Structural Funds for health?

Specific contract – N° SC 2011 62 51, implementing Framework Contract N° EAHC/2010/Health/01 (Lot 1)

RIVM, November 2012

Achterberg PW, Harbers MM

Executive summary

Introduction and background

Several Directorates within the European Union (EU) share interests in improving health and health systems and have formulated health-related policies and strategies. The Structural Funds (SF) are a major instrument of the EU Cohesion Policy that aims to support economic growth, improved quality of life and sustainable development as formulated in the Europe 2020 strategy. These SF, however, can and have been used to improve health and health systems both directly and indirectly. One question we aimed to answer was whether SF have been used to address chronic diseases and what best practices exist at Member State level.

The use of Structural Funds for Health

We found that about 1.5% of the total amount spent by the Structural Funds has gone into planned health investments. This, however, constitutes not only direct health sector investment in health infrastructure, but also indirect health sector investments and non-health sector investment with a potential for added health gain.

Especially the new Member States (countries entering the EU in and after 2004) clearly invested relatively often and much in improving their health care infrastructure with the use of SF. Furthermore, eHealth has been a major focus of investments from the SF. From the available literature we conclude, however, that there were also major problems and inefficiencies found and there are many points for improvement in using the SF for health.

Use of the Structural Funds for health can be improved

Another major conclusion from available evaluations was that the use of the SF could be much better lined up with the aim of reducing health inequalities. A discussion has emerged about the fact that currently only GDP (Gross Domestic Product) has been used as a criterion to qualify a region for SF support. Adding health indicators or health-related indicators such as the Human Development Index may serve the purpose of better focusing SF funding towards improving health systems and reducing health inequalities.

No information was found, however, about best practices in the use of SF specifically for chronic disease control in EU Member States. We then decided to provide an overview of summaries and reviews of existing good practices and best policies targeting chronic diseases in general as published by international organisations.

Conclusions

We conclude that given the current financial pressures on EU health systems and the possibility that this may increase the existing large health inequalities, the Structural Funds can be better geared towards improving health by introducing health-related indicators in the process of qualification for these funds.

Evaluation of the use of SF funding for health has identified the need for much more guidance and support of regional policy makers. They need to be able to plan, judge and implement health related and health system investments properly and in line with both EU health strategies and available knowledge about best practices.

Recommendations

- To improve the use of the Structural Funds for improving health and reducing, for instance, the burden of chronic disease and health inequalities, it would be important to add health-related indicators, such as life expectancy to GDP as selection criteria to qualify European regions for SF funding.
- National and/or regional health ministers should become more pro-active in promoting the use of Structural Funds for investing in health as the current financial crisis may hit the health sector strongly. There are clear opportunities but implementation will require willingness and commitment from health authorities in regions that are involved in the Structural Funds process.
- It would be important for DG SANCO to continue its interest and involvement in the Cohesion Policy and to become effectively involved in dialogues with DG REGIO and DG EMPLOYMENT on the future improved use of the Structural Funds as a source of support for health improvement and health sector investments.
- Health actors in EU regions should receive support to develop competencies to demonstrate that health fits well within regional development policies. This will enable them to apply principles of health impact assessment or to structure policies towards decreasing social inequalities in health. There is a role for the European Commission here.
- Supporting the systematic collection, evaluation and transfer of best practices in chronic disease control remains an important objective of future European health policies. Linking this to the use of the Structural Funds is a major EU challenge.

Table of Contents

Acknowledgements

The review of the draft version of this report by our RIVM colleagues Marieke Verschuuren, Nikkie Post and Ronald Gijsen is gratefully acknowledged. We thank dr. Jonathan Watson, dr. Kai Michelsen, dr. Lewis Dijkstra and Prof. dr. Helmut Brand for their advise and suggestions and for relevant information material.

List of textboxes

List of figures

1 Introduction

This report is the fourth in a series of four reports to be prepared by the Dutch National Institute for Public Health and the Environment (RIVM) in 2012 in response to a call for tender by DG SANCO (Directorate-General Health and Consumer Affairs). These reports should feed into DG SANCO's work on chronic diseases and/or the reflection process on chronic diseases (1). The first report provides an overview of the availability of chronic disease data in the European Union (EU). A second report provides an analysis of the outcomes of a European-wide stakeholder consultation as part of the so-called 'chronic disease reflection process'. The third report will give an overview of the burden of chronic diseases among Europeans around their retirement age, their impact on economic participation and interventions to improve social (including economic) participation of people with a chronic disease.

The current report provides answers to a more specific question by the Commission, which was phrased as: *the report should concentrate on information about beneficial Member State activities in the field of chronic diseases (examples of good practices), especially in relation to the use of Structural Funds for chronic diseases. The report should focus on mapping Member States good practices and developing a methodology to compare these best practices and extract common issues valid for all Member States.*

The use of the EU Structural Funds (SF) has never been explicitly linked to chronic diseases. However, since noncommunicable diseases (NCDs) as defined by the World Health Organization (WHO) account for an estimated 82% of the total disease burden in EU countries, we decided to first summarise and map the available information with regard to the use of the Structural Funds for improving health and health systems and for reducing regional health inequalities in a broader sense (chapter 4). Next, we have compiled lessons learned from the use of SF for health, in a general sense (chapter 5).

In chapter 6, we approach the part of the question about mapping good practices for chronic diseases in an indirect and overarching way. We give a short, but not exhaustive, overview of available reports from international organisations and experts that provide information on effective health policies, strategies and good practices which also contain common issues valid for several or all Member States. This information serves as an example of the type of information that can in the future contribute to better using the Structural Funds and reduce the burden of chronic disease.

The information in chapters 4, 5 and 6 has to be viewed upon in the context of the various policies and strategies at EU level that also deal directly or indirectly with health and health systems. The effects of the current financial crisis and its consequences for health need to be taken into account as well. This contextual information is described in chapter 3, Background and context.

2 Approach and methods

We collected information and data on the policy context, background and use of the Structural Funds from websites and existing reports, either from Commission sources or from EU funded projects or from other organisations and networks that operate in the area of health. This study, which had to be limited in scope, is therefore not an in-depth research study, but an overview of existing information.

We used a 'snowball-method' to collect further information. We started by asking suggestions for information sources from experts in this area that we have consulted (see below) and by following links provided on relevant websites to other relevant websites and by collecting references in the documents and reports that we found.

Dr Jonathan Watson, Dr Kai Michelsen and Prof dr Helmut Brand, who were all involved in EUREGIO projects that have looked into the use of the Structural Funds (SF) for health, have provided us with relevant suggestions, documents and sources of information. Dr Lewis Dijkstra (Directorate-General for Regional Policy, DG REGIO) provided data on the use of the Structural Funds in European regions.

We searched the health-oriented database PubMed for articles (in English) that appeared in or after 2006 and that described the actual use of Structural Funds for health by using the keywords 'structural funds' AND 'health' (see Annex 3).

Regional and national data on population health and economic variables at national and regional levels were accessed via the websites of Eurostat and the Health for All (HFA) database that is provided by WHO-Europe (World Health Organization Regional Office for Europe).

3 Background and context

Using the Structural Funds for health has to be embedded in a broader EU policy context. Before discussing these Funds in detail and their possible relevance for health we need to sketch the full context of other European health-related policies.

Various EU policies and strategies are aiming at health and health systems. We will therefore first present a concise summary of these interacting health policy perspectives and then address the EU Cohesion Policy and its main instrument the Structural Funds. This Cohesion policy focuses on economic, social and territorial (regional) disparities. It aims to reduce the significant gaps that exist within Europe between less favoured regions and more affluent ones. The so-called 'Structural Funds' act as the financial mechanism of the Cohesion Policy. They facilitate the structural adjustment of specific sectors, regions, or a combination of both and have made substantial investments aiming at improving health and health systems.

To sharpen the current policy context we end this chapter by discussing some issues that evolve from the current financial crisis and its implementation for future health policy making.

3.1 Interacting policy perspectives: social, economical, health oriented

Health makes an important contribution to the economy in the European Union (2). Research into the effect of health at the macroeconomic level, as described in historical studies that explored the role of health in specific countries over one or two centuries, has shown that a large share of today's economic wealth is directly attributable to past achievements in health. Health has become a very robust and sizeable predictor of subsequent economic growth, when the growth differences between poor and rich countries were studied (2). Next, the healthcare sector in the European Union has become a substantial part of the economy in terms of labour participation and technological investments. Health is also the most valued asset in the life of an individual. The European Union has therefore taken the importance of health into some of its major strategies and policies.

The EU is required by its founding treaty to ensure that human health is protected as part of all its policies. The EU's current health strategy 'Together for Health' (2008-2013) aims to protect and improve human health. This is the responsibility of DG SANCO (Directorate-General for Health and Consumer Affairs) and the strategy is implemented, among other things, through so-called health programmes. One of the aims of these health programmes is to generate and disseminate health information and knowledge needed for improving the health of EU citizens. This is for instance reflected in separate health information strands in the first and second Action Programme on Public Health. DG SANCO's mandate is especially in the area of public health, i.e. on health protection, disease prevention and health promotion.

In addition, contributing to the development of high-quality, accessible and sustainable health systems and services is part of different EU policy agenda's: social protection, public health, and recently also economic and financial affairs.

Several EU Councils focus on health issues

One of several Councils of the European Union (EU Councils), i.e. the one that deals with health and social matters (EPSCO: Employment, Social Policy, Health and Consumer Affairs Council) and that oversees the EU social protection and inclusion processes has dealt with healthcare issues for some time (3, 4). In 2011 the EPSCO Council has recommended the use of the Structural Funds to advance health system objectives and reduce health inequalities (5).

Another Council, the Economic and Financial Affairs Council (ECOFIN) has discussed the issue of financial sustainability of health and long-term care already for the first time in 2003. As the European Union recognises the prime responsibility of Member States for their own healthcare systems, it has taken until 2006 that the EU health ministers addressed the issue of health systems for the first time. They stressed the importance of safeguarding overarching values of universality, access to good quality care, equity, and solidarity (6).

As we already indicated DG SANCO has mainly focused on the public health part of health systems, i.e. on health protection, disease prevention and health promotion. It is obvious, however, that the distinction between healthcare and public health is often a thin line.

One major new health policy area in the European Union and beyond is the recent focus on chronic diseases, also addressed as noncommunicable diseases (NCD's). Textbox 1 summarises the activities that are proposed by the European Commission to be taken up within the European Union and its Member States.

This policy focus on NCD's has also emerged in response to the wider problem of increased ageing that is currently taking place throughout the EU. In this regard the recent EIP-AHA (European Innovation Partnership on Active and Healthy Ageing) is a recent EC initiative in which numerous stakeholders are joining forces in developing strategies and interventions to improve healthy ageing, also aiming at chronic diseases and chronic care (7).

Other EU policy areas that are important in this regard are policies and actions related to health inequalities and health in all policies, with their related areas of importance such as mental health and health at the workplace and environmental health.

Textbox 1: Chronic diseases high on the international and EU agenda

The Council of the European Union has recently published a Council Conclusion paper 'Innovative approaches for chronic diseases in public health and healthcare systems'. In this, the Council has invited the Member States and the Commission to "*initiate a reflection process aiming to identify options to optimize the response to the challenges of chronic diseases, the cooperation between Member States and summarize its outcomes in a reflection paper by 2012*"(1).

In addition, the United Nations (UN) High Level Meeting on noncommunicable diseases in New York in September 2011 confirmed that addressing chronic diseases has now become a global priority (8).

In its conclusions, the Council invited the Member States to:

- further develop patient-centred policies for health promotion, primary prevention and secondary prevention, treatment and care of chronic diseases, in cooperation with the relevant stakeholders, especially patients' organisations;
- ensure that these policies contribute to the reduction in health inequalities, taking into account a Health in all Policies approach;
- identify and exchange good practices with regard to these policies and to existing comparable data on the incidence and prevalence of, and the clinical and social outcomes for, chronic disease;

The Council also invited the Commission to integrate, where possible, chronic diseases as a priority in current and future European research and action programmes (1).

We conclude that health and health systems are now becoming part of a very complex EU policy environment in which chronic diseases and chronic care are implicitly or explicitly a central element. Issues such as ageing and health, health in all policies, health system performance and health inequalities are major elements of the underlying set of overlapping EU health policy perspectives.

Another EU policy perspective that can in potential influence health and health systems directly or indirectly is the Cohesion Policy that we will discuss next in some more detail.

3.2 EU Cohesion policy and Structural Funds

The Treaty on the Functioning of the European Union has established in its title on Economic, Social and Territorial Cohesion, that '*the Union shall develop and pursue its actions leading to the strengthening of its economic, social and territorial cohesion'*.

The Treaty of Lisbon has introduced the concept of territorial cohesion and as such recognised a strong territorial dimension for the cohesion policy, also referred to as the Regional Policy. This territorial approach requires a unique and modern governance system, combining different levels of government (European, national, regional and local). Member States thus conduct their economic policies and coordinate them for the promotion of the 'economic, social and territorial cohesion'.

The Cohesion policy, of the European Union is implemented with the aid of European Funds: the Structural Funds (SF) and the Cohesion Fund (CF). They aim to reduce regional disparities in terms of income, wealth and opportunities. Europe's poorer regions receive most of the support, but all European regions are eligible for funding under the policy's various funds and programs.

The Structural Funds consist of the European Regional Development Fund (ERDF) and the European Social Fund (ESF). Together with the Common Agricultural Policy (CAP), the Structural Funds and the Cohesion Fund make up the great bulk of EU funding, and the majority of total EU spending.

The tasks, priority objectives and the organisation of the Structural Funds, as guided by the Regional Policy framework, are defined by the European Parliament and the Council of the European Union. This occurs by ordinary legislative procedure and consulting of the Economic and Social Committee and the Committee of the Regions, which then leads to the publication of Regulations.

The division of money by the various Structural Funds is guided by three major policy 'objectives' (see Textbox 2):

1) The 'convergence objective';
2) The 'regional competitiveness and employment objective', and;
3) The 'European territorial cooperation objective'.

The mentioned funds, i.e. ERDF, ESF and CF, all three fund the first objective. The ERDF and ESF both fund the second objective as well and the ERDF is the single source for the last objective (9). Within the total of € 347.4 billion (bn) allocated for this period: 81.5% has in total been allocated to the convergence objective, 16% to the competitiveness and employment objective and 2.5% to the European territorial cooperation objective.

The current Regional Policy framework is set for a period of seven years, from 1 January 2007 to 31 December 2013. The overall budget for this period is € 347 bn. That is divided into € 201 bn for the European Regional Development Fund, € 76 bn for the European Social Fund, and € 70 bn for the Cohesion Fund.

In November 2006, the European Commission has adopted a new initiative for the 2007-2013 programming period under the Territorial Cooperation objective called 'Regions for Economic Change'. This has introduced new ways to activate regional and urban networks and to help them work closely with the Commission. This occurred with the aim to have innovative ideas tested and rapidly disseminated into the Convergence, Regional Competitiveness and Employment, and European Territorial Cooperation programmes.

Textbox 2: Structural funds: three major objectives

Convergence objective

The aim is to ***reduce regional disparities*** in Europe by helping those regions whose **per capita** gross domestic product (GDP) is less than 75% of the EU to catch up with the ones which are better off.

Some regions in the EU as constituted before the two most recent enlargements are now above the 75% threshold simply because the EU average GDP has fallen with the addition of the newest member countries. Those regions still need help from the cohesion policy, so they now receive *"**phasing out**"* support until 2013.

Number of regions concerned: 99.
Number of Europeans concerned: 170 million.
Total amount: €283.3bn (81.5% of total budget).
Type of projects funded: improving basic infrastructure, helping businesses, water and waste treatment, high-speed internet connection, training, job creation, etc.

Regional competitiveness and employment

The aim is to create jobs by promoting competitiveness and making the regions concerned more attractive to businesses and investors.

This objective covers ***all regions in Europe*** not covered by the convergence objective. In other words, it is intended to help the richer regions perform even better with a view to creating an ***knock-on effect*** for the whole of the EU to encourage more balanced development in these regions by ***eliminating any remaining pockets of poverty***.

Some regions, which used to be under the 75% threshold that would qualify them for inclusion in the convergence group, receive extra funding to help them ***"phase in"*** to their new objective.

Number of regions concerned: 172.
Number of Europeans concerned: 330 million.
Total amount: €55bn (16% of total budget).
Type of projects funded: development of clean transport, support for research centres, universities, small businesses and start-ups, training, job creation, etc.

European territorial cooperation

The aim is to encourage **cooperation across borders** - be it between countries or regions - that would not happen without help from the cohesion policy. In financial terms, the sums concerned are negligible in comparison with the other two objectives, but many countries and regions would like to see that change in future.

Number of regions concerned: all
Number of Europeans concerned: 500 million
Total amount: € 8.7bn (2.5% of total budget)
Type of projects funded: shared management of natural resources, risk protection, improving transport links, creating networks of universities, research institutes etc.

Source: DG REGIO website: http://ec.europa.eu/regional_policy/how/index_en.cfm#2

In practice, every region in the EU is covered by two of three main objectives of cohesion policy (convergence, regional competitiveness plus employment, and European territorial cooperation). However, most of the funds are targeted where they are most needed, i.e. at regions with a GDP per capita under 75% of the EU average. The actual definition and division of regions and their eligibility is rather complex, but explained in more detail on DG REGIO's website (10).

3.3 The financial crisis: public spending and health systems under pressure

The recent financial and economic crisis and the austerity measures that followed have affected public spending in many Member States and this includes spending for health systems. The EU Social Protection Committee (SPC) holds the opinion that focusing on health inequalities can improve healthcare efficiency. So, the EC Directorate-General for Economic & Financial Affairs (DG ECFIN) and the Economic Policy Committee (EPC) have recently zoomed in on health systems and their efficiency. The aim is to better understand the drivers of health expenditure and get more value for money out of resources put into the health sector.

In the quest for policies that strengthen financial sustainability as well as access to and quality of services, one of the most important challenges in the coming years is to get more value for money out of health sector resource allocation. This was further underpinned in a joint report on health systems prepared by the European Commission and the Economic Policy Commission (11). The report identifies several policy challenges that need to be addressed 'resolutely' given the current system strengths and weaknesses. These include improving health through more effective health promotion and disease prevention in and outside the health sector.

EU Member States have confirmed the urgency of tackling this challenge, and the need to further strengthen health promotion and disease prevention in this respect. The ECFIN Council highlighted the contribution of health to economic prosperity and pointed out that 'there appears to be scope to improve the health status of the population without increasing health spending' in many countries. According to ECFIN ministers, 'getting more value for money is crucial if countries are to ensure universal access and equity in health' and this should be factored in to proposals in the framework of the Europe 2020 strategy (11).

The currently existing large health inequalities within the EU, which we will look into in some more detail later, increases the urge to act and implement effective policies.

We conclude that political pressure is rising to intensify the use of the Structural Funds for improving health and health systems and reducing health inequalities throughout the European Union. The financial crisis and its implications for public funding have put national and regional health system expenditures under pressure, while populations are ageing and chronic diseases become more important. This emphasises the need for improvements, including those needed in the area of chronic diseases, and the need for investments, for instance by the Structural Funds.

An important question is then, if and how the Structural Funds have been effective instruments to improve health and health systems up to now and how this could be improved further. To that end the next chapter will provide an overview of what is known about the use of Structural Funds for health in the past.

4 The use of the Structural Funds for health

Below we shortly discuss the use of the Structural Funds for health and summarise findings of EU funded projects and networks that have supported regions and Member States in getting and implementing SF.

What are the Structural Funds currently used for?

As we saw before, the Structural Funds are not just used for direct investments in health. At the website of Directorate-General for Regional and Urban Policy (DG REGIO) (12) where the Cohesion Policy 2007-2013 is presented we find a number of areas with partly overlapping headings that give an indication of where the money is spent on.

The total project area is divided into areas with various partly overlapping headings, i.e.: *Air quality; Business support; Business advisory services; Education and training, life long learning; Employment and labour market; Energy, Environment, Environmental technologies, Health, ICT-access, e-inclusion; Innovation, research and technological development; Railways, Rural Development; Social inclusion, jobs, education and training; Social inclusion, equal opportunities; Social infrastructure; Structural Funds management and government; Territorial Co-operation; Tourism; Tourism and culture; Transport; Urban development; Waste disposal and recycling*.

Under a description of the various EU regions that benefit from funds under different headings, i.e. convergence regions, phasing-out regions, phasing-in regions and competitiveness and employment regions, we find the heading 'success stories'. When we look for projects that focus on health among these success stories, we find that only 6 projects out of several hundred are registered there under the heading 'health'. No details about best practices in the use of SF for health are available there, however.

Still, we envisage that many other projects deal indirectly with health or public health for instance by dealing with air quality or environmental pollution control, or promoting affordable and sustainable housing. We conclude that the structure of the programming until now has not anticipated strongly on the goal of improving health and healthcare, and has led to a prioritization of social and environmental issues.

An overview of health investments by the Structural Funds

A good overview of the direct and indirect use of Structural Funds for health has been provided by the EUREGIO III project (13). The amount of health investments from the EU Structural Funds was found to vary enormously between Member States.

The total sum of planned health investments for the 2007-2013 period has been estimated at around € 5 billion, i.e. about 1.5% of the total amount gone into the Structural Funds. This amount, however, constitutes not only direct health sector investment in health infrastructure, but also indirect health sector investments and non-health sector investment with a potential for added health gain. The estimate is probably a conservative estimate of the potential amount of health investments for this period.

The three forms of health investment can be differentiated further as follows:

- ***Direct health sector investments*** contain a clearly targeted/planned investment in health infrastructure. These investments have gone under the following headings: infrastructure; e-health; education and training; quality management; emergency services; health promotion; inpatient services, outpatient services, access to services and 'other'.
- ***Indirect health sector investments*** are investments in sectors where also a positive impact for health can be expected, like e.g. employment and labour market policies. The various categories of such investments are: workplace health, health and safety, e-health, urban development, inclusive employment and 'other'.
- ***Non-health sector investments*** are those investments that have a potential added health gain, specifically potential impacts on the wider economic, social and environmental determinants of health. Again we find a series of categories of actions/activities according to which these kind of investments are classified: knowledge hubs, inclusive employment, innovation clusters, urban development, sustainable transport, environmental quality, social cohesion, leisure facilities, active ageing, community engagement, renewable energy.

The review that we cite here (13) showed that health investments in health infrastructure have mainly been taken up in Member States with Convergence objective regions, i.e. the 'new' Member States that entered the EU in and after 2004. Health infrastructure is the core element of direct investment in Bulgaria, Czech Republic, Greece, Hungary, Lithuania, Latvia, Poland, Romania and Slovakia. This underpins the modernisation of healthcare services in these countries.

How are countries and regions supported to get funding?

Support for regions in getting and implementing SF funding has been provided through two networks. The first is HealthClusterNet, a network of regional authorities that are concerned with procurement practice, with employment for vulnerable social groups, with capital investments and with the promotion of innovation. The second is provided by the earlier mentioned EUREGIO III project and focuses on capacity-building of experts and on regional policy makers that are potential funds applicants. This is implemented through international workshops and training events. The 'Building Healthy Communities' project (2008-2011) has focused on cities and also worked to improve health and guide cities to use European funding to support their actions.

In addition, there are some industry networks. For example, COCIR, the European coordination committee of the industry that deals with radiological, electromedical and healthcare IT. They envisage future 'sustainable' healthcare 'through a wide scale adoption of healthcare IT systems and related telemedicine technologies throughout the Member States' (14).

5 Lessons learned from the use of the Structural Funds for health

Below we discuss the information on lessons learned from the use of the Structural Funds for health provided by European projects and the scientific and grey literature.

5.1 Information from EUREGIO III

EUREGIO III: exploring the use of SF for health

The EUREGIO III project (2009-2011) (see Textbox 3) has explored and assessed the use of SF for direct health investment in the 2000-2006 and 2007-2013 SF periods. The project has systematically addressed the collection of evidence from existing SF projects that pointed at effectiveness, efficiency and sustainability of health system investments.

To this end the project has studied various case studies[1] of projects that used Structural Funds and worked on health related investments. The project has undertaken stakeholder surveys and many other forms of consultations with experts and policy makers that were also involved in the use of SF for direct health system improvements (15).

The case studies were grouped according to certain criteria (13). One set of case studies consisted of specifically Structural Funds related projects. The other group of case studies contained not specifically Structural Funds related projects but projects of which the SF relevance could be high. These were used as non-SF comparative reference sources.

Textbox 3: Three EUREGIO projects

Several projects that bear the name 'EUREGIO' have been funded over the years under DG SANCO's Public Health Programme. They have aimed to support regions of the European Union in the area of public health and health services including support on how to best make use of the existing Structural Funds.

The first EUREGIO project (2005-2007) was entitled 'Evaluation of cross-border regions in the European Union (EUREGIO)'. This first EUREGIO project has developed 'good practices for better health' for EU cross-border regions (16) and was followed by EUREGIO II, a project which had in its broader title the indication: 'Solutions for improving health care cooperation in border regions'. One of the aims of EUREGIO II was to assist regions to get and use the EU ERDF for health-related purposes (17).

This EUREGIO II project was complementary to the project 'Health investments in Structural Funds 2000-2006: learning lessons to inform regions in the 2007-2013 period' (EUREGIO III).

[1] http://www.euregio3.eu/pages/practical-knowledge-database/

Projects were then selected that offer good practice pointers for the future, such as (15):

- Measurable contribution to reducing health inequalities;
- Consistency with Europe 2020 aims and objectives;
- Coherence with master planning 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.

Given the emerging financial and economic crises it was logical that the focus of the evaluation of these case studies has been partly reshaped to case studies that offer relevant and important precedents and learning experience for the future, which implies that the investment strategy to be followed must at least address (15):

- 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 EU Presidency that called for reform of health systems to move on from an unsustainable hospital-centred model towards more sustainable and effective integrated care systems.

EUREGIO III: analysis of funding areas and strategies for health

The analysis made by the EUREGIO III project showed that much of the focus for SF investment during the past and current programme cycles (2000/6 – 2007/13) has been on capital expenditure for hospital and health facility renewal and on eHealth projects.

There are a number of primary areas of focus for hospital and health facility renewal:

- Quality improvement, including patient safety;
- Improving patient access and empowering patients;
- Managing clinical costs and reducing administrative costs;
- Facilitating the introduction of new models of care.

However, capital asset spending has largely resulted in replication of existing hospital centric models of service delivery which are currently being challenged by alternative and more effective and sustainable models of care. There has been little evidence of innovation aimed at transformational change away from the dominance of hospitals as the primary focus of healthcare. It is then suggested that projects of this kind are unlikely to meet future SF criteria.

The EUREGIO III project found that eHealth is the fastest growing area of new investment (SF and non-SF) and now represents about 35% of all new capital investment in healthcare.

The principle areas of spending in support of eHealth initiatives are:

- Computer-based patient records;
- ePrescribing;
- Interoperability of ICT systems.

Investments aiming at applying eHealth to improve continuity of care are lagging behind these growth areas, however. The progress in this particular area appears to be slow and fragmented. In addition, the development of eHealth programs that support integration and continuity of care, which is a pre-requisite for transformational change in models of care, is significantly under-developed. To a large extent this results from professional resistance, public apathy and possibly concentrating too much on the technical dimensions of eHealth.

Conclusions drawn from EUREGIO III

Evaluating the use of Structural Funds by the EUREGIO III project has identified a number of issues that need improvement:

- The need to enhance policy effectiveness;
- Difficulties with the process of acquiring funds;
- Weak capacity;
- Lack of strategic approach.

The project also found that the current SF process has tended to favour single (monofocus) projects. This is contrary to what is stated in the EU Council Conclusions 'Towards modern, responsive and sustainable health systems' (6 June 2011), which strongly advocates the need to develop a more integrated and pluralistic model of healthcare in place of the hospital centered default model which is now common across most MS (4). The Structural Funds can have a major role to play in supporting this shift.

Still, EUREGIO III also concluded that there has been a more recent (2007/13) shift towards spending on 'healthy ageing' projects in line with the new 'Europe 2020' Strategy.
It was not analysed, however, if a specific focus was introduced on chronic diseases, for example.

An important conclusion is that the actual development of modernised care structures or procuring new care services based on the use of Structural Funds is very complex. Keeping the size of structural investments matched with the development of human capital can often be problematic; i.e. new hospitals will need doctors and nurses. The timing of decision making and stakeholder involvement often led to significant delays in the use of the Funds.

A final conclusion was the remaining need for guidance and support and the translation of knowledge and learning generated by existing projects (knowledge brokering) and the need for capacity building and technical support.

EUREGIO III recommendations for future SF investments

New goals and aims needed

Several of the projects that were investigated in EUREGIO III already addressed new priority focus areas as defined in previous EU Council conclusions (June, 6, 2011) and a draft Cohesion Policy 2014-2020 Proposal, i.e. healthcare reform and master planning, integrated care, eHealth and technology innovation and integration, healthy ageing, hospital development/redevelopment.

The outcomes of this evaluation by EUREGIO III pointed further at several potential new goals and aims to be taken up by future SF projects. These are, among others, making a

measurable contribution to reducing health inequalities, being consistent with the policy aims and objectives of the Europe 2020 strategy, maintaining coherence with planning frameworks and regional development plans, improving workforce competencies and skills, looking for sustainable investment changes and departing from realistic starting points. This was especially important in the MS that joined the EU in and after 2004 that have each their own historical peculiarities in their health systems.

In summary, according to EUREGIO III it is essential that future projects should:

- Take a real commitment to what can be called 'transformational change', i.e. a shift away from a hospital centric model of care to more pluralistic, community-based and integrated care;
- A focus on affordable and sustainable investments with all complexities is essential;
- Address health inequalities, including creating equal access to basic healthcare services (general practitioners, outpatient clinic, polyclinic, community-based care). This may require addressing priorities at the NUTS3 (small regions for specific diagnoses) level as major inequalities can exist at that level in Europe.

5.2 Other sources of information

Publications on the use of Structural Funds for health

A selection of case studies has been published as a book which exemplifies previous capital investments for health in the EU (18). This book included early examples of the use of the Structural Funds, but mostly referred to situations in relatively rich countries in the European Union.

We also found two articles on the use of Structural Funds for health in the literature that is covered by PubMed. A first, short, article by McCarthy (14) provides a quick overview of the backgrounds and spending on health in the new Member States. The article ends by identifying a few opportunities, which are stated as follows:

- *The structural funds can support country health systems through attracting and retaining workers, support for IT, the link to pensions and social security, and through research and innovation for economic development. The health sector also needs to make the 'health = wealth' argument, demonstrating that health is a beneficial investment rather than a cost.*

According to McCarthy the health sector should also encourage beneficial indirect investments, e.g. through business sector attention to health and safety, and in 'health in all policies' through other European programmes.

The article concludes that in many of the new Member States, upgrading acute hospitals has been the first priority. Although healthcare for elderly people depends on good hospital assessment and treatment, this is only one part of the picture. More can be done at home with suitable community support, and long-term care provision is needed for people where family carers are no longer available. In addition, it is suggested that an important issue exists in EU countries in the area of planning for social and health-care services for the increasing proportions of elderly people.

A final important field, according to McCarthy, is the need for more attention for health research. The Structural Funds already have separate operating programmes for research, and

several of the new Member States are planning to spend >10% of their total funds on research in general. However, the emphasis for health research has mostly been on biomedical research, for example biotechnology and science parks. Ministries of health should engage with ministries for science to make the case for more research in public health. The latter point is elaborated in more detail in a recent article by the same author (19), which discusses the outcomes of the STEPS project that has made an inventory of public health research in European Member States.

EU project: Building Healthy Communities

The now finished 'Building Healthy Communities' project (2008-2011) has worked on improving health and guiding cities to use European funding to support their actions. This Building Healthy Communities Thematic Network consisted of a partnership of 10 cities from seven EU Member States who worked together over the 30 months in order to capitalise knowledge and practices on urban factors influencing health and to create opportunities for cities to shape and implement healthy policies for their citizens. Partner Cities in this project were: Amaroussion (Greece), Bacău and Baia Mare (Romania), Belfast and Barnsley (United Kingdom), Lecce and Torino (Italy), Lidingö (Sweden), Łódź (Poland) and Madrid (Spain). Their experience is summarised in the projects final report (20).

The cities in the Building Health Communities project developed a very different set of local action plans. The project organised three thematic workshops to provide the cities with knowledge on how to assess and monitor health in cities, on different models of healthy lifestyles (and thus policies) and on the available opportunities for funds in the current EU programming period (especially as regards Structural Funds). To be able to more concretely assess health in urban policies a training session on health impact assessment (HIA) was organised. The need to improve the effectiveness of local policies led to a meeting in which the use of social marketing techniques for designing health policies has been analyzed.

6 Sources of best practices to reduce the burden of chronic disease

In its original aim this report wanted to *concentrate on information about beneficial MS activities in the field of chronic diseases (examples of good practices), especially in relation to the use of Structural Funds for chronic diseases. It should focus on mapping Member States good practices and developing a methodology to compare these best practices and extract common issues valid for all Member States.*

We saw in the previous chapters, however, that no information was found that identified best practices for the use of SF for chronic disease control in EU Member States and these could therefore not be mapped. A closely related question is then what can MS do to use existing best practices and policies to support the use of the Structural Funds for improving the burden of chronic diseases in the future?

In our view providing best practices to MS regarding improvements for their health and health systems can and should be based on the existing evidence, best practices and recommendations that have been compiled by international organisations and try to be in line with the existing EU policy frameworks that we discussed before. Many of these focus directly or indirectly on chronic diseases. Finally, this should align with the aims of the Cohesion Policy, i.e. focus on health inequalities as well.

Several international organisations (WHO, the Organisation for Economic Co-operation and Development (OECD), the Worldbank) have published extensive reports that summarise best practices and strategies to improve health and health systems, to reduce regional and socio-economical health disparities, deal with ageing and health and give priority to combating NCD's (noncommunicable diseases). This information also reflects common issues valid for all Member States.

Textbox 4 provides a - non exhaustive - selection of relevant reports produced by qualified international organisations in the chronic disease area. To allow a better focus on inequalities we like to point at a report by WHO in that selection, that addressed the use of the Structural Funds to reduce Health inequalities.

We finally like to refer to a recent white paper by EPPOSI, the European Platform for Patients's Organisations, Science and Industry (21). This report provides a systematic framework of recommendations and suggested actions that deal with desirable policy responses, patient empowerment and practice level advice to better and more systematically approach chronic diseases. Using Structural Funds for chronic disease control could be supported by such a systematic action framework.

Textbox 4: Overview of sources on chronic disease control and reducing health inequalities

Basic reports by international organisations and renowned experts providing best practices, strategies, interventions, evidence on management and organisation of care for chronic diseases.

Chronic diseases: general (strategies and actions)

WHO. A strategy to prevent chronic disease in Europe. A focus on public health action. The CINDI vision: WHO, 2004

WHO. Global status report on noncommunicable diseases 2010. Geneva: WHO, 2011.

Beaglehole R, Bonita R, Horton R, Adams C, Alleyne G, Asaria P, et al. Priority actions for the non-communicable disease crisis. Lancet. 2011 Apr 23;377(9775):1438-47.

Suhrcke M, Nugent RA, Stuckler D, Rocco L. Chronic Disease: An Economic Perspective, Confronting the epidemic of chronic diseases, London: Oxford Health Alliance, 2006. London: Oxford Health Alliance, 2006.

WHO-Europe. Gaining health. The European strategy for the prevention and control of noncommunicable diseases. Copenhagen: WHO Regional Office for Europe, 2006.

WHO-Europe. EUR/RC61/12 Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016. Copenhagen: WHO Regional Office for Europe, 2011.

Chronic diseases, prevention, risk factors and life style

WHO-Europe. WHO European action plan for food and nutrition policy 2007-2012. Copenhagen: WHO Regional Office for Europe, 2008.

WHO-Europe. Steps to health. European framework to promote physical activity for health. Copenhagen: WHO Regional Office for Europe, 2007.

WHO-Europe. EUR/RC61/13 European action plan to reduce the harmful use of alcohol 2012–2020. . Copenhagen: WHO Regional Office for Europe, 2011.

Sassi F, Hurst J. The Prevention of Lifestyle-Related Chronic Diseases: an Economic Framework. OECD health working paper no. 32 Paris: OECD, 2008.

Bemelmans WJE, Verschuuren M, Van Dale D, Savelkoul M, Wendel-Vos GCW, Van Raaij J. An EU-wide overview of community-based initiatives to reduce childhood obesity. Bilthoven: RIVM2011.

Oortwijn W, Nelissen E, Adamini S, van den Heuvel S, Geuskens G, Burdorf L. Social determinants state of the art reviews: health of people of working age - Full Report. Luxembourg: European Commission Directorate General for Health and Consumers. 2011

Chronic diseases: health system and disease management

Busse R, Blümel M, Scheller-Kreinsen D, Zentner A. Tackling Chronic Disease In Europe Strategies, interventions and challenges. Copenhagen: European observatory on Health Systems and Policies, 2010.

Velasco-Garrido M, Busse R, Hisashige A. Are disease management programmes (DMPs) effective in improving quality of care for people with chronic conditions? Health Evidence Network report. Copenhagen: WHO Europe, 2009.

Rijken PM, Bekkema N. Chronic Disease Management Matrix 2010: results of a survey in ten European countries. Utrecht: Nivel, 2011.

Nolte E, Mckee M. Caring for people with chronic diseases. A health system perspective. European observatory on Health Systems and Policies, 2008.

OECD. Health care systems: Getting more value for money, Economics Department Policy Notes, No. 2, OECD, Paris, 2010.

Chronic diseases: disease specific (examples)

GOLD. (Global Initiative for Chronic Obstructive Lung Disease). Global Strategy for Diagnosis, Management, and Prevention of COPD, 2011. http://www.goldcopd.org/uploads/users/files/GOLD_Report_2011_Feb21.pdf.

IDF. (International Diabetes Federation) Diabetes prevention studies. 2012 [cited 2012 August 24]; Available from: http://www.idf.org/diabetes-prevention/prevention-studies.

Inequalities

WHO Europe. How health systems can address health inequities through improved use of Structural Funds. Copenhagen, WHO Regional Office for Europe, 2010.

7 Conclusions, discussion and recommendations

Conclusions

We conclude that the evidence of effective healthcare investments by means of the Structural Funds is scarce and quite diffuse in scope and focus. Some learning points can be found among the studies investigated, which, however, may not always or automatically be applicable to other regions. The currently evaluated projects were not specifically focusing on chronic diseases and no information on best practices in using the SF for chronic disease control is available.

SF investments for health not focused on newer care models

Evaluations show that much of the focus for SF investment during the past and current programme cycles (2000/6 – 2007/13) has been on capital expenditure for hospital and health facility renewal and on eHealth projects. Capital asset spending has largely resulted in replication of existing hospital centric models of service delivery. These are currently challenged by alternative and more effective and sustainable models of care. There has been little evidence that SF were used for innovation aimed at transformational change away from the dominance of hospitals as the primary focus of healthcare.

No evidence is available of actual outcomes such as decreasing health inequalities or health improvements by the use of Structural Funds. This is not illogical, however, as no criteria for health improvement or health inequalities were defined by which the funding was allocated. Furthermore, the use of Structural Funds often mingles with the use of local and other funds and any effects found would be shared effects.

Future SF projects need stricter alignment with existing health policies

It appears important that new goals and aims should be taken up by future SF projects and these should and can be better related to existing health policies. Given the focus of the Cohesion Policy this implies aiming more clearly at reducing health inequalities.
A focus on making a measurable contribution to reducing health inequalities is essential as is being consistent with the policy aims and objectives of the Europe 2020 strategy. This will automatically address the issue of reducing the burden of chronic diseases as well and automatically bring into focus policies that aim at improving health system efficiencies, improve health in all policies and active and healthy ageing.

Need for technical support to better use the SF for health

One conclusion from the evaluation of the use of SF for health was the remaining need for technical support and expertise to regional and national policy makers in drawing up health-related plans for investments.

Technical support would also involve, in our view, input about best practices on chronic diseases of the kind that is provided by the reports that we compiled in Textbox 4 in chapter 6. This is the information base that needs to be used for assessing regional health needs and regional health system performance deficiencies.

The major problem appears to be the question of how to get the right expertise to MS regions at the right time and this would also be one of the major challenges for the European Commission. Solving this problem would, in our view, imply the need for working across Directorates and especially for working closely together with the relevant international organisations, such as WHO and OECD in bringing the right expertise and knowledge to the right place at the right time.

A final important issue, which we did not discuss in this report, is the fact that in order to be able to assess and monitor regional population health and perform health system assessments good and comparable data are needed, which are currently often lacking at the regional level.

Discussion

New health indicators needed to qualify regions to apply for Structural Funds

The conclusion that the use of the SF could be much better lined up with the aim of reducing health inequalities is also in line with the observation that serious discussion has arisen about the fact that currently only GDP is used as a criterion that qualifies a European region for support from the Structural Funds.

We will dwell upon this problem in some more detail in the following discussion by looking at indicators that could help in better selecting regions that would qualify for SF money to reduce health inequalities.

Differences within the EU in economic prosperity, poverty rates but also in measures of population health status are still large, although their absolute levels may have improved over time as well.

Differences in health and wellbeing exist not only between the Member States, but also within the Member States at the regional and local levels. Even within relative prosperous European regions special groups or specific urban or rural areas may often show a much lower well-being or health status than is average for that region.

With the expansion of the European Union the socio-economic variability and health inequalities between the Member State has greatly increased as well. Currently, the European Union is facing larger health inequalities than the United States of America (USA) (see Textbox 5 and Figure 1).

Income related to health, but not without significant variation

At the regional level in the EU27 we see that economic prosperity as measured by relative income is strongly related to health as measured by life expectancy (Figure 2). There is a strong correlation between the average regional income per head (indexed to the EU average) and the regional life expectancy at birth. EU regions with half the average income have on average a 5 to 8 year lower life expectancy. Regions with 75% of the average income also lag 5-6 years behind in life expectancy.

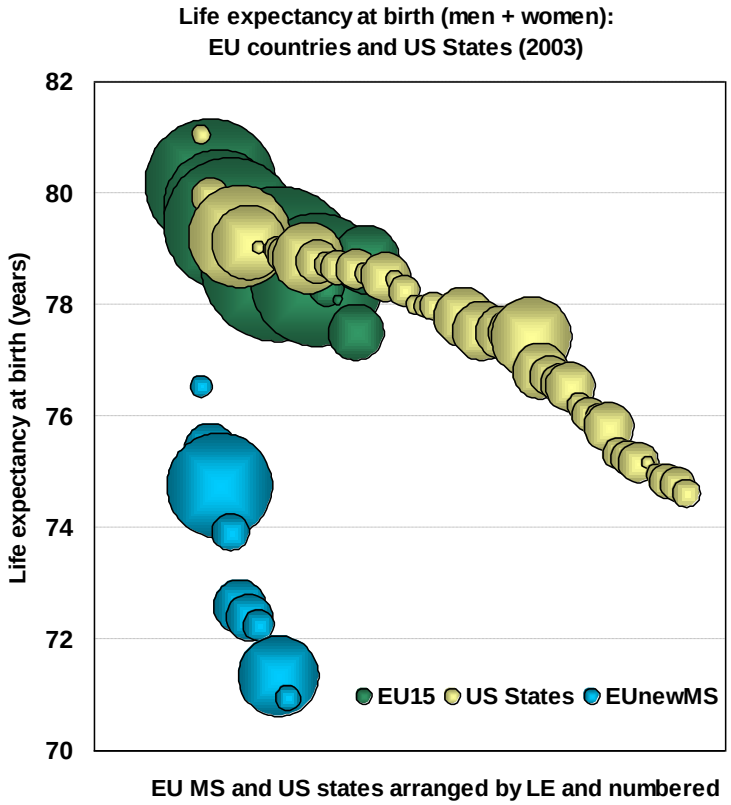
Still, we also see that regions with an income more or less equal to the EU average may differ in their life expectancy by 5-6 years. We also see that regions with a slightly less than average income may have higher than average life expectancies.

Textbox 5: EU facing larger health inequality challenge than the USA

Socio-economic and regional health differences also occur outside Europe. This is illustrated in Figure 1 that displays a comparison of the life expectancies of the individual states within the USA compared to European Member States. US states and EU Member States are often similar in either population numbers or economic prosperity.

Figure 1: Differences in life expectancy in US states, EU 15 and new Member States (Data sources: CDC wonder[2] and WHO-HFA database[3]).

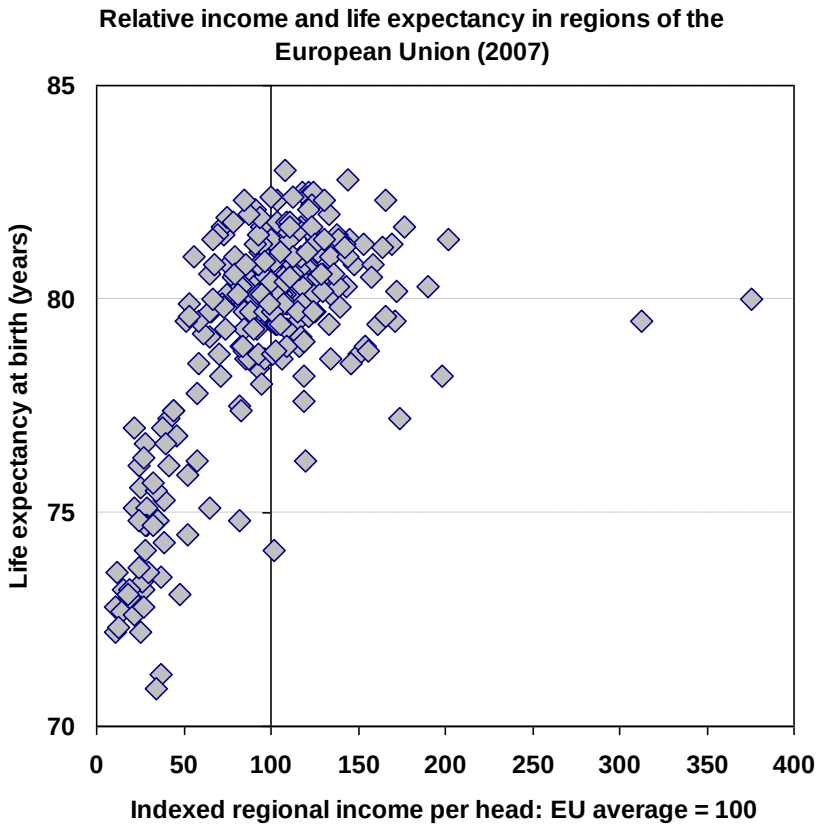
(Bubble size relates to population size; x-axis position not relevant).



The variation in life expectancy among US states is rather large, i.e. about 5.5 years and larger than the variation in life expectancy between the countries of the EU15, which is about 3 years. About fifteen of the US states have lower life expectancies than the lowest scoring EU15 country. However, adding 10 new Member States to the EU, has caused a much larger variation in life expectancy between the EU Member States, i.e. more than 9 years and this is much larger than the USA variation. A 6 year difference in life expectancy equals to a twofold increased mortality risk at all ages. This shows that European Union currently faces a much larger challenge in reducing health inequalities than the USA.

[2] http://wonder.cdc.gov/wonder/help/populations/population-projections/MethodsTable2.xls
[3] http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-health-for-all-database-hfa-db2

Figure 2: Differences in life expectancy in EU regions versus regional income, in 2007 (Data source: Eurostat[4]).



It is quite clear therefore that starting with GDP as a single criterion for dividing the Structural Funds to improve health and health systems will not automatically lead to the best or most effective investment in terms of improving health as this may not select regions that are farthest behind in terms of health and inequalities. Taking health indicators, i.e. life expectancy, or health-related indicators into account would improve the selection.

Taking into account differences in life expectancy when selecting regions that apply for Structural Funds, would also nearly automatically lead to focusing on chronic diseases, because the major part of mortality and differences in life expectancy is determined by chronic diseases, such as cardiovascular diseases, cancers, diabetes and chronic obstructive pulmonary disease.

Still, other indicators, that deal with other aspects of inequality have been proposed as well. One such composite indicator may be the HDI (Human Development Index), which combines life expectancy, GDP and education. Another composite indicator is the Human Poverty Index 2 (HPI-2) which combines a measure of longevity, risk of poverty, low education, and long-term unemployment as suggested in a study by DG REGIO (22). Both these indexes are suitable to guide SF investments better towards reducing regional health inequalities.

[4] http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database

Recommendations

We would like to recommend:

- To improve the use of the Structural Funds for improving health and reducing, for instance, the burden of chronic disease and health inequalities, it would be important to add health-related indicators, such as life expectancy to GDP as selection criteria to qualify European regions for SF funding.

- National and/or regional health ministers should become more pro-active in promoting the use of Structural Funds for investing in health as the current financial crisis may hit the health sector strongly. There are clear opportunities but implementation will require willingness and commitment from health authorities in regions that are involved in the Structural Funds process.

- It would be important for DG SANCO to continue its interest and involvement in the Cohesion Policy and to become effectively involved in dialogues with DG REGIO and DG EMPLOYMENT on the future improved use of the Structural Funds as a source of support for health improvement and health sector investments.

- Health actors in EU regions should receive support to develop competencies to demonstrate that health fits well within regional development policies. This will enable them to apply principles of health impact assessment or to structure policies towards decreasing social inequalities in health. There is a role for the European Commission here.

- Supporting the systematic collection, evaluation and transfer of best practices in chronic disease control remains an important objective of future European health policies. Linking this to the use of the SF is a major EU challenge.

References

1. Council of the European Union. Council conclusions 'Innovative approaches for chronic diseases in public health and healthcare systems' (2011/C 74/03). Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2011:074:0004:0005:EN:PDF Official Journal of the European Union 832011. 2011.
2. Suhrcke M, McKee M, Sauto Arce R, Tsolova S, Mortensen J. The contribution of health to the economy in the European Union. Available at: http://ec.europa.eu/health/ph_overview/Documents/health_economy_en.pdf: DG Health & Consumer Portection2005.
3. EPSCO. Joint report (EPSCO / ECOFIN 7166/03) by the Commission and the Council on supporting national strategies for the future of health care and care for the elderly. Available at: http://ec.europa.eu/employment_social/soc-prot/healthcare/elderly_en.pdf 2003.
4. European Commission. Communication from the Commission of 20 April 2004 - Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the 'open method of coordination'. COM (2004) 304 final. Available at: http://ec.europa.eu/employment_social/soc-prot/healthcare/com_04_304_en.pdf. 2004.
5. EPSCO. Council Conclusions (EPSCO): Towards modern, responsive and sustainable health systems. Brussels, 6 June 2011. Available at: http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/122395.pdf2011.
6. Council of the European Union. Council Conclusions on Common values and principles in European Union Health Systems. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF. Official Journal of the European Union. 2006;2006/C 146/01.
7. EIP-AHA. European Innovation Partnership on Active and Healthy Ageing. 2012 [cited 23 November 2012]; Available from: http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing.
8. UN General Assembly. Resolution adopted by the General Assembly. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. A/RES/66/22011.
9. DG REGIO. Regional Policy: Three objectives. 2012 [cited 4 November 2012]; Available from: http://ec.europa.eu/regional_policy/how/index_en.cfm.
10. DG REGIO. Regional Policy: Is my region covered? 2012 [cited 4 November 2012]; Available from: http://ec.europa.eu/regional_policy/how/coverage/index_en.cfm#3.
11. AWG. Joint Report on Health Systems prepared by the European Commission and the Economic Policy Committee (AWG). European Economy Occasional Papers nr 74. 2010.
12. DG REGIO. Regional Policy: purpose. 2012 [cited 23 November 2012]; Available from: http://ec.europa.eu/regional_policy/what/index_en.cfm.
13. Watson J. Health and Structural Funds in 2007-2013: Country and regional assessment. Available from: http://wiki.euregio3.eu/download/attachments/6260097/WATSON_Health+and+SF+Country+and+regional+assessment.pdf: Directorate-General for Health and Consumer Affairs 2009.
14. McCarthy M. Health and the European Structural Funds in the new member states. Eur J Public Health. 2011 Mar 11.

15. EUREGIO III. EUREGIO III: lessons learned about improving investment in regional health systems using Structural Funds. Executive Summary, March, 2012. Available at: http://euregio3.eu/media/attachment/EUREGIO_III_Final_report-_Executive_Summary.pdf. 2012.
16. Brand H, Hollederer A, Wolf U, Brand A. Cross-border health activities in the Euregios: good practice for better health. Health Policy. 2008 May;86(2-3):245-54.
17. EUREGIO II. EUREGIO II Project website. 2012 [cited 1 October 2012]; Available from: http://www.maastrichtuniversity.nl/web/Institutes/FHML/FHML/DepartmentsCAPHRI/InternationalHealth/ResearchINTHEALTH/Projects/EUREGIOII.
18. Rechel B, Erskine J, Dowdeswell B, Wright S, McKee M. Capital investment for health. Case Studies from Europe: WHO, on behalf of the European Observatory on Health Systems and Policies. 2009.
19. McCarthy M. Public health research support through the European structural funds in central and eastern Europe and the Mediterranean. Available at: http://www.health-policy-systems.com/content/10/1/12. Health Research Policy and Systems. 2012;10(12).
20. Urbact. Building healthy communities. Final Report. October 2011. Available at: http://urbact.eu/fileadmin/Projects/Building_Healthy_Communities__BHC_/documents_media/Final_Report_bhc_saved.pdf. 2012 [cited 23 November 2012].
21. Pavlickova A. Building a workable model for the holistic management of chronic conditions in Europe. EPPOSI AIP-CCM White Paper. Brussels. 2012.
22. Bubbico RL, Dijkstra L. The European Human Development and Human Poverty Indexes. Available at: http://ec.europa.eu/regional_policy/sources/docgener/focus/2011_02_hdev_hpov_indices.pdf: DG Regional Policy2011.

Disclaimer

This report was produced and funded under the EU Health Programme (2008-2013) in the frame of a specific contract with the Executive Agency for Health and Consumers (EAHC) acting under the mandate of the European Commission.

Annex 1: Websites visited

(Date of visit to website in brackets)

BHC (Building Healthy Communities); project under URBACT: http://urbact.eu/en/projects/quality-sustainable-living/building-healthy-communities-bhc/homepage/ (19-10-'12)

DG REGIO (Regional policy): http://ec.europa.eu/regional_policy/how/index_en.cfm, (4-11-'12)

DG REGIO (Regions covered by SF)*:* http://ec.europa.eu/regional_policy/how/coverage/index_en.cfm#3, (4-11-'12)

DG REGIO (Regional Policy: How does it work?) http://ec.europa.eu/regional_policy/how/index_en.cfm#3, (3-10-'12)

DG SANCO (health and the structural funds): http://ec.europa.eu/health/health_structural_funds/policy/index_en.htm (1-9-'12)

EIP-AHA: http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=home (10-11-'12) (=European Innovation Partnership on Active and Healthy Ageing)

EUREGIO (Euregio I): http://www.euregio.nrw.de/ (1-10-'12)

EUREGIO III: http://euregio3.eu/ (1-10-'12)

HealthClusterNet: http://healthclusternet.eu/ (1-11-'12)

Innovation Union: http://ec.europa.eu/research/innovation-union/ (10-11-'12)

URBACT: http://urbact.eu/ (11-11-'12)

Annex 2: List of abbreviations

AHA	Active and Healthy Ageing
AWG	Economic Policy Committee
bn	billion
CAP	Common Agricultural Policy
CDC	Centres for Disease Control (USA)
COCIR	European Coordination Committee of the Radiological, Electromedical and Healthcare/IT-Industry.
DG ECFIN	Directorate-General for Economic Affairs
DG EMPLOYMENT	Directorate-General for Employment, Social Affairs and Inclusion
DG REGIO	Directorate-General for Regional Policy
DG SANCO	Directorate-General for Health and Consumer Affairs
EC	European Commission
ECOFIN	Economic and Financial Affairs Council
EIP-AHA	European Innovation Partnership on Active and Health Ageing
EPC	Economic Policy Committee
EPSCO	Employment, Social Policy, Health and Consumer Affairs Council
ERDF	European Regional Development Fund
ESF	European Social Fund
EU Council	Council of the European Union
EU	European Union
EU15	The 15 countries making up the European Union before 1 May 2004: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom
EU27	The 27 Member States of the European Union since 1 January 2007: these are the EU15 countries plus Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia
EUREGIO 1, 2, 3	three EU funded projects
Eurostat	European Statistical Agency
GDP	Gross Domestic Product
HDI	Human Development Index
HFA	Health For All database (WHO)
HIA	Health Impact Assessment
HPI-2	Human Poverty Index 2
ICT	Information and Communication Technology
IT	Information Technology
MS	Member State (EU Member State)
NCD	noncommunicable disease
NUTS3	Nomenclature of Territorial Units for Statistics, NUTS 3: small regions for specific diagnoses
OECD	Organisation for Economic Co-operation and Development
RIVM	National Institute for Public Health and the Environment (the Netherlands)
SF	Structural Funds
SPC	Social Protection Committee
STEPS	EU funded project
UN	United Nations
Urbact	EU funded project
WHO	World Health Organization
WHO-Europe	World Health Organization Regional Office for Europe

Annex 3: PubMed Search Results

Search: Title and Abstract for ‘structural funds’ AND ‘health’. Exclude articles not in English and before 2006.

Ask P, Ekstrand K, Hult P, Lindén M, Pettersson NE.
NovaMedTech - a regional program for supporting new medical technologies in personalized health care.
Stud Health Technol Inform. 2012;177:71-5.

McCarthy M.
Public health research support through the European structural funds in central and eastern Europe and the Mediterranean.
Health Res Policy Syst. 2012 Apr 5;10:12.

McCarthy M.
Health and the European Structural Funds in the new member states.
Eur J Public Health. 2011 Mar 11. [Epub ahead of print]

Excluded

Mazurek M.
[Structural funds as a source of financing investments in health care units].
Przegl Epidemiol. 2010;64(4):577-81. Polish.

Choiński J, Jastrzębski J.
The opening ceremony of the Radiopharmaceuticals Production and Research Centre at the Heavy Ion Laboratory of the University of Warsaw, May 15, 2012. Followed by an International Conference PETRAD2012.
Nucl Med Rev Cent East Eur. 2012 Aug 25;15(2):163-4.