion policy has also become one of the main drivers for achieving the goals of the renewed Lisbon Strategy.[5] Cohesion Policy is applied through four three regional cohesion objectives: convergence regions (including phasing-out regions); competitiveness and employment regions[6] (including phasing-in regions) and the European Territorial Cooperation objective.

This new Cohesion Policy has three goals:

- To provide a more strategic approach to growth, socioeconomic and territorial cohesion: ensuring a closer link with the Lisbon strategy with key priorities set out at EU level in the . the Community Strategic Guidelines) and delivering an annual report of the Commission and Member States to be debated by the Spring European Council;

- Simplification: by reducing the number of objectives and regulations,throughsingle-fund programmes, streamlined eligibility rules for expenses; more flexible financial management and through more proportionality and subsidiarity regarding control, evaluation and monitoring;

- Decentralisation through the stronger involvement of regions and local players in the preparation of the programmes;

Within the total of €347.4 billion allocated for this period: 81.5% has been allocated to the convergence objective (convergence and phasing-out regions), 16% to the competitiveness and employment objective (including phasing-in regions) and 2.5% to the European territorial cooperation objective.[7]

Under the ***Convergence objective*** the aim is to promote growth-enhancing conditions and factors leading to real convergence for the least-developed Member States and regions. In the EU-27, this objective concerns – within 17 Member States – 84 regions with a total population of 154 million, and per capita GDP at less than 75 % of the Community average, and – on a "phasing-out" basis – another 16 regions with a total of 16.4 million inhabitants and a GDP only slightly above the threshold, due to the statistical effect of the larger EU. The amount available under the Convergence objective is €282.8 billion, representing 81.5 % of the total. It is split as follows: €199.3 billion for the Convergence regions, while €14 billion are reserved for the "phasing-out" regions, and €69.5 billion for the Cohesion Fund. The latter applies only to 15 Member States who show a Gross National Income (GNI) per inhabitant less than 90% of the Community average.

Outside the Convergence regions, the ***Regional Competitiveness and Employment objective*** aims at strengthening competitiveness and attractiveness, as well as employment, through a two-fold approach. First, development programmes will help regions to anticipate and promote economic change through innovation and the promotion of the knowledge society, entrepreneurship, the protection of the environment, and the improvement of their accessibility. Second, more and better jobs will be supported by adapting the workforce and by investing in human resources. In EU-27, a total of 168 regions will be eligible, representing 314 million inhabitants. Within these, 13 regions that

4 Council Decision on Community Strategic Guidelines on Cohesion, (2006/702/EC) - http://ec.europa.eu/regional_policy/sources/docoffic/2007/osc/l_29120061021en00110032.pdf

5 http://ec.europa.eu/growthandjobs/key/cohesion-policy/index_en.htm

6 See Annex A. Regional Cohesion Groups

7 See website of DG REGIO: http://ec.europa.eu/regional_policy/policy/object/index_en.htm

are home to a total of 19 million inhabitants represent so-called “phasing-in” areas and are subject to special financial allocations due to their former status as “Objective 1” regions. The amount of €55 billion – of which €11.4 billion is for the “phasing-in” regions – represents just below 16% of the total allocation. Regions in 19 Member States are concerned with this objective.

The former programmes Urban II and Equal are integrated into the Convergence and Regional Competitiveness and Employment objectives.

The ***European Territorial Co-operation objective*** will strengthen cross-border cooperation through joint local and regional initiatives, trans-national cooperation aiming at integrated territorial development, and interregional cooperation and exchange of experience. The population living in cross-border areas amounts to 181.7 million (37.5 % of the total EU population), whereas all EU regions and citizens are covered by one of the existing 13 trans-national co-operation areas. €8.7 billion (2.5 % of the total) available for this objective is split as follows: €6.44 billion for cross-border, €1.83 billion for trans-national and €445 million for inter-regional co-operation.[8]

Additionally, the European Commission adopted in November 2006 a new initiative for the 2007-2013 programming period under the Territorial Cooperation objective called **“Regions for Economic Change”**[9]. It introduces new ways to dynamise regional and urban networks and to help them work closely with the Commission, to have innovative ideas tested and rapidly disseminated into the Convergence, Regional Competitiveness and Employment, and European Territorial cooperation programmes. Financing for the networks projects linked to the initiative is possible under INTERREG IVC (the 2007-2013 interregional cooperation programme) and URBACT II (the 2007-2013 cooperation programme on urban issues).

In the context of the Regions for economic change initiative, two health-related themes have been identified dealing with the themes of “Making Healthy Communities” and “Promoting healthy workforce in healthy workplaces”[10]. Under the first theme an URBACT network of 10 European cities has been established and started work from January 2009. One of its objectives is to focus on the use of Structural Funds in developing health gains.[11]

**Key point** - *The planned total sum of direct health investments (primarily in health infrastructure) for the 2007-2013 phase is approximately €5 billion (about 1.5% of total SFs). However, NSRFs and OPs also show that health gains will be achieved through indirect investments that include health sector impacts as well as impacts on the broader economic, social and environmental determinants of health[12].*

8 See: http://ec.europa.eu/regional_policy/cooperation/index_en.htm

9 Further information available at: http://ec.europa.eu/regional_policy/cooperation/interregional/ecochange/index_en.cfm

10 Commission Staff Working Document accompanying the Communication from the Commission “Regions For Economic Change”, SEC(2006) 1432 - http://ec.europa.eu/regional_policy/cooperation/interregional/ecochange/doc/staffworkingdocument_en.pdf

11 http://urbact.eu/thematic-poles/social-inclusion-and-governance/thematic-networks/building-healthy-communities/presentation.html

12 See Tables 1, 3 and Annex B

## B. European Regional Development Fund (ERDF)

| Table 1: Allocation of ERDF/CF by theme 2007-2013 and % | | | |
|---|---|---|---|
| Culture | 2.2 | Investment in social and health infrastructure | 6.2 |
| Energy | 4 | Mobilisation for reforms in field of employment and inclusion | 0.1 |
| Environmental protection and risk prevention | 18.7 | Reduction of additional costs limiting outermost regions development | 0.2 |
| Improving access to employment and sustainability | 0.4 | Research & technological development, innovation and entrepreneurship | 23.8 |
| Improving human capital | 0.4 | Strengthening institutional capacity at national, regional and local level | 0.6 |
| Improving social inclusion of less favoured people | 0.1 | Technical assistance | 3 |
| Increasing adaptability of workers, firms, enterprises and entrepreneurs | 0.3 | Tourism | 2.3 |
| Information society | 5.6 | Transport | 28.3 |
| | | Urban and rural regeneration | 3.8 |

LEGEND for Table 1

| | |
|---|---|
| *Direct health sector investment shown in NSRF's/OPs* | |
| *Indirect health sector investment shown in NSRF's/OPs* | |
| *Non-health sector investment with potential health gain (economic, social, environmental, personal) shown in NSRFs/OPs* | |

Health projects can be funded through ERDF under the Convergence or European Territorial Cooperation objective. In the current ERDF Regulation, Article 4, Point 11)[13], *Investments in health and social infrastructure which contribute to regional and local development and increasing the quality of life* are eligible in Convergence regions. Article 6 (1e) refers to cross-border activities *developing collaboration, capacity and joint use of infrastructures, in particular in sectors such as health, culture, tourism and education.*
However, for all regions there is a new and substantially different operational context for the 2007-13 ERDF Operational Programmes:

- Programmes must contribute to the delivery of the objectives of the renewed Lisbon strategy of stronger growth and more and better jobs;
- Central Governments are keen to ensure that ERDF programmes are clearly aligned to domestic and regional policies and funding streams;
- Whilst contributing to European regional policy goals, the Programmes will also contribute to the delivery of Regional Strategies, e.g. economic, social cohesion, sustainable development;
- It is expected that this approach will lead to the programmes making fewer, but more strategic investments.

Health actions can be supported under a range of ERDF priorities[14], although the major investment in Convergence regions will focus on health infrastructure including medical equipment. For example:

13 Regulation (EC) No 1080/2006 on the European regional development fund - http://ec.europa.eu/regional_policy/sources/docoffic/official/regulation/pdf/2007/feder/ce_1080(2006)_en.pdf

14 See Annex B: types of investment with health impact

- Investment in health and social infrastructure: building and restructuring hospitals and primary health centres; developing multiple function infrastructure (e.g. healthcare, social care and education); restructuring inpatient specialist care (e.g. diagnostic centres); restructuring outpatient services; modernization and revision of equipment (e.g. diagnostic, surgical, technological, informatics);

- Energy: low energy consuming buildings; development of systems to produce energy using mild energy sources (e.g. in the hospitals);

- Urban and rural regeneration: improving localized health service provision in marginalised and rural communities;

- Strengthening institutional capacity: integrated emergency medical services with effective communications networks;

- Additionally, as from 2007, a major emphasis is being given to health promotion and disease prevention, e.g. through health awareness measures.

The abovementioned areas for health investments are reflected in all 27 NSRFs and OPs, but the actual implementation will vary. For example, the use of an ERDF Investment Framework (Table 2 below) can deliver a more strategic approach to commissioning activity. It can also ensure that the programme invests in fewer, more strategic projects in order to contribute effectively to the Programmes' overarching objectives. This approach can also tackle upfront a range of issues that have caused delays and concerns during the 2000-2006 programming period such as ERDF eligibility, state aid compliance, strategic fit, match funding requirements with timescales[15].

15 Government Office of the East Midlands, 2007

| Table 2: Scope of an ERDF Investment Framework | | | |
|---|---|---|---|
| **Product** | **Purpose/content** | **Input/steer** | **Endorsement/ responsibility** |
| *ERDF Operational Programme* | • Programme strategy<br>• Policy context<br>• Evidence / need<br>• Programme priorities | • Regional stakeholders<br>• OP Drafting Group<br>• Ex-Ante Evaluators<br>• European Commission<br>• Government Departments | • Regional Partnership Board<br>• European Commission |
| *ERDF Investment Framework* | • Detailed narrative on indicative actions<br>• Identify 'products' to invest in<br>• Key and lead partners<br>• Delivery mechanisms<br>• Required programme outcomes and outputs for activity type<br>• Broad principles regarding available funding and intervention rates | • Regional stakeholders<br>• Shadow Programme Monitoring Committee (PMC)<br>• Priority Axis sub-groups | • Programme Monitoring Committee (PMC)<br>• Development Agency Programme Secretariat |
| *ERDF Commissioning documents* | • eligibility<br>• State Aid compliance<br>• Procurement method<br>• Specific, detailed calls<br>• Available match funding/ intervention rates for specific activity<br>• Required outputs | Priority Axis sub-groups | • PMC or appropriate sub-group<br>• Development Agency Programme Secretariat |

## C. European Social Fund (ESF)

| Table 3: Allocation of ESF by theme 2007-2013 and % | | | |
|---|---|---|---|
| Improving access to employment and sustainability | 28.4 | Investment in health and social infrastructure | 0.2 |
| Improving human capital | 32.9 | Mobilisation for reforms in the fields of employment and inclusion | 1.2 |
| Improving social inclusion of less favoured people | 13.1 | Research & technological development, innovation and entrepreneurship | 0.1 |
| Increasing adaptability of workers, firms, enterprises and entrepreneurs | 17.8 | Strengthening institutional capacity at national, regional and local level | 2.7 |
| Information society | 0.2 | Technical assistance | 3.3 |

LEGEND for Table 3

| | |
|---|---|
| *Direct health sector investment shown in NSRF's/OPs* | |
| *Indirect health sector investment shown in NSRF's/OPs* | |
| *Non-health sector investment with potential health gain (economic, social, environmental, personal) shown in NSRF's/Ops* | |

The ESF is the structural instrument to support the EU employment policies in regions categorised both under the Convergence or the Regional Competitiveness and Employment objective. The fund is aligned to intervention lines defined by the renewed Lisbon Strategy and the European Employment Strategy. In this context it is more directly positioned in relation to health than other Cohesion policy tools, i.e. ERDF or CF.

The current **Regulation on the ESF 2007-2013**, Article 3.1(a) (ii), provides financial support to actions to increase the adaptability of workers or enterprises, to promote *more productive forms of work organisation, including better health and safety at work, the identification of future occupational and skills requirements, and the development of specific employment, training and support services, including outplacement, for workers in the context of company and sector restructuring*[16].

Investment in health can be supported by both the ESF and ERDF, depending on the nature of the co-financed activities. Health-related actions can be supported under all of the ESF priorities and are usually linked to relevant national strategies and programmes. For example actions to

- Enhance access to employment: Supporting inactive people due to health reasons and marginalized social groups (e.g. older people, female unemployed, people with disabilities) to access the labour market and strengthening cooperation between health and employment services through the provision of one-stop-shops for job seekers (e.g. Austria, ROP Burgenland; Cyprus, OP 'Human resources, employment and social cohesion'; Czech Republic, OP 'Education for Competitiveness' Priority 2)

- Reduce absence due to illness: This goes beyond general occupational health and safety. Dealing with this factor is an accepted part of enterprises' overall planning to use human resources as part of the production process It comes under more naturally under the heading of 'growth policy' (e.g. Denmark OP 'More and Better Jobs' Priority 2; Hungary OP 'Social Renewal' Priority axis 6; Latvia OP 'Human resources and employment' Priority 'Promoting employment and health at work'? SE?)

16 Regulation (EC) No 1081/2006 on the European Social Fund- http://ec.europa.eu/regional_policy/sources/docoffic/official/regulation/pdf/2007/fse/ce_1081(2006)_en.pdf.

- Reinforce social inclusion of people at a disadvantage through counselling and guidance on health and lifestyle issues to enable people from vulnerable social groups to (re)join the labour market (e.g. Belgium, OP 'Federal State' Priority 1 'Multidimensional approach to reach the goal of decreasing/eradicating poverty'; Finland, NSRF Strategic Priority 'Promoting employment and staying in the labour market'; Greece, NSRF General Objective 9 'Promote social inclusion'; Lithuania, OP 'Development of human resources' Priority 1 and 2)

- Provide attractive workplaces: Actions range from maintaining and improving the well-being of workers (e.g. Bulgaria OP 'Human resources development'; Portugal OP 'Human Potential' 4th priority 'the promotion of equal opportunities'), through preventive programmes adapted to the needs of specific employee groups (e.g. Poland OP 'Human Capital' Priority II – Objective 4; Romania NSRF Strategic Objective 3 'Employment and combating unemployment') to increasing employers and employees awareness about rights and obligations (e.g. Estonia NSRF Strategic Objective 1).

- Foster Health promotion: This includes enhancing local capacity to plan and implement public health activities on a regional level; increasing health awareness and the skills of people to make healthy choices in relation to physical activity, diet and nutrition, smoking, drinking and drug misuse (e.g. Estonia NSRF Strategic Objective 1 'Educated and active people'; Hungary OP 'Social Renewal' Priority axis 6 'Health preservation and human resource development in the health care system')

- Invest in human capital: This is often undertaken through establishing lifelong learning opportunities for health professionals related to health issues in the working environment, promoting healthy lifestyles through revision of the education system, networking between universities, enterprises and the health sector (e.g. Netherlands OP 'Employment' Strategic Objectives 'Increasing adaptability and investing in human capital' and 'Increasing labour supply'; Poland OP 'Human Capital' Priority II – Objective 5; Slovakia OP 'Education' (Convergence Regions) and OP 'Education' (Competitiveness and Employment Regions) Priority axis 2 'Continuing education as an instrument of human resource development)

- Improve living conditions and urban environments: brings the social aspect alongside the economic and environmental aspects of urban regeneration and can include innovative personal services and 'one-stop-shops' especially for vulnerable social groups (e.g. OP Metropolitan France, Priority 6 'Support urban projects on social cohesion and multi-modality'; Romania OP 'Human resources development' Priority axis 3 " Increasing adaptability of workers and enterprises")

- Develop administrative capacity: Ensuring the design, monitoring and evaluation of health policies as part of health system reforms, capacity building in delivery of revised health policies, improved effectiveness and costs, promoting innovative approaches to health care (e.g. Hungary OP 'Social Renewal' Priority axis 6, action area 'Development of human resources and services to support restructuring of health care'; Latvia OP 'Human resources and employment', Priority "Promoting employment and health at work"; UK Convergence OP West Wales and the Valleys, Priority 3 'Making the connections – modernizing and improving the quality of our public services'

## D. The Cohesion Fund (CF)

The CF is a structural instrument that has helped targeted Member States to reduce economic and social disparities and to stabilise their economies since 1994. It has been revised and is now delivered through national Operational Programmes often linked to the "Convergence" objective for the period 2007-2013.

Member States with a Gross National Income of less than 90% of the Community average will receive a total of €70 billion for investment in the areas of *environment and trans-European transport networks*. The Cohesion Fund will finance projects in Bulgaria, Cyprus, Czech Republic, Estonia, Greece, Hungary, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovakia and Slovenia. For Spain this will be on a transitional basis.

Projects within the two investment areas may include either indirect health investment or potential health gains from non-health sector investments. Transport, road and public transport projects can have benefits in terms of improving access to health and social care services for patients, carers and outreach services. Environmental projects might include water supply, renewable energy, waste water treatment and solid waste projects. In all these areas, hospitals can benefit from and contribute to environmental quality:

- Environmental projects should contribute to achieving the objectives of Article 174 of the EC Treaty in the following areas:[17] Quality of the environment, human health, utilisation of natural resources and regional or worldwide environmental problems. These projects include those resulting from measures taken under Article 175 of the EC Treaty and are in line with the priorities given to the EU environmental policy by the Fifth Programme of Policy and Action in relation to the Environment and Sustainable Development[18];

- Transport infrastructure projects financed by Member States within the framework of the guidelines referred to in Article 155 of the EC Treaty; however, other trans-European network projects contributing to achieving the objectives of Article 154 of the EC Treaty may be financed until the Council adopts appropriate guidelines.

The level of funding (as under the convergence objective) is a maximum of 85% of expenditure on a project, depending on the type of action .

## E. Technical assistance for regions: the 4 Js

The European Investment Bank (EIB) offers a range of upstream technical assistance (the 4 J's) in addition to financial support. The form of this assistance varies according to geographical constraints and is mentioned in several of the 27 NSRFs and their supporting OPs.

**The JEREMIE Initiative** (Joint European Resources for Micro to Medium Enterprises)[19]:

JEREMIE is a common initiative of the European Commission and the European Investment Bank, in order to promote better access to finance for the development of micro, small and medium-sized enterprises (SMEs). According to art. 44 of Council Regulation 1083/2006 the JEREMIE initiative sets out a scheme for deployment of structural funds, which is beyond the grant system and supports by using financial engineering instruments [20]. It offers the possibility of flexibility depending on regional or national needs, avoids the application of the "n+2/n+3" rules[21] and provides access to knowledge

17 See: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:321E:0001:0331:EN:PDF

18 http://ec.europa.eu/environment/archives/env-act5/pdf/5eap.pdf

19 Further information available at: http://ec.europa.eu/regional_policy/funds/2007/jjj/jeremie_en.htm

20 Council Regulation (EC) No 1083/2006 laying down general provisions on the European Regional Development Fund, the European Social Fund and the Cohesion Fund – http://ec.europa.eu/regional_policy/sources/docoffic/official/regulation/pdf/2007/general/ce_1083(2006)_en.pdf

21 See: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:1999:161:0001:0042:EN:PDF

and experience of the EIB Group[22]; as well as the possibility of attracting additional funds from the private sector, resources of the EIB Group and other international financial institutions.

The JEREMIE initiative is an important element for enabling an improvement in functioning conditions for SMEs in EU Member States.

**JESSICA Initiative** (Joint European Support for Sustainable Investment in City Areas)[23]:

JESSICA is a shared initiative of the European Commission, the European Investment Bank and the Council of Europe Development Bank, in order to promote sustainable investment, and growth and jobs, in urban areas. JESSICA enables to set up urban development funds (UDF), supported by Structural Funds means and other types of funding, which allow to accelerate projects implemented within integrated plans for municipal development.

The JESSICA initiative responds to development needs of urban areas which are of key importance for stimulation of growth at a local, regional and national scale. The NSRFs and Operational programmesin many EU Member States show awareness of the challenges connected with development of urban areas.

**JASPERS Initiative** (Joint Assistance in Supporting Projects in European Regions)[24]:

JASPERS is a shared initiative of the European Commission, the European Investment Bank and the European Bank for Reconstruction and Development (EBRD), to provide technical assistance to convergence regions for preparation of large scale infrastructure investment projects over certain trashhold primarily in the sector of transport and environment. Large health infrastructure projects are eligible for JASPERS assistance as well.

Support of JASPERS experts will be an important element contributing to identification and the effective preparation of investment projects especially in the newer EU-12 MS in the current period. In first instance, support will be granted to projects in sectors, in which Member States or regions have had little experience yet. This comprises in-depth sector analyses (also regarding state aid and environment related issues) as well as model projects, so that existing solutions could be applied in other similar projects. To maximise effects of the JASPERS initiative, this support might also be used for preparation of horizontal guidelines, which would be applicable both for bigger and for smaller projects.

**JASMINE Initiative** (Joint Action to Support Micro-finance Institutions in Europe): is an European initiative for the development of micro credit in support of growth and employment. It is a pilot initiative which has been developed by the European Commission , the European Investment Bank and the European Investment Fund. The first transactions are supposed to start early 2009. The JASMINE pilot initiative primarily targets EU-based non-bank microfinance institutions in development phase, sustainable or close to sustainability.

**Key point** - *None of the four J's prioritize health sector development. However, JASPERS is able to provide technical assistance also to health projects, the JEREMIE and JASMINE initiatives could be applied to projects that engage local SME's better in regional health sector supply chains or health innovation clusters. The JESSICA and JASPERS initiatives could be revised to promote added value health gains from projects that have the potential to impact on the broader economic, environmental and social determinants of health.*

22 The EIB Group consists of the European Investment Bank and the European Investment Fund (EIF)

23 Further information available at: http://ec.europa.eu/regional_policy/funds/2007/jjj/jessica_en.htm

24 Further information available at: http://ec.europa.eu/regional_policy/funds/2007/jjj/jaspers_en.htm

# AREAS OF INVESTMENT

The amount of health investments from the eU structural Funds  varies to a great extent between Member States. The total sum of planned health investments for the 2007-2013 period was calculated at around €5 billion (1.5% of the total amount of Structural Funds). However, this amount constitutes direct health sector investment in health infrastructure. In reality, this calculation is a conservative estimate of the potential amount of health investments for the current period

Three areas of health investment can be identified: (i) **direct health sector investment** in which health infrastructure is clearly targeted/planned; (ii) **indirect health sector investment,** i.e. investments in sectors where also a positive impact for health is expected, like e.g. employment and labour market policies; (iii) **non-health sector investment** that has potential added health gain, specifically potential impacts on the wider economic, social and environmental determinants of health.

All three areas appear in Operational Programmes funded by both ERDF/CF and ESF.

Although health-related investments could be supported through Structural Funds already in the previous period (2000-2006), the category “health investments” was not clearly included as a sub-category. However, the share of the total Structural funds Fs budget allocated to health infrastructure is more or less the same in the two programming periods.

## A. Direct health sector investment

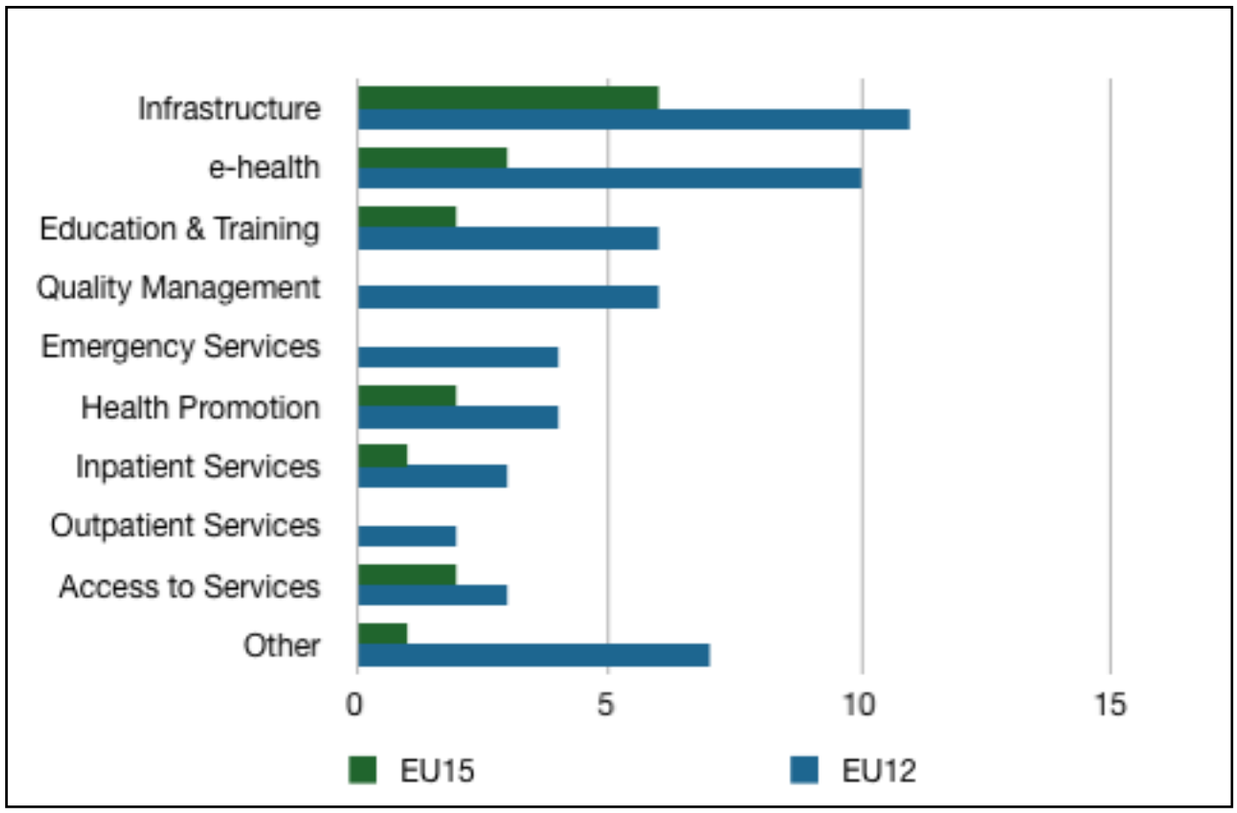



*Figure 1: Direct health sector investment in 2007-2013 per country*

In general, health investments in health infrastructure are mainly foreseen in Member States with Convergence objective regions- the new Member states.[25]: In Bulgaria, Czech Republic, Greece, Hungary, Lithuania, Latvia, Poland, Romania and Slovakia, health infrastructure is the core element of direct investment . This is essentially intended to underpin the modernisation of healthcare

25 See Annex B: types of investment with health impact

services. Improving access to services, especially in rural areas and for people in vulnerable social groups and ethnic minorities is one of the drivers of modernisation in the EU-12 Member States. In the EU-15, direct investments are found in the NSRFs and ROPs under the Convergence objective. in Germany, Greece, France, Italy, Portugal and Spain.

Hungary sits at one end of the continuum of identifiable direct health investment at 5.4% of Structural Funds allocated to health, while Germany is at the opposite end with the lowest relative amount of direct investment (0.1% of allocated SFs).

European Social Fund financed Operational Programmes with direct health sector investment are especially strong in Convergence Regions and consequently in the new EU MemberStates like Estonia, Hungary, Latvia, Lithuania and Poland. Such investments are less obvious in for the Competitiveness and Employment Regions.

Looking in more detail at the findings shown in Figure 1 above, the health services category includes inpatient, outpatient, emergency and primary care services. Investments in these areas are shown in 7 of the 12 new Member States[26]. In addition to health infrastructure investment, a fairly small number of Member States intends to invest in health promotion and disease prevention. This also relates to investment in health and safety at work under the area of 'indirect health sector investments'. Both are presented in ESF Operational Programmes that focus on themes such as social renewal and human capital.

Health information and especially e-health is identified as a key area of direct investment in those regions under the Convergence objective and especially in the EU-12 Member States. This can include, for example, investment in electronic patient cards, patient record databases, and telemedicine or in connecting specialist networks.

### A.1. Delivering effective health infrastructure investment

Since health infrastructure investment is the main focus of direct health sector investment it will be crucial to ensure that expenditure on infrastructure will be achieved as planned during the 2007-2013 period. In particular, upfront option appraisal would be required to enable sustainable and strategic investment planning[27].

There are a number of factors that can promote or hinder the effectiveness of healthcare investment[28]. The aspects that regions would need to address include:

- **Sustainable investment**: Healthcare buildings should be built, renovated, or reconfigured to meet future needs – as far as this is possible. In the interests of sustainability, it might be useful to consider joint capital investment projects with other sectors in order to reduce the overall capital burden. The Halton and St. Helens, Knowsley and Warrington LIFT (Local Improvement Finance Trust) project in North West England could be seen as an example of this approach.[29]

- **Arguing the case for the economic value of health infrastructure investment**: Regional health organisations should be able to show that the benefits of rational planning of health infrastructure extend far beyond the immediate needs of treating patients. Education and

26 idem

27 See Samset K. and Dowdeswell B. *Strategic planning: getting capital investment right*. In: Rechel B., Wright S., Edwards N., Dowdeswell B. and McKee M. *Hospitals of the future: improving health capital investment.* European Observatory on Health Systems and Policies (in press).

28 Erskine J., Dowdeswell B. and Watson J. (eds.) *How the health sector can contribute to regional development: the role of affordable capital investment.* HCN Report 2, October 2006. www.healthclusternet.org

29 www.haltonandsthelenspct.nhs.uk/pages/YourServices.aspx?iPageId=440

training of senior policy makers and planners is highly recommended since the experience has shown that best value for communities is obtained when local personnel have the significant knowledge and experience of new capital models.

- **E-health and community-based care:** The demographic development of many regions will require increased levels of high-quality home care. It is crucial to invest in ICT projects that reduce levels of hospitalization, e.g. as in the Sjuhärad Province of Västra Götaland (Sweden)[30] and as it is proposed in Basilicata Region (Italy). For regions with low population density, or with widely dispersed communities, e-health based solutions can be more cost effective than the traditional hub and spoke hospital model.

- **Societal values:** Focusing too closely on capital, and in how it interacts with economic development, entails the risk of losing sight of the social, human values connected to health care buildings.. Regional and local authorities should take forward policies that better reflect the wishes and needs of their population. The positive impact has been shown in particular through examples where health-care facilities have become part of the local structure, e.g. the hospital A.Cardarelli of Naples (Italy)[31].

- **The value of master planning**: Master planning is increasingly emerging as an element of regional development that promotes an integrated approach to urban regeneration, stimulation of local economies, provision of private care and the positioning of hospitals. It provides a clear vision of what people are collectively aiming for. For example, the extent that health infrastructure improvement is seen as key in developing R&D businesses in the health field is shown in the ROP for South Transdanubia (Hungary).

**Key point** - *Using health infrastructure investment to ensure modernisation of health care services is the core element of direct health sector investment. It also has the clearest budget allocation in NSRFs and (R)OPs. However, sustainability needs to be ensured through strategic investment planning.*

## B. Indirect health sector investment

Indirect health sector investments can be found in the NSRFs and ESF funded (Regional) Operational Programmes but there is rarely any indication  if specific expenditure is anticipated. Indirect health investments can be observed where investment starts in another sector but will also include an element of investment in health services or resources. For example in the area of employment the major focus of indirect investment is the workplace and the workforce. A healthy workforce is a key factor in increasing labour market participation and productivity, and boosting competitiveness at national and regional levels, as confirmed by the Community Strategic Guidelines on Cohesion, which identify key priorities for Cohesion Policy in line with the Lisbon strategy.[32]

30 www.actprogramme.org.uk/images/BSG_07_Hanson&Magnusson.pdf

31 Watson J and Agger S. The economic and community impact of health capital investment. In Rechel B, Wright S, Edwards N. Dowdeswell B and McKee M. *Investing in hospitals of the future.* European Observatory of Health Systems and Policies (In press – due early 2009)

32 Council Decision on Community Strategic Guidelines on Cohesion, (2006/702/EC) - http://ec.europa.eu/regional_policy/sources/docoffic/2007/osc/l_29120061021en00110032.pdf

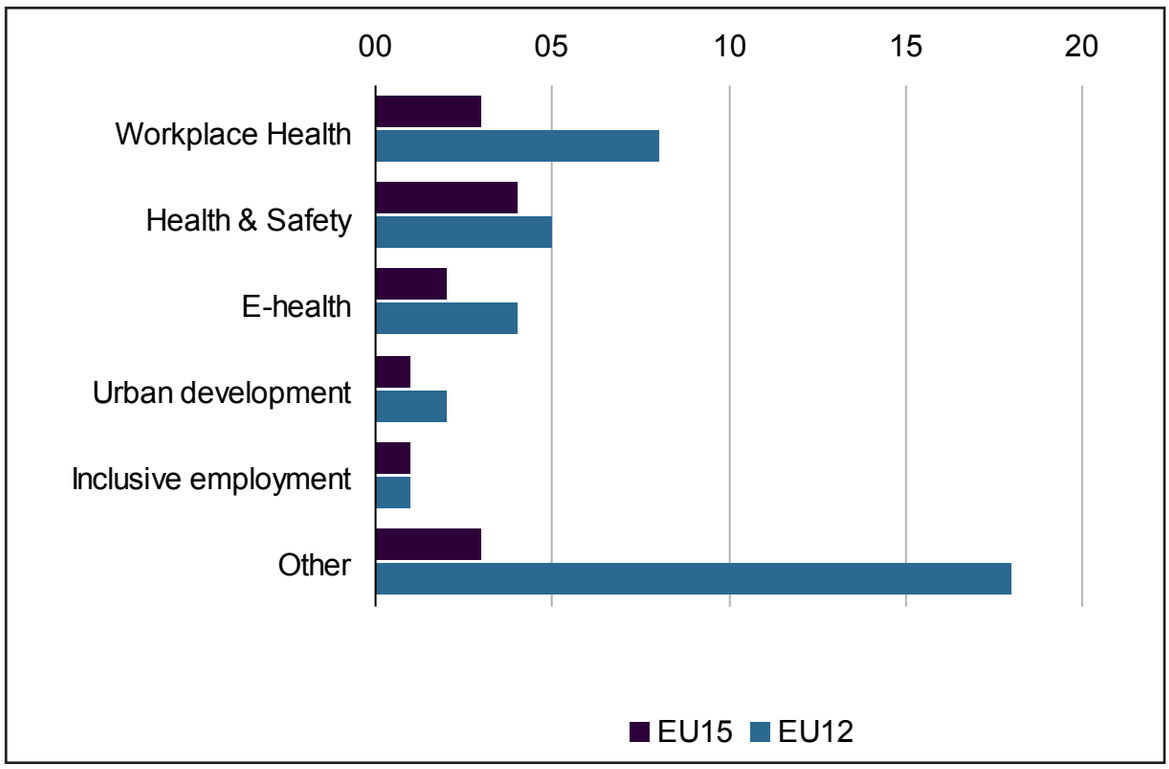



*Figure 2: Indirect health sector investment in 2007-2013 per country*

This investment focus is shared across Convergence and Competitiveness and Employment regions and is categorised in a number of ways: health and safety, occupational health, workplace health. Related to this, ageing populations as a basic demographic challenge are identified in most NSRFs. Allocated total investment in the category "Active ageing and prolonging working lives", under the current programming period, is calculated at around €1 billion of the total amount of Structural Funds.

It is estimated that by 2050 the number of people in the EU aged 65 and over will grow by 79% and the 80+ age group will grow by 181%.[33] A report published in 2006 by DG ECFIN says, for example, that *the pure demographic effect of an ageing population is projected to push (public) health care expenditure by between 1 and 2 % of GDP in most EU Member States. However, if healthy life expectancy evolves broadly in line with change age-specific life expectancy, then the projected increase on spending in health care due to ageing would be halved*[34].

There is general recognition that ageing creates specific challenges for health and social care services, pensions and welfare benefits and for all employers in the public and private sectors. Taking into account also groups who are out of work for different reasons, it shows that the labour market is tightening. This requires employers to identify and recruit new employee groups while retaining the older workforce. This challenge is addressed in most ESF Operational Programmes across the EU and is linked to relevant national strategies

In order to increase employment and employability, many NSRFs respond to the need to increase the adaptability of the workforce and enterprises. It also plans to improve the flexibility of labour markets while increasing the number of years that citizens can be economically active and productive. The

33 See: The 2009 Ageing Report: Underlying Assumptions and Projection Methodologies for the EU-27 Member States (2007-2060), p. 43: http://ec.europa.eu/economy_finance/publications/publication13782_en.pdf

34 The impact of ageing on public expenditure: projections for the EU-25 Member States on pensions, health care, long term care, education and employment transfers (2004-2050), European Commission, Dg Ecfin 2006, p. 133, http://ec.europa.eu/economy_finance/epc/documents/2006/ageingreport_en.pdf

NSRFs address the issue of preventing social exclusion due to poor health or old age, supporting the inclusion of individuals that are at risk of social exclusion on the labour market and enhancing their employability through their involvement in vocational education and training. In consequence key investment are envisaged in essential social support and community care services.

The *urban development category* also first appears in this area of investment. Bulgaria, the Czech Republic and Portugal share the emphasis on improving the urban environment and the quality of services in metropolitan areas by improving quality of life across all social groups. This aims in particular at making cities more attractive for investors.

### B.1 Delivering healthy working lives

Supporting healthy workplaces combined with increasing inclusive employment activities requires regional health systems to work in partnership with other public, business and NGO sector employers at national, regional and local levels. It will be crucial to modernise regional health systems and to maintain attractive and inclusive employment strategies. In addition, planned indirect health sector investment and non-health sector investments can be considered as interrelated. The following issues need to be considered by the Member States and regions in order to achieve an increase in healthy working lives:

- **An integrated approach to workforce development:** Investment in the workforce needs an integrated approach and should be considered in the context of shifts in service provision, the needs of other sectors (e.g. social services, community care, regional training and skills development), developments in technology and of broader societal values**Understanding principles and processes that are effective**: Most EU regions face common challenges (e.g. rising healthcare costs, shift from acute to primary care, etc.), but governance, politics and labour markets can vary greatly. In addition, differences in employment policies between and within countries make it unlikely that good practices can be simply transferred. It is therefore essential to understand the principles and processes that led to success (or lack of success).

- **Integrating inclusive employment into mainstream human resources policies**: There is the need to integrate the goal of inclusive employment into mainstream human resources policies in order to create more diverse, adaptable and flexible workforces.-In this context special attention should be paid to people with disabilities, migrants, ethnic minorities and long-term unemployed.

- **Improving the attractiveness of working life**. This comprises several elements:

    - To connect regional health systems with regional development and employment policies. This needs to be considered for actions that aim at maintaining and improving a flexible, attractive, inclusive and high-quality workforce.

    - To enable European regional health systems to have flexible approaches to employment. The objective is to ensure health sector workforces which are affordable and capable of providing health-care that adapts to changes in service priorities while reflecting local health and well being needs.

    - To create and maintain a health sector workforce that is a sustainable employment opportunity within an ageing workforce also through recruiting and retaining measures for vulnerable groups.

    - To learn from good practices in the private and public employment sector about how to improve the attractiveness of the working life for all employee groups.

**Key point** - *A basic demographic challenge identified in most NSRFs is recognition that populations are ageing. This has led many EU Member States to stress the need for creating diverse and flexible workforces across all sectors of society. Within the health sector and along the health sector supply chain there is a need to ensure those employment opportunities for vulnerable social groups are part of mainstream organisational human resources policy.*

## C. Non-health sector investment with potential health gain

In this third area of investment, attention is paid to non-health sector investment that has potential added value for health, specifically potential impacts on the wider economic, social and environmental determinants of health. In terms of SF allocations, this area is supported by almost all ERDF, CF and ESF investments.[35] A challenge for local and regional authorities would be to ensure the sustainability of such investments. Concerning regional health systems, this means assessing their potential to contribute to economic growth, social cohesion and environmental quality as well as service delivery. The business sector can contribute to health improvement, social cohesion and environmental quality in addition to its core focus on economic competitiveness.

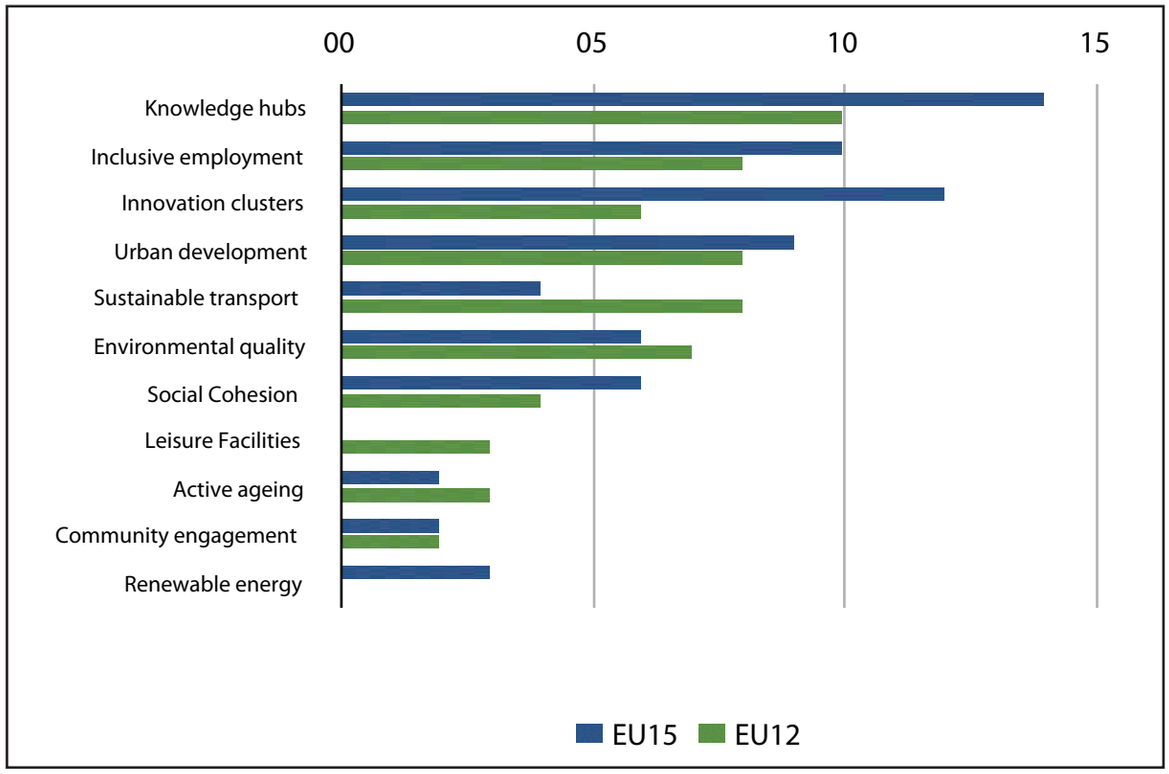



*Figure 3: Non-health sector investment with potential health gain in 2007-2013 per country*

The most widely shared investment priority across MS is the development of knowledge hubs and associated innovation clusters. This reflects a main goal of the renewed Lisbon Agenda for Growth and Jobs . In the NSRFs and (R)OPs, this form of investment primarily targets collaboration between the private sector (especially SMEs) and universities/research centres. For example, actions include:

- Introducing new technology and making greater use of ICT, supporting cooperation and networking between similar companies and connecting them with centres promoting innovation, research centres and higher education institutions (e.g. Cyprus OP for Sustainable Development and Competitiveness, under the priority theme “Strengthening the productive base of the economy

35 See Annex B: types of investment with health impact

and supporting enterprises").

- Developing further the knowledge, R&D, innovation and entrepreneurial base of the regional economy and supporting collaboration and technology transfer between research institutions and the business sector in order to boost regional growth and competitiveness (e.g. Ireland ROP Southern and Eastern Region, Strategic objective 2, Priority 1 "Innovation and the knowledge economy").

- Strengthening the R&D sector by supporting the development of centres of high research potential. Support will include financing of scientific research, including investment in infrastructure, setting up innovative enterprises. In addition, developing co-operation in the field of innovation between enterprises and the R&D sector as well as science and technology and promoting transfer of new technologies and know-how (e.g. Poland ROP Mazowieckie, Priority I).

### C.1 Engaging regional health systems in the knowledge-based economy

Looking at the health innovations market and related knowledge hubs or innovation clusters, a key element would be a better involvement of the public health sector in developing, managing and anticipating health innovations at the local and regional level. The shift in health policy and health service design to prevention and the management of chronic conditions requires the development and application of health innovations within regions that support emerging integrated care models, in which hospitals are just one element.

To maximise health gain from the knowledge economy there is a clear need to ensure that regional health systems, their elements and the workforce are engaged in and contribute to knowledge hubs and innovation clusters. Good practice examples already exist that provide lessons on how this can be achieved (e.g. TrusTech)[36] and Bionow (North West England)[37], TSB Medici (Berlin)[38], EUROSCAN[39] and Human Technology Styria[40]. If health innovation knowledge hubs and innovation clusters are using SFs to contribute to sustainable regional development, the following points need to be considered:

- Regions would need to identify and/or develop a coherent regional, economic, development organisation to take the lead on this agenda.

- Regions would need to develop a shared vision and common values between key stakeholders to provide the basis for effective inter-sectoral collaboration.

- Stakeholders would need to create regional health innovation objectives which have to be integrated into their Regional Master Plan.

Urban development also plays a role in the current section. In such diverse Member States like Austria, the Czech Republic, Cyprus, Hungary, Latvia, Poland and Portugal planned urban development has explicit and implicit implications for health gain. For example, in several Hungarian ROPs the following priorities are identified:

- In action areas identified and selected under urban development strategies, social urban rehabilitation operations will be supported to develop the urban environment and the local community. The related projects will involve modernising infrastructure, including actions to

36 See Watson J., Worch S., Mylord H. and Hartley M. (2007), *How the health sector can contribute to regional development: the role of health innovations.* Health ClusterNET, Report 4 - www.healthclusternet.org (For case examples from TrusTech, TSB Medici (Berlin) and Human Technology Styria)

37 See www.bionow.co.uk

38 See www.tsbmedici.de

39 See www.euroscan.bham.ac.uk

40 See www.humantechnology.at

raise energy efficiency, to avoid ghettos of minorities (e.g. Roma) and to foster health promotion services together with providing basic infrastructure as needed (e.g. ROP Southern Transdanubia priority axis 4 “Integrated urban development”, focus: Assistance for socially integrated urban rehabilitation operations; ROP Northern Hungary, priority axis 3 “Settlement development”; ROP Central Transdanubia priority axis 3 “Sustainable settlement development”).

- Beyond investment in health care infrastructure (OP Social Infrastructure), social care also contributes to building human capital and improving prospects for employability. All these activities are supplemented by the development of community and recreational institutions, which are contributing to the useful spending of the population’s leisure time. (e.g. Hungary ROP Northern Great Plains, priority axis 4 “Development of human infrastructure”).

In terms of potential health gain the impacts of such investment on the wider health determinants (economic, social, environmental) can be identified and should contribute to improving individual and family quality of life as well as personal well-being.

Although not shown in Figure 3 above, there are other interesting examples of sustainable development measures that may have a longer-term impact on health gain. This includes integrated planning (Sweden), one-stop shops (UK) and rural one-stop shops (Estonia), health tourism (Czech Republic, Portugal), green spaces (Netherlands) and e-procurement (Lithuania).

**Key point** - *To maximise health gain from the knowledge economy there is a clear need to ensure that regional health systems, their elements and the workforce are engaged in and contribute to knowledge hubs and innovation clusters. Good practice examples already exist that provide lessons on how this can be achieved.*

# CAPACITY TO IMPLEMENT AT REGIONAL LEVEL

A critical question for implementing health and health-related investments under Structural Funds is whether the planned actions laid down in the adopted NSRFs and OPs are underpinned by existing or planned capacity in the Member States or regions.

A common development across the EU-27 has been building capacity at national level based on evaluation and experience of the 2000-2006 period. Another key step has been the active engagement of regional stakeholders in the development of Regional Operational Programmes for the 2007-2013 period. Across the EU, a range of regional governments and other bodies have assumed the role of Managing Authorities for regional OPs, membership of Monitoring Committees and as intermediary bodies. However, it is not clear if sufficient investment has been made in building appropriate capacity at regional level to ensure effective management and implementation..

Although there seems to be limited mention of capacity building at regional level in most of the EU-12 Member States, some positive examples could be listed (i) some mention of workforce development in Slovakia; (ii) a holistic approach to capacity building in Latvia; (iii) inter-sectoral groups and partnerships in Hungary (e.g. Regional Sub-committees) and Romania (e.g. Regional Coordination Committees); (iv) bottom-up planning in Slovenia. Even in the older EU Member States there are few explicit statements about regional capacity building. Where these appear, they seem to focus on the partnership aspect of capacity building, e.g. Regional Growth Forums (Denmark), economic and social partners engaged in the implementation (Netherlands), and regional development programmes (Sweden).

In this context, it would be crucial to provide evidence of the sustainability which needs to be considered as being critical for ERDF, CF and ESF investments. For this reason a capacity building framework needs to be introduced to establish analysis and reporting structures (see Diagram 1 below[41]). Experience shows a continuing significant gap between national priorities and objectives and capacity to deliver at local and regional levels.

41 Adapted from New South Wales Health Department. *A framework for building capacity to improve health.* 2001.

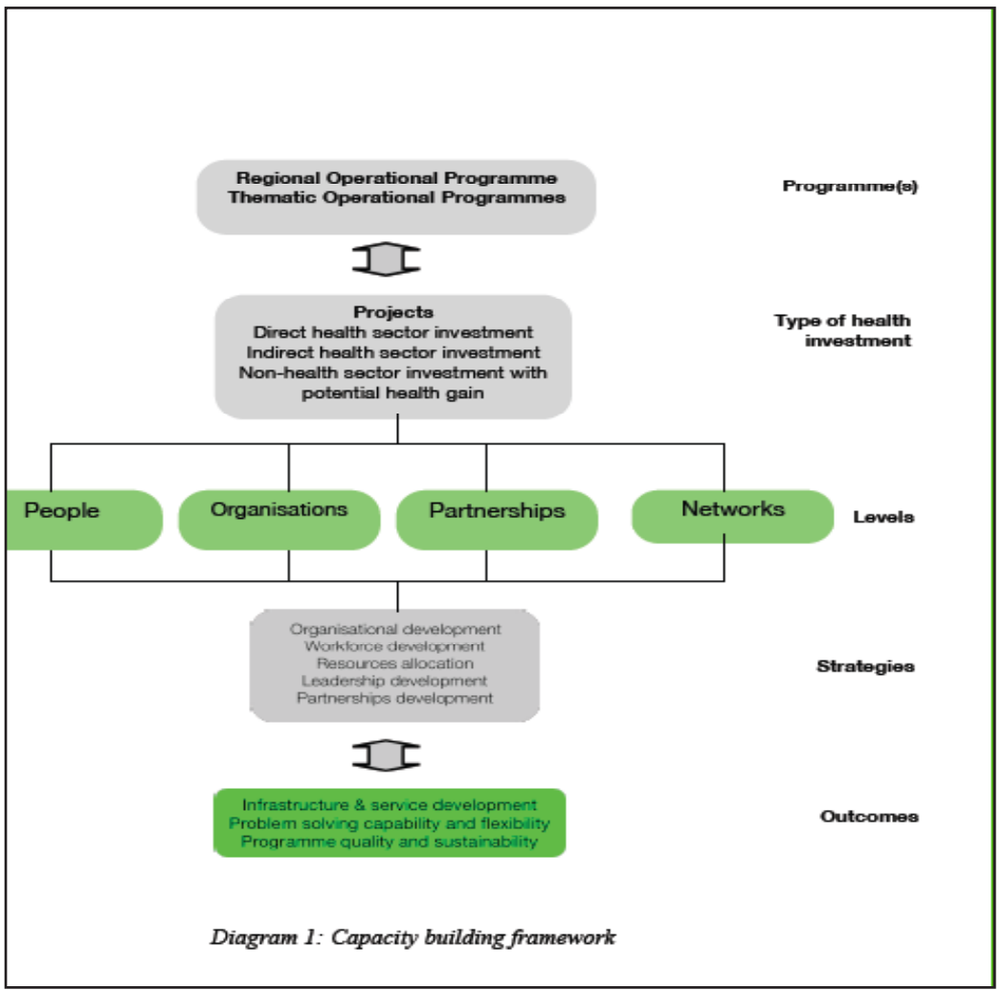



*Diagram 1: Capacity building framework*

Capacity building in public health is conceptualised and organised in many ways. It has often been described as the invisible work that is essential in building health infrastructure, maintaining and sustaining programmes and creating flexible problem solving capability in Public Health across all sectors. This work is often visible as strategies for workforce and organisational development, leadership and partnership development, and as resources allocation. Capacity building is the necessary "process" work of health improvement. Defining the capacity building effort enables strategic activity in the health sector and other sectors to be made more operational and measurable.

Overall, conceptualising and mapping the domains, levels and integrated aspects of a capacity building approach helps with building the link between this critical approach and the successful development of Structural Funds programmes, projects and services. At a system level, capacity building aims to create dynamic and innovative approaches to action, and most importantly flexible and responsive systems to tackle new and emerging health challenges and opportunities. At a practical level, exposing capacity building effort provides decision makers, researchers and practitioners with insights to effective and sustainable practice.

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# ANNEX A
# REGIONAL COHESION POLICY GROUPS

The EU Member States are covered by one or more of the Cohesion Policy objectives. To determine geographic eligibility, the Commission bases its decisions on statistical data. Accordingly, Europe is divided into various groups of regions corresponding to the NUTS classification (common nomenclature of territorial units for statistics).

The map on page 6 shows the European regions covered in the 2007-2013 period by the Convergence and Regional Competitiveness & Employment objectives. The regional cohesion policy groups are given below.

## Convergence objective

Regions whose GDP per inhabitant is less than 75% of the Community average are eligible for funding under the Convergence objective:

| Country | Regional coverage |
|---|---|
| Bulgaria | the whole territory |
| Czech Republic | Střední Čechy, Jihozápad, Severozápad, SeverovyÅLchod, JihovyÅLchod, Střední Morava, Moravskoslezsko |
| Estonia | the whole territory |
| France | Guadeloupe, Guyane, Martinique, Réunion |
| Germany | Brandenburg-Nordost, Mecklenburg-Vorpommern, Chemnitz, Dresden, Dessau, Magdeburg, Thüringen |
| Greece | Makedonia, Thraki, Thessalia, Ipeiros, Ionia Nisia, Dytiki Ellada, Peloponnisos, Voreio Aigaio, Kriti |
| Hungary | Dél-Alföld, Dél-Dunántúl, Észak-Alföld, Észak-Magyarország, Közép- Dunántúl, Nyugat-Dunántúl |
| Italy | Calabria, Campania, Puglia, Sicilia |
| Latvia | the whole territory |
| Lithuania | the whole territory |
| Malta | the whole island |
| Country | Regional coverage |
| Poland | the whole territory |
| Portugal | Alentejo, Azores, Norte |
| Romania | the whole territory |
| Slovenia | the whole territory |
| Slovakia | the whole territory |
| Spain | Andalucia, Castilla-La Mancha, Extremadura, Galacia |
| United Kingdom | Cornwall and the Isles of Scilly, West Wales and the Valleys |

## Phasing-out

Phase-out assistance systems have been set up for regions which benefited from considerable financial assistance before enlargement. This should avoid drastic changes between the two programming periods (2000-06 and 2007-13).

These systems are granted to those regions which would have been eligible for funding under the Convergence objective if the threshold of 75% of GDP had been calculated for the EU at 15 and not at 25:

| Country | Regional coverage |
|---|---|
| **Austria** | **Burgenland** |
| **Belgium** | **Province du Hainaut** |
| **Germany** | **Brandenburg-Südwest, Halle, Lüneburg, Leipzig** |
| **Greece** | **Kentriki, Makedonia, Dytiki Makedonia, Attiki** |
| **Italy** | **Basilicata** |
| **Portugal** | **Algarve** |
| **Spain** | **Asturias, Murcia, Ceuta, Mellia** |
| **United Kingdom** | **Highlands & Islands** |

## Competitiveness and employment objective

All regions that are not covered by the Convergence objective or by transitional assistance (phasing-out) are eligible for funding under the Competitiveness and employment objective. A phasing-in system of transitional assistance is granted until 2013 to regions that were covered by Objective 1 in the previous period but whose GDP exceeds the 75% of the GDP average for the EU15. The regions eligible under this framework are:

| Country | Regional coverage |
|---|---|
| **Cyprus** | the whole territory |
| **Éire-Ireland** | **Border, Midland and Western** |
| **Finland** | **Itä-Suomi** |
| **Greece** | **Sterea Ellada, Notio, Aigaio** |
| **Hungary** | **Közép-Magyarország** |
| **Italy** | **Sardegna** |
| **Portugal** | **Madeira** |
| **Spain** | **Castilla-Leon, Com Valenciana, Canarias** |
| **United Kingdom** | **Merseyside, South Yorkshire** |

# ANNEX B
# TYPES OF POTENTIAL HEALTH INVESTMENT BY EU COUNTRY[42]

*Note: The potential health gain from non-health sector investment is categorised as one or more of the following: economic, social, personal, environment.*

| Types of investment with health impact | | | |
|---|---|---|---|
| **EU Member State** | **Direct health sector investment** | **Indirect health sector investment** | **Non-health sector investment with potential health gain** |
| **Belgium** | | Workplace health | Urban development, knowledge hubs, innovation clusters, social cohesion |
| **France** | Infrastructure, access to health services | - | Knowledge hubs, innovation clusters, urban development, social cohesion, environmental quality, renewable energies |
| **Ireland** | - | - | Knowledge hubs, urban development, social inclusion, ICT infrastructure, sustainable transport, inclusive employment, |
| **Luxembourg** | - | - | Knowledge hubs, innovation clusters, sustainable transport, urban development, active ageing, inclusive employment |
| **United Kingdom** | - | - | Knowledge hubs, innovation clusters, inclusive employment, community engagement, occupational health, urban development, sustainable communities, one-stop shop services |
| **Austria** | - | - | Knowledge hubs, environmental quality, mobility, urban development, energy efficiency |

42 Based on 2007-2013 NSRFs and OPs priorities

| Types of investment with health impact | | | |
|---|---|---|---|
| **EU Member State** | **Direct health sector investment** | **Indirect health sector investment** | **Non-health sector investment with potential health gain** |
| **Czech Republic** | Infrastructure, e-health | Workforce development, modernisation of facilities, workplace health, equality of access, transport, urban development | Workplace health, inclusive employment, social inclusion, occupational health & safety, active ageing, sustainable transport, knowledge hubs, urban development, health tourism |
| **Germany** | Infrastructure | Health & safety | Knowledge hubs, innovation clusters, environmental quality, urban development, inclusive employment |
| **Hungary** | Infrastructure, inpatient care, outpatient care, emergency services, primary care, e-health, health promotion, education & training, quality management | Crisis helpline services, modernisation of regional health services, rehabilitation network | Innovation clusters, knowledge hubs, waste management systems, public administration IT/ inclusive employment, health tourism, urban development, leisure facilities |
| **Netherlands** | - | - | Knowledge hubs, innovation clusters, environmental protection, inclusive employment, social inclusion, green space, community engagement, education & training |
| **Slovakia** | Infrastructure, access to services, outpatient care, e-health, education & training, quality management, health promotion, | Access to services, social inclusion, long-term care, health & safety | Urban development, green space, sustainable transport, waste management, medical research, health promotion, safe & healthy food |
| **Slovenia** | Infrastructure, e-health, education & training, quality management | Health & safety, occupational health | Knowledge hubs, innovation clusters, inclusive employment, social inclusion |
| **Italy** | Infrastructure, access to health services, health promotion & prevention, education & training | Health & safety, health enterprises | Knowledge hubs, innovation clusters, environmental quality, social cohesion, renewable energy, sustainable transport, urban development |

| Types of investment with health impact | | | |
|---|---|---|---|
| **EU Member State** | **Direct health sector investment** | **Indirect health sector investment** | **Non-health sector investment with potential health gain** |
| **Malta** | Infrastructure, e-health | Occupational health & safety | Procurement, sustainable transport, environmental protection, mobility, urban development, inclusive employment, social inclusion, knowledge hubs. |
| **Portugal** | Infrastructure, e-health | Workplace health, health & safety, inclusive employment, e-health, social cohesion, urban development | Workplace health, inclusive employment, occupational health & safety, sustainable transport, innovation clusters, knowledge hubs, urban development, health tourism |
| **Spain** | Infrastructure, e-health | Workplace health, health & safety | Knowledge hubs, innovation clusters, workplace health, inclusive employment |
| **Denmark** | - | Digital health care | Inclusive employment, workplace health, active ageing, occupational health & safety |
| **Estonia** | Infrastructure, e-heath, primary care, health promotion & disease prevention | Workplace health/ socially vulnerable groups | Workplace health, knowledge hubs, environmental hazard warning systems, one-stop shop rural infrastructure, sustainable transport, leisure facilities |
| **Finland** | - | - | Knowledge hubs, regional innovation structures, micro-enterprise clusters |
| **Latvia** | Infrastructure, access to services, emergency services, e-health, health research, education & training | Workplace health, health protection services, inclusive employment, public sector management | Knowledge hubs, innovation clusters, sustainable transport, leisure facilities, environmental protection, urban development |

| Types of investment with health impact | | | |
|---|---|---|---|
| **EU Member State** | **Direct health sector investment** | **Indirect health sector investment** | **Non-health sector investment with potential health gain** |
| **Lithuania** | Infrastructure, quality assurance, access to services, inpatient care, primary care, emergency services, mental health services, health promotion, e-health, education & training | Effective public administration, monitoring & research, ICT, workplace health, social inclusion | Inclusive employment, active ageing, innovation clusters, knowledge hubs, e-procurement, rehabilitation services, environmental protection |
| **Poland** | Infrastructure, healthy working lives, occupational health, education & training, quality management | Telemedicine, ICT infrastructure | Community engagement, inclusive employment, sustainable transport, knowledge hubs, innovation clusters, health food cluster, ICT infrastructure, urban development |
| **Sweden** | - | - | Knowledge hubs, innovation clusters, inclusive employment, occupational health, integrated planning |
| **Bulgaria** | Infrastructure, e-heath, inpatient care, health promotion & disease prevention | Workplace health, Urban development | Skilled & adaptable labour force, occupational health & safety, social protection/social inclusion |
| **Cyprus** | - | Medical tourism, rural IT, workforce development, rural health care, urban specialist & tertiary care | Knowledge hubs, SME support infrastructure, expanding entrepreneurship, inclusive employment, active ageing, education & training, public administration capacity, sustainable transport, urban development, recycling |
| **Greece** | Infrastructure, e-heath, inpatient care, health promotion & disease prevention, education & training, health monitoring | Medical tourism | Knowledge hubs, innovation clusters, inclusive employment, social inclusion, public administration capacity, environmental protection |

| Types of investment with health impact | | | |
|---|---|---|---|
| **EU Member State** | **Direct health sector investment** | **Indirect health sector investment** | **Non-health sector investment with potential health gain** |
| **Romania** | Infrastructure, e-health, emergency services, quality management | Health & safety, workplace health, occupational health services | Sustainable transport, environmental protection, knowledge hubs, community engagement, urban development, inclusive employment, social inclusion |