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How health systems can address health inequities through improved use of Structural Funds

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This briefing on policy issues was commissioned by the WHO Regional Office for Europe as a deliverable for the WHO/European Commission joint project on equity in health (2006WHO03). This is one of six briefings on policy issues produced through the project, which has as its focus improving health intelligence, building capacity and know-how for policy-makers and practitioners on tackling socially determined health inequalities as part of health system performance. WHO partnership in this project is in keeping with strategic objective 7 of the WHO Medium-Term Strategic Plan (2008–2013). This strategic objective is to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human rights-based approaches. The project has received funding from the European Commission under the Public Health Programme 2003–2008. However, the sole responsibility for the study lies with the author and the European Commission is not responsible for any use that may be made of the information contained therein.

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Acronyms and abbreviations

AER	Assembly of European Regions
BHC	Building Healthy Communities
CF	Cohesion Fund
CE	Council of Europe
CSDH	WHO Commission on Social Determinants of Health
DG SANCO	Directorate-General for Health and Consumers
EA16	EU Member States that adopted the euro as their currency
EC	European Commission
ECB	European Central Bank
ECD	early childhood development
ECHAA	European Centre for Health Assets and Architecture
ERDF	European Regional Development Fund
ESF	European Social Fund
EU	European Union
EU12	Member States belonging to the EU since 2004
EU15	Member States belonging to the EU before 2004
EU27	current EU Member States (countries belonging to the EU after January 2007)
EURoma	European Network on Social Inclusion and Roma under the Structural Funds
IIAP	International and Ibero American Foundation for Administration and Public Policies
GDP	gross domestic product
GNI	gross national income
GP	general practitioner
HCN	Health ClusterNET
HIA	health impact assessment
HIAP	health in all policies
HSKN	Health Systems Knowledge Network
MA	managing authority (of Structural Funds)
NGOs	nongovernmental organizations
NSRF	national strategic reference framework
OP	operational programme
PHC	primary health care
PPP	public-private partnership
PPCP	public-private community partnership
RDF	Rural Development Fund
RHS	regional health systems
ROP	regional operational programme
SDH	social determinants of health
SERI	Sustainable Europe Research Institute
SF	Structural Funds
SMEs	small and medium-sized enterprises

Executive summary

The Structural Funds (SF) and the Cohesion Fund are allocated by the European Union (EU) as part of its regional policy. 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 various funds and programmes.

This briefing explores how SF can contribute to the reduction of health inequities in the EU and the potential role of health systems and public health infrastructures in achieving this. A health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health. Health systems have four functions: service delivery, financing, resource generation, and stewardship (WHO Regional Office for Europe, 2008a).

The specific objectives of this briefing are to:

- describe opportunities for health systems to influence the use of SF to reduce health inequities in the EU by describing three opportunities: stewarding a “health and equity in all policies” approach to SF allocation, funding measures to safeguard the health and social inclusion of disadvantaged populations, and using SF to support the strengthening of health systems in more disadvantaged regions;
- describe challenges in using SF to reduce health inequities in the EU, specifically in relation to the sustainability of SF-financed interventions and insufficient capacity and competency of health staff engaging in SF processes; and
- explore potential action areas for health system stakeholders to increase their capacity and competency to engage in SF processes and make the case for investments to reduce inequities through actions within and beyond the health sector.

The briefing draws on a range of policy guidance documents, evidence, resources and experiences to inform analysis. This includes:

- recent, current and emerging EU communications (in particular, *Solidarity in health: reducing health inequalities in the EU* (EC, 2009a)), policy frameworks, research and interventions;
- ongoing assessment of how SF are used for health-related investments; and
- findings and recommendations of the WHO Commission on the Social Determinants of Health (CSDH) and its associated knowledge networks.

Action on health inequities is first and foremost a matter of safeguarding human rights. The Treaty of Lisbon gives higher priority to human rights, equality and solidarity as key principles under which the EU acts. The right to health extends also to the conditions required for good health.

Since 2008/2009, the need to use SF to reduce health inequities also has a strong economic rationale. Although health inequities-related losses ascribed to health as a capital good appear modest in relative terms (1.4% of gross domestic product (GDP)), they are significant in absolute terms (estimated in 2004 as up to €141 billion per year). Valuing health as a consumption good, however, reveals the much larger estimated impact of €1 trillion per year, or 9.4% of GDP, stemming from health inequities (Mackenbach, Meerding & Kunst, 2007).

To address the human rights and economic consequences of health inequities means that current strategies need to be reinvigorated and combined with new strategies to directly tackle known social determinants. Health systems have a key role in advocating and facilitating effective and sustainable policy interventions to reduce health inequities through the use of SF. The main opportunities available to use SF in reducing health inequities covered in this briefing are using them to:

- promote health and equity in all policies
- improve the health of socially excluded groups
- improve health systems in Convergence Regions.

The relative lack of experience of health systems in using SF requires considerable and ongoing investment in relevant capacity building (organizational development, workforce development, leadership development,

partnership development, resources allocation) at all levels (from national and regional to local) if the potential of using SF to reduce health inequities is to be realized, effective and sustained.

Integrating health equity into SF will require national health ministries and regional health systems (RHS) of current EU Member States (EU27) to engage with two key parts of the SF process as part of their stewardship role: **SF management**, from policy initiation to completion; and **SF delivery**, from communicating agreed priorities, through procurement and project implementation, to final audit.

As part of the planning process for the next SF period (2014–2020) and implementation of relevant EU policy frameworks (EU, 2000; EC, 2009a; EC, 2010; EPF, in press), the following could benefit from more immediate attention (Dowdeswell & Watson, in press).

- At **SF-management** level, the SF initiation phase for 2014–2020 provides an opportunity for EU27 ministries of health and regional health systems to present a case for using SF to reduce health inequities by integrating equity indicators into the process begun by the European Commission (EC, 2009b).
- Particular emphasis should be given to the role of regional health systems in using SF to address social determinants of health (SDH) and health inequities, as they are closer to communities and have more operating flexibility than national ministries of health. Importantly, regional stakeholders also have considerable experience in facilitating intersectoral action and in merging national policy priorities into regional strategies and master plans.
- At **SF-delivery** level, there is a need to improve the design of comparable implementation processes across the EU27 for the 2014–2020 period. From a range of issues, the following are critical:
 - Prior to their being assessed, project applications should be able to meet criteria that include: an evidence-based rationale, relevance to equity-oriented objectives in regional master plans and/or national strategies, and financial sustainability once SF funding ends;
 - related to this, health systems can work in their stewardship function in partnership with managing authorities of SF to facilitate health and/or integrated impact assessments as part of the pre-assessment process for SF applications; and
 - there is a real need for ongoing support to be available for regional public health systems and for intersectoral partners to make best use of SF for health generally and to reduce health inequities specifically.
- Building the capacity of health staff to reduce health inequities through SF cannot simply focus on workforce development. It needs to be nested in a broader capacity-building approach (including organizational development, partnership development, leadership development and resources allocation) that ensures sustainable capacity is achieved at system, organization, team and individual levels.
- In the context of improving health equity, a necessary step is to establish a process to share learning from the CSDH and recent and current EU-funded projects to build an accessible knowledge base mirroring the CSDH overarching principles for action and recommendations that can inform future research, policy and practice.

Key messages

- The goal of the EU is to foster economic development while maintaining social cohesion. An approach based on equity in health may enhance the efficiency of the different policies and contribute to this EU goal.
- Health inequities exist and, in some instances, are increasing within EU countries and in Europe as a whole, but health inequities are not inevitable.
- Health inequities are strongly influenced by the actions of individuals, governments, stakeholders and communities and can also be influenced by European processes.
- Action to reduce health inequities means tackling those factors that impact unequally on the health of the population in a way that is avoidable and can be dealt with through public policy.
- Health systems at national, regional and local levels have a clear stewardship function to work with other sectors to address the determinants of health and reduce health inequities. They are also in a position to act as exemplars by ensuring that equity measures are integrated across all health system functions.
- The Council of the European Union's conclusions on equity and health in all policies, backed by the Spanish Presidency of the EU in the first semester of 2010, specifically calls for review of the possibilities for assisting Member States to make better use of EU Cohesion Policy and SF to support activities to address social determinants of health and help to move forward on equity in health (Council of the European Union, 2010).
- Key opportunities for using SF to reduce health inequities include:
 - taking a "health and equity in all policies" approach to SF allocation;
 - funding measures to safeguard the health and social inclusion of disadvantaged populations; and
 - using SF to support the strengthening of health systems in more disadvantaged regions.
- The two key challenges that need to be addressed if these opportunities are to be realized are:
 - ensuring the sustainability of SF-financed interventions, including sources of co-financing; and
 - building the capacity and competency of health staff engaging in SF processes at all levels, from national, to regional, to local.
- Taking these opportunities and addressing the challenges requires action at different levels of the public health system. Issues that need particular attention include:
 - improving understanding and confidence of all health stakeholders to effectively engage with the SF process;
 - increasing the capacity of regional health stakeholders and governance to prepare the case for using SF to reduce health inequities;
 - exploring how regional health systems can use SF to address SDH and health inequities; and
 - building capacity in terms of skills, know-how and institutional arrangements for regional government policy-makers and health professionals to reduce health inequities through the use of SF.
- There are opportunities for ministries of health and regional health systems in EU Member States to:
 - make the case for integrating health equity into the next post-2013 Cohesion Policy phase;
 - contribute to the implementation of equity-oriented actions and monitoring of equity in the context of the Europe 2020 strategy; and
 - prompt innovation in the SF process in ways that promote solidarity, equity and attention to the most-disadvantaged populations.



Towards this end, the following actions may be useful.

- The use of a set of conditions at the pre-assessment stage (before managing authorities of SF fully process a funding application) could be explored. The conditions would clearly show: an evidence-based rationale; that the project is integrated into the delivery of equity-oriented objectives in the relevant regional master plan and/or national strategies that can impact on the promotion of population health and reduce health inequities; and that the project is financially sustainable once SF funding ends.
 - Project management could be allowed flexibility in adapting to changing social circumstances, thereby ensuring the relevance, impact and sustainability of funded projects addressing key determinants of health.
 - “Return on investment” principles (that is, principles that show the economic and social benefits of action versus the consequences of inaction) could be applied to inform investment decisions in the project development phase.
 - Ministries of health, regional health systems and SF beneficiaries could identify and develop investments that target strategic and structural change by combining the use of the European Regional Development Fund (ERDF) and the European Social Fund (ESF) in line with CSDH action principles.
- There is a real need for ongoing support for regional public health systems and intersectoral partners to be available to make best use of SF. There are opportunities for national- and regional-level health authorities to work with other ministries (those that oversee SF management) to facilitate such support to subnational levels with key stakeholders. National and regional health authorities can also promote and support intercountry learning on opportunities for health systems to influence the use of SF to reduce health inequities in the EU.

1. Introduction

Structural Funds (SF) and the Cohesion Fund (CF) are allocated by the European Union (EU) as part of its regional policy.¹ 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 various funds and programmes. In the current 2007–2013 period, the overall budget is €347 billion (DG Regional Policy, 2009). This briefing aims to explore how SF can contribute to the reduction of health inequities in the EU and the potential role of health systems as defined in the Tallinn Charter (WHO Regional Office for Europe, 2008) in achieving this.

The specific areas explored in this briefing are as follows.

- Opportunities for health systems to influence the use of SF to reduce health inequities in the EU are detailed. Three opportunities are described: stewarding a “health and equity in all policies” approach to SF allocation; funding measures to safeguard the health and social inclusion of disadvantaged populations; and using SF to support the strengthening of health systems in more disadvantaged regions.
- Challenges in using SF to reduce health inequities in the EU, specifically in relation to the sustainability of SF-financed interventions and insufficient capacity and competency of health staff engaging in SF processes, are described.
- Potential action areas for health system stakeholders to increase their capacity and competency to engage in SF processes and make the case for investments to reduce inequities through actions within and beyond the health sector are explored.

The briefing draws on a range of policy guidance documents, evidence, resources and experiences to inform analysis. This includes:

- recent, current and emerging EU communications, policy frameworks, research and interventions;
- ongoing assessment of how the SF are used for health-related investments; and
- findings and recommendations of the WHO Commission on the Social Determinants of Health (CSDH) and its associated knowledge networks.

The key policy processes this work relates to are:

- follow-up to the European Commission (EC) communication on solidarity in health (EC, 2009a) and Council conclusions on health and equity in all policies (Council of the European Union, 2010);
- World Health Assembly resolutions on reducing health inequities through action on the social determinants of health (SDH) (World Health Assembly, 2009) and sustainable health financing, universal coverage and social health insurance (World Health Assembly, 2005);
- the EC/WHO Joint Declaration (WHO Regional Committee for Europe, 2010); and
- current and emerging EU strategies that frame possibilities for action to reduce health inequities, such as the current Cohesion Policy (EU, 2006), the Europe 2020 strategy (EC, 2010) and the Charter of Fundamental Rights of the European Union (EU, 2000).

¹ Although this briefing focuses on EU Member States, its analysis and ideas will be highly relevant to other countries in the WHO European Region, especially those that are EU-candidate and potential candidate countries.

2. Using SF to reduce health inequities in the EU

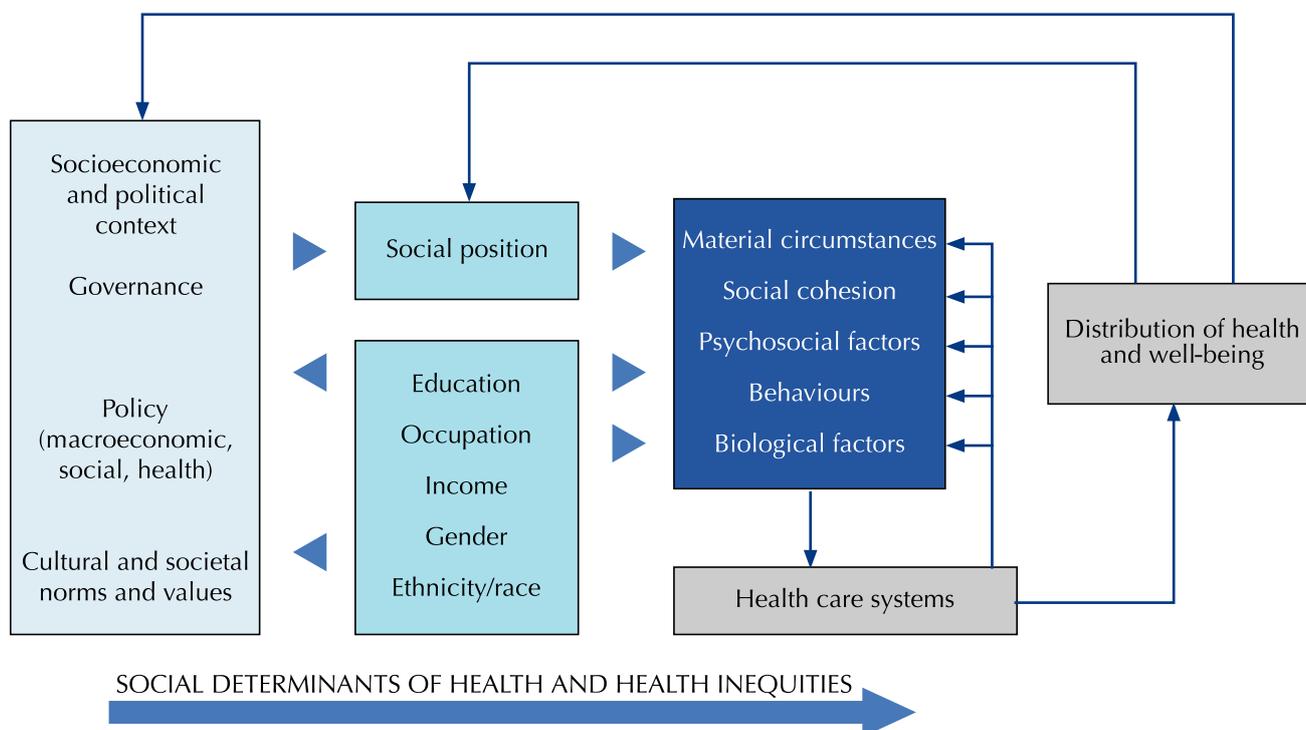
Within the Lisbon Treaty (EU, 2007), the goal of the EU is to foster economic development while maintaining social cohesion. An approach based on the promotion of population health and the reduction of health inequities may enhance the efficiency of different policies and contribute to the achievement of this goal. Although economic growth contributes to development and striving for full employment is key to reducing health inequities (EMCONET, 2007), the health gaps among different socioeconomic groups may widen if equity issues are not properly considered (Council of the European Union, 2010). This has the potential to undermine sustainable development.

The foundation for action is that health is acknowledged as a human right within the renewed Lisbon Treaty and by WHO (2008). The 55 Articles of the Charter of Fundamental Rights list political, social and economic rights for EU citizens. Under the Lisbon Treaty, the Charter is legally binding (except for those Member States with an opt-out for this provision). It is intended to ensure that EU regulations and directives do not contradict the European Convention on Human Rights (CE, 1950), which is ratified by all EU countries (and to which the EU as a whole has acceded under the Treaty of Lisbon).

The economic impact of health inequity has been assessed in European research that distinguishes between health as a “capital good” (that is, associated with labour productivity) and as a “consumption good” (contributing to an individual’s happiness and well-being). Health inequities-related losses ascribed to health as a capital good appear modest in relative terms (estimated at about 1.4% of gross domestic product (GDP)) in a study of 22 of the current EU Member States (EU27). They are, however, very significant in absolute terms (estimated at about €141 billion per year) (Mackenbach, Meerding & Kunst, 2007:41). Valuing health as a consumption good, however, reveals the much larger estimated impact of €1000 billion per year, or 9.5% of GDP (Mackenbach, Meerding & Kunst, 2007:41).

The CSDH has developed a framework (Fig. 1) as a guide for policy-driven interventions targeting the SDH. This framework suggests interventions that take action on the circumstances of daily life and their structural drivers (CSDH, 2008:42). These two levels of action are shaped by the current situation, trends in health inequities and the SDH in the EU and by relevant EU policy frameworks available to address them, including the right to health. Health systems have a key role in advocating and facilitating effective and sustainable policy interventions to reduce health inequities through the use of SF.

Fig. 1. CSDH conceptual framework



Source: CSDH (2008), amended from Solar & Irwin (2007).

Health inequities, SDH and EU policy frameworks

Health inequities exist across the EU, both between and within its Member States (Whitehead & Dahlgren, 2007).² A social gradient in health runs through society, with the poorest generally suffering the worst health. This social gradient is a product of the social and economic conditions in which people live their daily lives and includes access and entitlements to resources such as education, employment and housing, different levels of participation in civic society, and control over their lives. The SDH are influenced by public policy decisions (or lack of them) made by governing authorities at EU, national, regional and local levels. Together, these daily conditions and the structural drivers are responsible for a major part of health inequities (CSDH, 2008:1).

Cross-national variability in the social gradient is clearly demonstrated with a range of relevant indicators that draw on available data from Eurostat (Eurostat, 2010a) and other sources (such as: Busse et al., 2010; Thümmler, Britton & Kirch, 2009; Mackenbach et al., 2008) and so are not covered in detail in this briefing. This variability is reflected in the differences that exist between socioeconomic groups within all EU countries, within and between regions. These start at a young age and persist and widen during life, and may be passed on to the next generation.

Differences in life expectancy at birth between the lowest and the highest socioeconomic groups (for example, between: manual and professional occupations; people with primary-level and post-secondary education; low and high income quintile) range from 4 to 10 years for men and 2 to 6 years for women. In some countries, the gap has widened in the recent decades. Infant mortality is higher in the lowest socioeconomic groups. Moreover, people with lower education, income or occupation also spend more time in poorer health. Inequities are also linked to migration status and ethnicity. Overall, these groups are more likely to report very bad health than their richest counterparts (EC, 2009a).

With the CSDH framework (Fig. 1), three interconnected policy agendas are critical for interventions on the structural drivers and conditions of daily life:

- Cohesion Policy (see Sections 2.2 and 3.1) (Council of the European Union, 2006);
- “solidarity in health” (EC, 2009a), which commits EU Member States to health and equity in all policies (also discussed in Section 2.3); and
- the Europe 2020 strategy (EC, 2010).

The most recent of these policy agendas (EC, 2010) emerged from the 2008/2009 economic crisis. Ministries of health and regional health systems (RHS) need to understand this policy agenda because it will be a key driver for post-2013 Cohesion Policy, consequently maximizing health gains from SF in the 2014–2020 period.

The main objective of the Europe 2020 strategy is to bring together the economic, social and environmental agendas of the EU in a more structured and coherent way, including through the use of funding programmes and policy initiatives. The strategy lays out five targets to be achieved by the EU by 2020:

- a 75% employment rate for the 20–64 age group;
- a 3% investment rate in research and development;
- “20/20/20” climate and energy targets (the reduction of greenhouse gas emissions by at least 20%, a share of final energy consumption coming from renewable energy sources increased to 20%, and an energy sufficiency of 20%);
- improvement in education levels (a reduction of school drop-out rates and an increased share of the population having completed tertiary or equivalent education); and
- promotion of social inclusion, including a reduction of poverty.

The first three of these have already been recognized as drivers in the renewed Lisbon agenda. The last two are more challenging: in the education and social fields, competences remain at national and sometimes regional level. As with health status, educational and social starting points vary considerably between and within EU Member States. The last of these targets is very significant in addressing health inequities, as the Europe 2020 strategy states that: “A major effort will be needed to combat poverty and social exclusion and reduce health inequalities to ensure that everybody can benefit from growth” (EC, 2010:16).

² Health inequity is usually measured using health inequality as a proxy – implicitly conflating equity and equality.

In addition to measurable targets, the 2020 strategy also introduces a series of actions and policies grouped under three main headings: smart growth, sustainable growth, and inclusive growth. There are seven flagship initiatives: innovation union; youth on the move; a digital agenda for Europe; resource-efficient Europe; an industrial policy for the globalization era; an agenda for new skills and jobs; and European platform against poverty.

SF and health

As was cited above, SF and CF are funds allocated by the EU as part of its regional policy. 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 regional policy's various funds and programmes. The current programmes run from 1 January 2007 to 31 December 2013. Box 1 describes the three types of SF. More detail about the SF system from EU to local levels can be found in the Annex.

Box 1. SF 2007–2013

With €201 billion, the European Regional Development Fund (ERDF) supports programmes addressing regional development, economic change, enhanced competitiveness and territorial cooperation throughout the EU. Funding priorities include modernizing economic structures, creating sustainable jobs and economic growth, research and innovation, environmental protection and risk prevention. Investment in infrastructure also retains an important role, especially in the least developed regions.

The European Social Fund (ESF) has €76 billion and focuses on four key areas: increasing the adaptability of workers and enterprises; enhancing access to employment and participation in the labour market; reinforcing social inclusion by combating discrimination and facilitating access to the labour market for disadvantaged people; and promoting partnership for reform in the fields of employment and inclusion.

The CF contributes €70 billion to interventions in the field of the environment and trans-European transport networks. It applies to Member States with a gross national income (GNI) of less than 90% of the EU average. As such, it covers all 12 new Member States as well as Greece and Portugal. Spain is also eligible for the CF, but on a transitional basis (so-called "phasing out").

Cohesion Policy for 2007–2013 (Council of the European Union, 2006) included a health priority for the first time. Three main areas of health-related SF investment were identified for 2007–2013: direct, indirect and non-health sector investment (Watson, 2009). These built on limited health investment available to Objective 1 regions in the 2000–2006 period (see case example C, Box 4, below).

In the current SF period, a conservative estimate of €5 billion is allocated from ERDF to support direct health system investments;³ a further €6 billion is earmarked for ageing and e-services priorities, including e-health (Dimitrova, 2010).

In addition to ERDF, the ESF is used to support EU employment policies in regions categorized under both the Convergence and regional Competitiveness and Employment objectives. ESF provides funding for activities aiming to improve human capacity, to support healthy population and workforce, such as health promotion and disease prevention programmes, training of the health workforce, and health and safety at work measures. That said, only 13% of ESF is actually related to addressing social inclusion of the most vulnerable groups. Furthermore, as the European Court of Auditors has remarked, ESF has suffered from a lack of effective impact measures (European Court of Auditors, 2006).

Although this health funding opportunity exists, it is still up to national governments to take advantage of it by identifying health care improvements as a key priority in their national programmes and by allocating sufficient budgetary means to secure the necessary co-financing requested from Member States under the SF rules. The EC estimates that it takes Member States about two years to elaborate their national strategic reference frameworks (NSRF) for spending EU funds. It is important for national authorities to therefore ensure that national and regional operational programmes (ROP) for SF identify health improvements as a priority. Without an appropriate and explicit national framework in place, there can be no EU funding allocation to health.

³ These include: health infrastructure investment, inpatient care, access to health care by vulnerable social groups, emergency care, medical equipment, screening, education and training for health professionals.

Opportunities for using SF to reduce health inequities

Three types of opportunity for using SF to reduce health inequities are explored: using SF for health and equity in all policies; using SF to improve the health of socially excluded groups; and using SF to improve health systems in Convergence Regions. These were chosen because of their relevance to policy factors that will shape the use of SF in the next 2014–2020 cohesion period.

Opportunity 1: using SF for health and equity in all policies

The best opportunities for using SF to strengthen health and equity in all policies can be found at different levels that impact on the conditions of daily living and the structural drivers of social determinants. These opportunities include:

- exploring options for integrating health equity into EU policy frameworks that will drive SF in the current 2007–2013 and next 2014–2020 periods (see also Sections 2.1, 2.2 and 3.1);
- using the stewardship function of health systems to translate relevant CSDH policy priorities into national and regional economic, social and health strategies and master plans that in turn inform NSRF planning and priorities for the 2014–2020 period;
- integrating the need for equity-oriented health impact assessments (HIAs) as a pre-assessment criterion for all future SF project funding applications;
- developing and applying comparable regional health inequity indicators to the monitoring and evaluation of SF programmes and projects (such as I2SARE and EU-URHIS2 – see Section 4.1 below); and
- working in partnership with other sectors to invest in achieving added value from non-health system SF investment opportunities in thematic operational programmes (OPs) and ROPs.

It is possible that EU Member States, especially in the EU12 (countries joining the EU after May 2004) and Convergence Regions across the EU will increasingly look to SF as a source of support for health-sector investment and wider health gains, including those that reduce health inequities. In fact, this has been requested through the Council of the European Union (Council of the European Union, 2010), backed by the Spanish Presidency of the EU in the first semester of 2010, which specifically calls for:

... reviewing the possibilities for assisting Member States to make better use of EU Cohesion Policy and Structural Funds to support activities to address social determinants of health and help to move forward on equity in health (Council of the European Union, 2010).

The “health and equity in all policies” approach is based upon the idea that since health (and health equity) is determined to a large extent by factors outside the health area, an effective health policy must involve all relevant policy areas (Stahl et al., 2006; Council of the European Union, 2010). These include but are not limited to: social and regional policy; taxation; environment; education; and research. All the EU policies and strategies mentioned above are required by the EU Treaty to follow this approach. The intention is for health concerns to be an integral part of all policies at EU, national and regional levels, facilitated in part by the use of impact assessments and evaluation tools.

The “health and equity in all policies” approach (updated from the original “health in all policies” (HIAP) approach) reflects intersectoral action for health to address the structural drivers and conditions of daily life. Spearheading such efforts constitutes a key aspect of health systems’ stewardship function. The range of ways of implementing the approach (Blas & Sivasankara Kurup, in press) includes:

- the use of intersectoral government targets (France, Lithuania, Sweden, the United Kingdom) (Wismar et al., 2008);
- the use of health impact assessment (HIA) units at local authority, parliamentary and interministerial levels (Sweden, United Kingdom (Wales), the Netherlands and Lithuania, respectively) (World Health Assembly, 2009; Salay & Lincoln, 2008; Wismar et al., 2007; Davenport, Mathers & Parry, 2006; IMPACT, 2004);
- passing “shared” public health legislation, such as bans on smoking in public places (Ireland, Italy, Norway, United Kingdom (Scotland), Spain);
- facilitating intersectoral action, including horizontal public health committees (United Kingdom (England), Sweden – see case example A below), formal consultations and communication between sectors (United Kingdom (Wales)) and public health reporting with other sectors (Finland, the Netherlands, United Kingdom (Wales)).

The ability of all sectors, including the health sector, to act on the SDH may be challenged by lack of funds, competing priorities and lack of know-how. Health authorities can create strategies to improve their own capacity to address the SDH and provide technical expertise to other sectors to integrate health in their policies (see, for example, Box 2).

Box 2. Case example A: closing the “gap” through public health policy (Sweden)

In 2003, the Swedish Government adopted a comprehensive national public health policy for which the overarching aim is: “to create social conditions that will ensure good health, on equal terms, for the entire population”. The 11 objective domains based on the determinants of health are:

1. participation and influence in society
2. economic and social prerequisites
3. conditions during childhood and adolescence
4. health in working life
5. environments and products
6. health-promoting health services
7. protection against communicable diseases
8. sexuality and reproductive health
9. physical activity
10. eating habits and food
11. tobacco, alcohol, illicit drugs and gambling

The policy was updated in 2007 with a focus on individual choice and responsibility. After the CSDH 2008 report, an assessment was made of how current national public health policy matched the CSDH recommendations. Two overarching recommendations were made.

1. Reducing health inequities requires political action and commitment. It also requires action from several political sectors outside the health and medical care sector to set out strategies for implementing a “health in all policies” perspective. It is therefore necessary to establish an intersectoral, nationally coordinated committee to make recommendations for political actions and strategies for implementing health (and equity) in all policies.
2. As regional- and local-level actors largely drive public health practice in Sweden, methods to routinely follow-up a social inequities in health and equity-oriented perspective in public health practice should be developed as part of the implementation of public health policy. This should be integrated with current initiatives to establish independent regionalization (Wamala, 2010).

The second recommendation is especially relevant to maximizing health gains from SF. In Sweden, all regions are Competitiveness and Employment Regions, with each having an ERDF-funded ROP and an ESF-funded national operational programme. A national investigation has recently proposed that public health issues should remain a regional developmental issue. Sweden’s main Cohesion Policy priorities for 2007–2013 show potential for regional and local health services to guide implementation of public health policy through non-health sector investments (as partners and/or by HIA and/or monitoring impacts) that can address the SDH, such as:

- €204 million to be invested in activities to improve employability, education and skills (objective domains 2 and 4); and
- €459 million targeted at increasing labour supply through, for example, education schemes and skills training for early school-leavers, migrants, those on long-term sick leave and older people (objective domains 2 and 4).

Opportunity 2: using SF to improve the health of socially excluded groups

The best opportunities for improving the health of socially excluded groups using SF currently exists within ESF OPs/ROPs with priorities related to employment and social inclusion.

The main allocations for ESF in the 2007–2013 period are: improving human capital (32.9%); improving access to employment and sustainability (28.4%); increasing adaptability of workers, firms, enterprises and entrepreneurs (17.8%); and improving social inclusion of less favoured people (13.1%) (Watson, 2009:13). Given that these priorities were reflected in related national strategies, the 2007–2013 SF period has seen a singular drive to influence SDH and health inequities, summarized in the CSDH framework (Fig. 1).

Promoting the integration of inclusive and adequately paid employment into mainstream human resources policies is an important stewardship opportunity for health systems, especially where they can act as exemplars for intersectoral action (HCN, 2007a; HCN, 2007b). In this context, special attention should be paid to people with disabilities, migrants, ethnic minorities and those who are long-term unemployed. The following examples of CSDH recommendations related to employment are particularly relevant.

- National governments should develop and implement economic and social policies that provide secure work and a living wage that takes into account the real and current cost of living for health.
- Public capacity should be strengthened to implement regulatory mechanisms to promote and enforce fair employment and decent work standards for all workers.
- Governments should reduce insecurity among people in precarious work arrangements, including informal work, temporary work and part-time work, through policy and legislation to ensure that wages are based on the real cost of living, social security and support for parents (CSDH, 2008).

Beyond employment, another key area for ESF is reinforcing social inclusion by combating discrimination and facilitating access to the labour market for disadvantaged people. At European level, national action plans for social inclusion are coordinated through the open method of coordination. Member States agree common objectives and indicators that show how progress can be measured. These are translated into national action plans which are submitted as national strategic reports and assessed. In essence, the EU encourages the EU27 to examine their policies critically and highlights successes and enduring challenges. It seeks to create a better basis for policy-making by involving nongovernmental organizations (NGOs), social partners, local and regional authorities and those working with people in poverty.

There is specific consensus on the need to eradicate child poverty by breaking the vicious circle of intergenerational inheritance. This requires action to:

- promote the active inclusion in society and the labour market of the most vulnerable groups;
- ensure decent housing for everyone;
- overcome discrimination and increase the integration of people with disabilities, ethnic minorities and migrants, and other vulnerable groups;
- integrate the social, economic and environmental aspects of urban regeneration, including innovative personal services and “one-stop-shops”, especially for vulnerable social groups;⁴ and
- tackle financial exclusion and over-indebtedness (DG Employment, Social Affairs and Equal Opportunities, 2010).

The CSDH highlights the importance of early child development (ECD) programmes in reducing health inequities. It recommends that governments should build universal coverage of a comprehensive package of quality ECD programmes and services for children, mothers and other caregivers, regardless of ability to pay (CSDH, 2008). Such programmes include integrated services for breastfeeding and nutritional support; comprehensive support to, and care of, mothers before, during and after pregnancy; parenting and caregiver support; child care; early education (starting around age three); and services for children with special needs. There is strong evidence to show that investment in ECD and associated family policy can help to break the child poverty trap; SF could have an important contribution to make here, especially from 2014 onwards (EACEA, 2009:38) (see also Section 3.2).

In tackling social exclusion, ministries of health and RHS should give particular attention to the contribution that can be made by social inclusion NGOs. The value of developing effective partnership working and mutual respect with this sector is highlighted by Harvey (2008):

... social inclusion NGOs are often much closer to the target groups of the Structural Funds, trusted by them, have experience in delivering projects that work well and use proven methods that produce positive outcomes and results (e.g. community development).

However, special attention needs to be given to avoiding parallel systems run by non-state actors to meet the needs of populations experiencing social exclusion. The state has a primary role for safeguarding the rights and meeting the needs of these populations by ensuring that its existing services adequately serve them.

Cutting across these challenges, excluded populations, including the Roma, face more direct discrimination, experiencing greater social exclusion than the majority community, especially in accessing employment, education, health and social services. The Roma experience higher rates of illiteracy and poor school attendance

⁴ For examples, see summarized OP/ROPs for all EU Member States at: http://ec.europa.eu/health/health_structural_funds/used_for_health/info_sheets/index_en.htm

of children. They frequently live in segregated, isolated districts where the living conditions are often poor, with problems of extreme overcrowding and lack of basic facilities. This contributes also to aggravating their health conditions (European Parliament, 2010). The work outlined in Box 3 shows how the European Network on Social Inclusion and Roma under the Structural Funds (EURoma) is seeking to build knowledge, understanding and action to maximize the use of SF to improve equity for the Roma.

Box 3. Case example B: EURoma

The enlargement of the EU with countries with the highest concentration of Roma populations, Cohesion Policy and ESF priorities and Spanish experience of using ESF for Roma inclusion led to EURoma. It is a European network made up of representatives of 12 Member States determined to promote the use of SF to enhance the effectiveness of policies targeting Roma people and to promote their social inclusion. It was established as a result of the working seminar “Transnational cooperation on Roma community and social exclusion” held in Madrid in June 2007 and financed by the International and Ibero American Foundation for Administration and Public Policies (FIIAP).

Current partners are: Bulgaria, the Czech Republic, Finland, Greece, Italy, Hungary, Poland, Portugal, Romania, Spain, Slovakia and Sweden. Each Member State is represented by the relevant ESF managing authority (MA) or delegated administrative body and the organization responsible for policies targeting the Roma community (or the body to which it delegates its authority).

The primary aims of EURoma are the sharing of strategies, initiatives and approaches, learning based on experience and best practices, and the dissemination and standardization of such knowledge. In line with these aims, two work streams are undertaken:

- transmission and exchange of information through internal and external communication channels; and
- mutual learning: sharing of approaches and strategies, identification and transfer of experiences, creation of a forum for the organization and management of projects, and development of common and transversal products.

Source: EURoma (2008).

Despite the potential, there is limited evidence that SF have reduced inequities for disadvantaged groups. Short-lived projects have undertaken innovative actions, but these have rarely been mainstreamed and sustained (Degryse, 2010). Ultimately, the primary actors in reducing health inequities are the EU Member States. Their policies, combined with governance at national, regional and local levels, will be the main force in preventing inequities from persisting and growing. SF can contribute to these efforts.

In addition to employment and social inclusion, ageing populations across the EU and the emerging pensions crisis present another dimension to the social exclusion challenge. Most NSRFs give attention to ageing populations. 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 SF (Watson, 2009:20). Ageing creates specific challenges for health and social care services, pensions and welfare benefits and for all public and private sector employers. Also taking into account groups who are out of work for different reasons, the labour market is tightening. This requires employers to identify and recruit new employee groups while retaining the older workforce. To increase employment and employability, many NSRFs respond to the need to expand the adaptability of the workforce and enterprises by increasing the number of years that citizens can be economically active and productive. The importance of this is discussed below.

Opportunity 3: using SF to improve health systems in Convergence Regions

Convergence Regions are often disadvantaged geographically, economically and in terms of access to specialist health services. For these regions, strengthening health systems through a primary health care (PHC) approach is particularly relevant.⁵ The principles and values of the PHC approach are: tackling health inequities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health. In turn, this supports implementation of the Tallinn Charter (WHO Regional Office for Europe, 2008), which exemplifies a commitment to promoting the values of solidarity, equity and participation

⁵ The CSDH Health Systems Knowledge Network (HSKN) identified PHC as one of the four key overarching features of health systems that address health inequity (Gilson et al, 2007). Revitalising a PHC approach is relevant to the related challenges of chronic disease management, an ageing population and tightening public finances. Basic PHC activities vary between EU Member States but the core principles are most significant: universal access to care and coverage on the basis of need; commitment to health equity as part of development oriented to social justice; community participation in defining and implementing health agendas; appropriate technology that enables care to adjust to new and evolving realities; and intersectoral approaches to health.

through health policies and resource allocation, ensuring due attention is paid to the needs of the poor and other vulnerable groups (see Section 3 for more details).

Contributing to this new operating environment for the EU, the carbon agenda is now beginning to affect centralized medicine (the hospital-centric model) in terms of the buildings, their technologies and the travel implications for citizens. In parallel, new ideas are gaining ground about reshaping models of care to shift treatment into more accessible local community settings, thereby reducing reliance on the current high-cost (and sometimes slow-response) hospital-centric models of care delivery. The carbon agenda also fits well with managing the recurrent resourcing difficulties that most health systems are signalling, and breaking down the large critical mass of the workforce concentration in hospitals to more resourceful, adaptable, responsive and potentially lower-cost provision in the community. New dispersal technologies (e-health) are a major driver underpinning this shift.

Considering ERDF allocation, Hungary sits at one end of the continuum of identifiable direct health investment for Convergence Regions at 5.4% of SF allocated nationally to health, while Germany is at the opposite end with the lowest relative amount of direct investment (0.1%) (Watson, 2009:18). In Bulgaria, Czech Republic, Greece, Hungary, Lithuania, Latvia, Poland, Romania and Slovakia, health infrastructure is seen as the core element of direct health system investment. This is essentially intended to underpin the modernization of health care services.

Since health infrastructure investment is the main focus of direct health system investment, it will be crucial to ensure that expenditure on infrastructure is achieved as planned during the 2007–2013 period. In particular, upfront option appraisal would be required to enable sustainable and strategic investment planning (Samset & Dowdeswell, 2009). EUREGIO III research has identified very little option appraisal to inform major SF health investments in the EU12 and inadequate understanding of EU procurement processes. Funded under the EC 2008 health work programme, the EUREGIO III project provides practical evidence and lessons learnt to improve the effectiveness of health-related investments using SF (with a focus on the specific needs of the health sector). Following the 2008/2009 economic crisis, this has led to some major capital projects being “sliced” into smaller projects to facilitate faster procurement and SF spend but with little attention to the need for effective and integrated macro- and micro-level project management (Dowdeswell & Watson, in press).

However, focusing too closely on health infrastructure and on how it interacts with economic development entails the risk of losing sight of the social and human values connected to health services (Watson & Agger, 2009). To bring effective benefits to the citizens of Member States, SF need to accommodate local needs and respond to local challenges. Involving all actors, not only at EU and national level but also, and perhaps more importantly, at subnational level is a basic prerequisite for ensuring that alignment between real needs and SF operation is effectively achieved at all levels (EPF, in press).

In addition to health infrastructure investment, a smaller number of EU Member States will invest in health promotion and disease prevention that is highly relevant to addressing health inequities. In this respect, the CSDH recommends that: the health sector expands its policy and programmes in health promotion, disease prevention and health care to include a SDH approach, with leadership from the minister of health. This also relates to investment in health and safety at work under the area of “indirect health sector investments”. Both can be found in ESF OPs that focus on themes such as social renewal and human capital.

Improving access to services, especially in rural areas and for people experiencing social exclusion, is also a driver of modernization in the EU12. In the EU15 (Member States belonging to the EU before May 2004), direct health system investments are found in Convergence Regions using ERDF in Germany, Greece, France, Italy, Portugal and Spain, and while ESF funds are available for wider use (Watson, 2009). However, while ESF-funded priorities are identified in Estonia, Hungary, Latvia, Lithuania and Poland, they are less obvious in Competitiveness and Employment Regions. In the newer EU12, rural disadvantages are more extreme. The following provides some examples.

- The distribution of general practitioners (GPs) in **Bulgaria** is subject to regional variations within the country and those envisioned by the national health map. These variations cause inequities in access to health services, particularly for individuals in rural areas. According to the national health map, the number of working practices in 2005 exceeded the forecast number by 140% in the Targovishte region, but was 67% less than the expected number in the region of Silistra (Georgieva et al., 2007).

- Differences between rural and urban areas in **Romania** are particularly stark. Nearly 50% of the population is rural, yet in urban areas there were 3759 pharmacies registered compared to 1102 in rural areas. The implementation of a primary care pilot programme began in 1994 and involved a new way of financing PHC. Apart from this pilot approach, over 200 rural health clinics were upgraded and equipped with basic items for primary care. However, several reports showed that almost half of the rural health clinics had no doctor at the end of the primary care pilot, even when the dispensaries were upgraded with necessary medical equipment (World Bank, 2002). Differences in access between rural and urban areas persisted, as the limited financial incentives included in the scheme were not sufficient to attract more physicians to rural areas. There was no effect on hospital admissions, suggesting that GPs had not been strengthened as the gateway to the referral system, and there was no evidence regarding the impact on key coverage indicators (such as vaccination rates) or health outcomes (Vladescu et al., 2008).

Tackling deficits in rural health services needs to be part of a wider drive to address rural poverty.⁶ In June 2009, a conference hosted by the Hungarian Government emphasized that:

- there is a need for a multidisciplinary and harmonized definition of rural poverty;
- social issues need to be dealt with more vigorously than previously, using better targeted policies to tackle the disadvantages of vulnerable groups most at risk of poverty;
- rural poverty should be placed under social inclusion policies and should receive greater emphasis within the open method of coordination between EU Member States; and
- there is a need for more active involvement of NGOs (see Section 2.2), civil society and other actors at all levels, from European through to local (DG Employment, Social Affairs and Equal Opportunities, 2009).

Italy provides one example of policy integration and actor cooperation. In essence, their experience shows that health inequities in rural communities have potential to be addressed through the Rural Development Fund (RDF) where actions underpin sustainable local economies: for example, by promoting certain types of health care (such as therapeutic care) while contributing to rural development in line with its NSRF priorities (Finuola, 2008).

Rural disadvantage is not simply economic. The issue of social renewal and health professionals in rural disadvantaged areas can also be informed by the examples of Brandenburg (Box 4) and Norrbotten in using ERDF and ESF. Norrbotten is a sparsely populated county located in the northern part of Sweden. To overcome the constraints associated with its location, the Norrbotten administration made extensive use of the SF to implement an e-health strategy to give all its 250 000 inhabitants access to health care services “anywhere and anytime”. With the support of the ERDF, the Norrbotten region is now integrated into the largest cross-border open broadband initiative and has implemented successful projects in cooperation with bordering regions in Finland to ensure high quality of care for patients regardless of workplace or place of residence (EPF, in press).

A critical element in many of the regional examples is the role of regional master planning. It is an element of regional development that promotes an integrated approach to urban and rural regeneration, stimulation of local economies and the positioning of health services across sectors. In essence, it provides a clear vision of what people are collectively aiming for. In this respect, the Brandenburg and Norrbotten examples demonstrate the value of combined e-health and strengthened PHC solutions for rural regions. A related issue addressed in the Brandenburg example was linking health service developments with ERDF-funded improvements in road and rail transport systems in the region. This was considered critical in ensuring good access to services among the elderly and improving connections between small towns and cities in Berlin–Brandenburg so that the region could enhance its appeal to potential investors and ensure better accessibility for younger people to higher education.

Challenges in using SF to reduce health inequities

Challenge 1: ensuring financially sustainable changes over the long term

World Health Assembly resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance urged Member States:

... to ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole (World Health Assembly, 2005:clause 3).

⁶ A forthcoming briefing in this series will address health inequities and rural poverty.

The 2008/2009 economic crisis had a significant and ongoing effect on finances for public health systems. In 2009, government deficits and debts of both the euro area (EA16⁷) and the EU27 increased compared with 2008, while GDP fell. In the euro area, the government deficit-to-GDP ratio increased from 2.0% in 2008 to 6.3% in 2009, and in the EU27 from 2.3% to 6.8%. In the euro area, the government debt-to-GDP ratio increased from 69.4% at the end of 2008 to 78.7% at the end of 2009, and in the EU27 from 61.6% to 73.6% (Eurostat, 2010b).

Box 4. Case example C: modernizing health care services as part of rural development in Brandenburg–Nordost using SF (Germany)

Brandenburg–Nordost was an Objective 1 region in 2000–2006 and is currently a Convergence Region with a gross national product (GNP) of €18 000 to €22 000. The Fontanestadt Neuruppin is a case in point: rural, sparsely populated and with a diminishing number of doctors. Of those Neuruppiners in employment, 18% are employed in the public health sector. This region also has poor accessibility to higher education for younger people. At the time of the unification of Germany, it had a run-down rural infrastructure, including the state of hospitals, polyclinics and road networks. Politics led to the closure of previous state-run polyclinics in favour of single-physician offices while investing in medical technology for larger hospitals was favoured. This tended to neglect accessibility for widely dispersed rural communities.

A regional health master plan for Berlin–Brandenburg was developed in 2007 with 12 objectives. The RHS saw its challenge as being to modernize its services in ways that would provide quality access in a largely rural region while controlling budgets and prospectively enabling distance learning. In the master plan, the priorities for Brandenburg were medical technology and telemedicine, care of the elderly and prevention and rehabilitation: these were integrated into the wider master plan. These priorities have been translated into intersectoral action, ideas, and concepts by:

- building regional networks composed of all players
- developing common (transsectoral) clinical pathways
- trying to link these pathways with telemedicine
- extending telemedicine with telecoaching

In essence, what they seek to achieve is close-to-home health care (that is, health care services as close as possible to people's communities) directly financed with minimal bureaucracy.

What is critical for other RHS to understand is that modernizing RHS in ways that address health inequities, especially in rural regions, cannot take place in isolation. In the 2000–2006 SF period, these developments were linked to other SF OP priorities such as transportation, data highway communication, telemonitoring to support disadvantaged groups, rural teleworking and developing a lifelong learning network.

New innovative health care projects, such as “The sheltered way: technical and organizational network structures for cardiological processes”, are being explored to help take forward an ongoing modernization process. So far, the main lessons learnt are:

- ideologically inspired investments should be avoided
- the focus should be enlarged beyond prestigious projects, such as big hospitals
- networking of all regional stakeholders should be encouraged
- focal points in support of dialogue should be identified
- competition of ideas should be facilitated, but project choice should be based on quality
- synergy should be sought between ERDF and ESF investments.

Source: Schmailzl (2010).

The SF allow for the co-financing of projects up to 75% for most of the EU12, and up to 90% in some cases. The required financial contribution of 25% or even 10% of the total budget in the case of CF projects may be a challenge not only for the EU12, but also for most of the EU27, particularly where public debt is high (EUREGIO III, 2009).

For health systems, the impact of the 2008/2009 economic crisis on financial markets and banks has created a level of financial instability that is going to be long lasting as far as public sector spending is concerned. This raises questions for health systems about financial sustainability as a policy constraint (Thomson et al., 2009). It is suggested that co-financing of SF investments will need to seek more private sector funding as public budgets are tightened to reduce national debt. A number of public-private partnership (PPP) models are available (Rechel et al., 2009). There are three reasons why debt acquired in this way in the past may now be problematic.

⁷ The EU Member States that adopted the euro as their currency.

1. They assume a certain level of headline GDP growth to furnish revenue growth to the public agencies committed to making the payments. Following the crisis, these previous levels of assumed growth are now unlikely to be realized.
2. They assume growing workforces and working age populations, but both these are now likely to start declining in many European countries.
3. They assume unchanging dependency ratios between active and dependent populations, but these assumptions are no longer valid as population pyramids steadily invert (Hugh, 2010).

Private-sector investment in SF programmes has generally been much lower than anticipated. Also, with 37 banks still heavily dependent on European Central Bank (ECB) loans, it is unlikely that private sector investors are going to be able to raise new capital, except where the construction of the project is “secured” through a high public sector “stake”. For example, the PPP programme for school building in the United Kingdom (England) has collapsed. The private sector is actually seeking public sector guarantees that are simply not going to be forthcoming in the near to medium term future (ECB, 2010; Maley, 2010).

Given these concerns, consideration might also be given to other methods such as community and public bonds (Lane, Longstreth & Nixon, 2001). Another new model is referred to as “PPCP” – the public-private community partnership model. Here, government and the private sector work together for social welfare, eliminating the prime focus of the private sector on profit (UNDP India, 2010; UNDP, 2007). This model, which has been explored and applied in developing countries, could be considered for its relevance in the EU. In addition, consideration might be given to the private/non-profit partnership model of social enterprise (seToolbelt, 2010).

Other factors will affect health systems’ access to SF to address health inequities because of their potential impact on financially sustainable changes over the long term. These include the following.

- Failure to spend the allocated funds under this financial framework, or failure by a Member State to adequately police spending, will undermine that Member State’s right to funding under the framework beyond 2007–2013: this relates to the EU12’s “absorption capacity” for SF.
- Until 2008/2009, there was a tendency to see SF as a supplementary source (to within-country government funding) for infrastructure. Since the economic recession, there has been a marked slowdown and, in some cases, a moratorium has been imposed on routine capital spending. Related problems over bank lending are also highly visible. So, although many governments seek to re-energize their economies with “blasts” of non-recurrent capital spending, this has not really materialized for health because of revenue affordability reasons and the complexity of capital investment in health projects (capital spending is often difficult to protect in tight revenue budgetary circumstances).
- The emerging pensions crisis associated with an ageing population across the EU poses particular problems. 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% (EC, 2008:43). A 2006 report states that “the pure demographic effect of an ageing population is projected to increase [public] health care expenditure by between 1 and 2% of GDP in most EU Member States” (DG Economic and Financial Affairs, 2006:133).

In this new operating climate, ongoing financial instability provides an opportunity for health systems and finance ministries to champion the health equity agenda. It also supports the case for reorienting health services away from a hospital-centric approach to a more PHC-led, holistic-systems approach. Such shifts might be better achieved through economic and financial arguments that demonstrate a clear “return on investment”, rather than health-based arguments. This is important because public health systems are usually seen as spending vehicles or a cost item in public finances. The Ontario Hospital Association takes a perhaps more sustainable approach to health systems governance (OHA, 2009) by arguing that the economic crisis and financial instability provide opportunities to improve services and their wider contribution to society. In effect, health systems are investment vehicles strategically managing assets not just to achieve finite efficiencies, but also to contribute significantly to sustainable economic growth and social cohesion.⁸

⁸ For example, Health ClusterNET (HCN) works with EU regions and European partners to build and share practical knowledge about the contribution of health systems to regional development through: procurement that engages with local small and medium-size enterprises; inclusive employment; affordable capital investment; connecting public health systems to knowledge hubs and innovation clusters; and use of SF for health gains. Good practice informs policy agendas that avoid a “one-size-fits-all approach” (see: <http://www.healthclusternet.eu>).

Challenge 2: building capacity of health staff to engage in SF processes

A critical question for building capacity to engage in SF processes is if the planned actions laid down in the adopted NSRFs and OPs are underpinned by existing or planned capacity in the Member States or regions. Of particular concern is the apparent lack of investment in developing relevant expertise among intermediary bodies and potential SF beneficiaries in the EU12 at regional and local levels, despite commitments expressed in NSRFs.

More obviously, a common development across the EU27 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 ROP for the 2007–2013 period. Across the EU, regional governments have mainly assumed the role of MAs for ROPs. However, it is not clear if sufficient investment has been made in building appropriate capacity at regional level to ensure effective management and implementation (Watson, 2009:25–26). There is limited mention of capacity building at regional level in most of the NSRFs provided by EU12 Member States for the current SF period. Even in the older EU Member States, there are few explicit statements about regional capacity building. Where these appear, they seem to focus primarily on the partnership aspect of capacity building, such as regional growth forums (Denmark), economic and social partners engaged in implementation (the Netherlands) and regional development programmes (Sweden).

A key challenge in an environment of rapid and unexpected change is how to focus and provide opportunities to health staff at all levels to engage in the SF processes (see Section 3). A finding from an online survey with EU Member State regions conducted in 2007 (HCN, unpublished data, 2007) was that all respondents from Convergence Regions and Competitiveness and Employment Regions ranked access to practical (“how-to”) knowledge as a priority. One output of EUREGIO III is to develop an inventory of practical knowledge from in-depth assessment of health projects that were funded in the 2000–2006 period and in the current 2007–2013 period. Over 30 projects from across the EU27 are being assessed and interim findings will be presented in 2011. Box 5 summarizes some of the challenges in using SF for health-related investments that have been identified so far (Dowdeswell & Watson, in press).

Box 5. Summary of challenges in using SF

To date, EUREGIO III has identified a number of key challenges in using SF. These challenges should not be seen as being specific to public health systems, but as relating to a group of interdependent factors.

- SF investment can often be seen as opportunistic, whereas the availability of co-financing may be subject to different decision-making criteria, such as availability of PPP funding involving the commercial banking sector.
- A focus on the hospital-centric model of care delivery has become increasingly outmoded. In this context, available evidence about the value and impacts of the PHC approach and prevention and health promotion activities should be informing decision-making about more diverse and effective models of health care support and delivery. The major demographic and epidemiological transitions (ageing and chronic disease) are also creating new challenges, but there is good evidence to suggest that most health systems have not yet reshaped their investment strategy to meet these needs. This deficiency, unless corrected, poses further risks to health equity.
- Analysis of evidence indicates a need to increase knowledge of return-on-investment principles across most health systems, particularly in new EU Member States. This stems in large part from using bed ratios as the currency for capacity and capital planning as opposed to linking planning and investment to the newly emerging principles of care (disease) pathways and patient flow models.
- Too much SF spending is confined within tight sectoral or departmental boundaries. This creates problems of coherence and cohesion, especially in using ERDF and ESF together to target strategic and structural change.
- EUREGIO III has found that many projects and proposals are weak with regard to application of research findings and adoption of evidence-based practice. There is a good case for the establishment of regional reference centres to provide practical experience to guide SF beneficiaries through the SF system.
- Collected evidence suggests that applicants for SF funds find it difficult to bridge between local needs and EU policy objectives. Projects are often tuned (compromised) to fit EU criteria rather than being designed to produce the transformational change often implicit in EU policy shifts.
- Analysis of in-depth interviews suggests that most projects do not make allowances for sufficient planning lead-time or procurement time. There is also a significant lack of competency to undertake large-scale projects (the absorption-capacity dimension). Furthermore, pressure to deliver project spending targets can often compromise the quality and outcome of projects (Dowdeswell & Watson, in press).

3. Implications for health systems

This Section looks at the issues discussed as opportunities and challenges in Section 2.⁹ Particular attention is paid to: engaging with the SF process; how health system stakeholders can prepare the case for using SF to reduce health inequities; how RHS can use SF to address SDH and health inequities; and methods to build the capacity of health professionals to reduce health inequities through the use of SF.

Through their stewardship function, health systems at national, regional and local levels have a clear role in working with other sectors to address the determinants of health and reduce health inequities. Health systems are also in a position to act as exemplars by ensuring that equity measures are integrated across all health system functions.

However, as this section makes clear, in considering the policy options and actions available to reduce health inequities through the use of SF, the main focus will not be within health systems themselves. Direct health sector investment amounts to no more than 2% of the SF total budget, with ESF allocations yet to be clarified (Watson, 2009). At a time when the EU is seeking to reinvigorate the commitment and actions of its Member States to deliver sustainable and equitable economic growth, health systems need to take forward their role as major economic players as part of the stewardship function (WHO Regional Office for Europe, 2008a).

Implication 1: engaging health systems at all levels in the SF process

At the 2010 Open Health Policy Forum, a key issue for participants at a parallel workshop on positioning health at the centre of the post-2013 Cohesion Policy was whether health would remain a priority under the future funding period 2014–2020 – the fifth phase of Cohesion Policy. Currently, there are many competing priorities for a potentially smaller amount of money. This means that competition for SF will become more difficult, with greater emphasis on risk assessment, value for money and outcome evidence. While the focus post-2013 is likely to be on the poorest and territorially disadvantaged regions, it will be argued that Cohesion Policy should continue to be a policy for all regions (EPF, in press).

Participants from a range of European organizations, EU Member States and EC directorates understood that the EC is oriented towards the full alignment of Cohesion Policy with the newly agreed long-term strategy for smart, sustainable and inclusive growth (EC, 2010). Several equity-related themes are prioritized among the seven priorities: European platform against poverty; an agenda for new skills and jobs; innovation union;¹⁰ and youth on the move. There is no explicit reference to health, making it difficult to predict whether Cohesion Policy will be investing in health in the future programming period and, if so, to what extent (EPF, in press). Different scenarios are possible, and include:

- health will continue to feature as a priority for Cohesion Policy;
- health will exist as a subpriority under a number of other priorities for Cohesion Policy investment; and
- SF will no longer be used to invest directly in health, although attention will be given to investing in health determinants such as employment and social inclusion.

The second scenario is considered more likely and, in this respect, the Directorate-General for Health and Consumers (DG SANCO) representative showed that health could perfectly fit under all Europe 2020 overarching themes, notably smart, sustainable and inclusive growth (Table 1).

Integrating health equity into SF will depend on a range of actions, including the following.

- Health systems should remain updated on evolving SF processes. The initiation phase and preparation of NSRF and OP phase are the best times for this, as the SF process will remain largely unchanged for the next period once it is revised (probably modestly) and implemented¹¹ (Fig. 2).

⁹ These functions include delivering health systems financing (see Section 2, challenge 1), creating resources (Section 2, opportunity 2, opportunity 3, and Section 2, challenge 2) and providing stewardship (Section 2, opportunity 1).

¹⁰ Refocusing research and development and innovation policy on major challenges and closing the gap between science and the market.

¹¹ See also Section 2 for stewardship, resource allocation and service delivery examples.

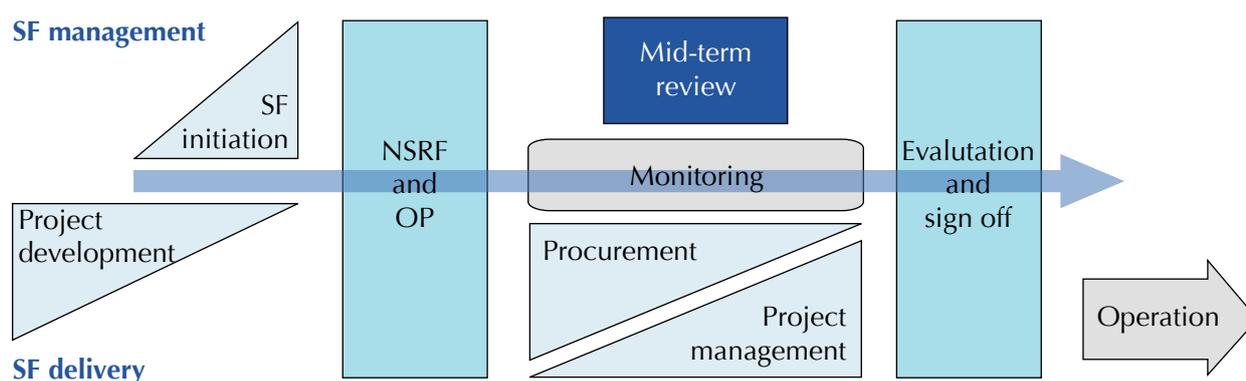
- As intermediary bodies in the SF process, ministries of health and RHS can ensure that they are aware of the effect of the EU procurement process on funded projects, and that potential SF applicants from their health system are familiar with the SF process and can demonstrate that a funded project will contribute to delivery of relevant national and regional strategies and master plans.
- The adoption of a new case study approach by the EUREGIO III project would facilitate the development of a focus on the issue of health inequities beyond formal reports in an attempt to identify connections between the investments made and reducing inequities.
- Setting up real-time knowledge sharing between SF beneficiaries and funded projects using a moderated Internet platform such as Facebook and blogging, would enable experience and challenges (such as those related to reducing health inequities) to be shared and mutual solutions sought (EUREGIO III, 2010). The Expert Group on Health Inequities and Social Determinants of Health could make a valuable contribution to this process.

Table 1. Relationship between public health systems and Europe 2020 overarching themes

Inclusive growth
Reduce health inequities
Empower citizens – health literacy and information to patients
Smart growth
E-health and telemedicine
User-oriented health care
Health innovation – demand-side driven innovation of processes and technologies
Sustainable growth
Healthy ageing – focus on health promotion and diseases prevention; improve healthy life years
Skilled and sustainable health workforce
Transformation of health systems to adapt to challenges and optimal use of resources
Cross-border health care

Source: Dimitrova (2010).

Fig. 2. Opportunities to integrate health equity into the SF process



Implication 2: making the case for using SF to reduce health inequities

In making the case for using SF to reduce health inequities, health systems need to navigate those factors that have tended to favour the tactical use of SF to ensure spending and short-term political gain rather than strategic transformative change (see Section 2, opportunities 1–3). Whatever EU Member State commitments are in relation to EU policy frameworks, a basic premise for understanding the SF process is that the emphasis has been on spending available funds. However, the Europe 2020 strategy and the evolving post-2013 Cohesion Policy may shift thinking to more sustainable “return-on-investment” principles, including reducing health inequities, as a

driver for achieving the goals of Europe 2020 and associated post-2013 Cohesion Policy priorities.

As part of their stewardship role, health systems are economic catalysts as well as providers of quality services. There is clear evidence that:

- health services have a direct impact on population health (Nolte & McKee, 2004) and, consequently, an indirect impact on the productivity of the workforce and national wealth (Suhrcke et al., 2005; López-Casasnovas, Rivera & Currais, 2005);
- the health sector represents one of the most important economic sectors and one of the largest service industries across the EU: according to WHO estimates, its output in 2005 accounted for 8.9% of GDP in the EU and 7.7% in the (much) wider WHO European Region (WHO Regional Office for Europe, unpublished data, 2008); and
- the performance of the health sector affects the competitiveness of the overall economy via its effect on labour costs, labour market flexibility and the allocation of resources (Suhrcke et al., 2005; López-Casasnovas, Rivera & Currais, 2005).

The case for using SF to reduce health inequities might consequently reflect the following relevant actions.

- The SF initiation phase (see Fig. 2) provides an opportunity for EU27 ministries of health to present a case for integrating relevant indicators into the process begun by the EC (EC, 2009b). This is critical as the financial, policy and capacity factors referred to above are likely to add up to significant competition for future SF and associated co-funding, with demand outstripping supply.
- Health systems need to consider the key elements of such a case at SF initiation, NSRF/OP, procurement and funding application phases, starting with an acceptable rationale that is forward looking and maps relevant synergies between sectors (Watson & Agger, 2009).
- A shared concept between sectors, especially around sustainable regional development, would be helpful. This integrates three core goals – economic growth, social stability and environmental protection – within one framework (Whitford & Potter, 2007; López-Casasnovas, Rivera & Currais, 2005; SERI, 2008; Jenkins, 2003; Buselich, 2002). Such integrated frameworks may be easier to achieve at regional level, as argued by the Sustainable Europe Research Institute (SERI, 2008). As pilots, they may become the triggers for larger-scale developments (Watson & Agger, 2009:191). The conditions of daily living (see Fig. 1) fit well into such integrated policy frameworks.
- In parallel, there is growing interest in the inclusion of health-related indicators in models of sustainable development. This can facilitate quantification of the socioeconomic and environmental consequences of direct health sector investment and the health impacts of indirect and non-health sector investments.¹² A next step could be to effectively integrate health equity considerations into a risk assessment of all SF funding applications and post-evaluation assessment of all OPs and projects. Essentially, there is a need to develop and use more inclusive, near real-time indicators that provide a more reliable knowledge base for policy-making, associated investment choices, monitoring and project management.¹³
- In thinking about how policy/strategy can be translated into practice, it is helpful to take the example of ECD to see how social determinants are interdependent in ways that are not always reflected in public policy (see Section 2 and CSDH, 2008:4–5). Investment in ECD is shaped by availability of sufficient material resources that assure supportive growing environments, preschool and later educational opportunities, food and housing. Much of this has to do with employment security (Scherer, 2009; Ward et al., 2009) and the quality of working conditions and wages of their parents and the subsequent life chances that a child has. The availability of quality regulated child care is an especially important policy option in support of early life (Epsing-Andersen, 2002). Looked at together, these are not issues that usually come under individual control. An SDH policy-oriented approach places such findings within crosscutting approaches. An SDH approach also underlines the importance of not measuring progress by GDP and economic growth alone. Rather, progress should be measured by improvements in multidimensional well-being, sustainability and equality (Stiglitz, Sen & Fitoussi, 2009; Degryse & Pochet, 2009; Jackson, 2009).

¹² The health sector is increasingly recognized as an important element in these frameworks, reflecting the concept of health and equity in all policies (Ollila et al., 2007).

¹³ The need for such data is affirmed by the EC (EC, 2009a), Council of the European Union (Council of the European Union, 2010) and the Sixty-second World Health Assembly (World Health Assembly, 2009).

- The second issue that is integral to successfully translating policy into practice is: community engagement and participation. Participation is an integral component of the “health for all” PHC movement. Its instrumental and intrinsic value was reaffirmed in the work of the CSDH. Following substantial review of literature and global policies, the HSKN concluded that health systems oriented toward health equity involve population groups and civil society organizations in decisions that “identify, address and allocate resources to health needs” (Gilson, 2007). The Council of Europe (CE) affirmed these principles in adopting a recommendation in 2000 (CE, 2000) on the development of structures for citizen and patient participation in the decision-making process affecting health care.

Implication 3: how regional health systems can use SF to address SDH and health inequities

RHS are demonstrably well placed to advance the three opportunities shown in Section 2. Regions are closer to their communities and have a degree of operating flexibility that national governments rarely seem to have. Importantly, regional governments have considerable experience in facilitating intersectoral action and in merging national policy priorities into regional strategies and master plans. They do this in ways that address regional and local needs that, in turn, help to improve the quality of life of their communities and make their regions more attractive places in which to invest and live.

In this sense, the stewardship role of a health system can be used to practically engage with other sectors. Case example D (Box 6) from Pomurje region of Slovenia provides a concrete example of how this works in practice (Buzeti & Zakotnik, 2008). However, RHS have different levels of responsibility and autonomy that might limit their ability to engage with other sectors and this can affect the stewardship role:

Where regions have been given responsibility for the basic elements of health policy – public health, primary care, rehabilitation services, acute hospitals and mental health services – it is vital that they also have the autonomy to plan, finance and implement the appropriate solutions to health needs [including tackling the SDH and reducing health inequities] (Watson & Agger, 2009:199).

The need for flexibility in finding and developing solutions to regional and local health needs does not appear to be adequately supported through the use of SF. Analysis of case material for EUREGIO III suggests that the current SF process appears to favour high-cost infrastructure investment with funded projects not fully assessing longer-term revenue implications (Dowdeswell & Watson, in press). This type of SF spend has relied on an average project duration of 10+ years, starting with an idea based on available evidence, accepted models and political priorities before procurement, implementation and final EC audit sign off. As the European Centre for Health Assets and Architecture (ECHAA) research director observed about the EUREGIO III case material that ECHAA and Imperial College London are collecting and analysing:

Early analysis of EUREGIO III case studies suggests that most health related capital investment projects in the 2000–6 and 2007–13 cycles tend towards a conventional, incremental and increasingly outmoded acute hospital centric focus. The structure of the SF process may also limit justifiable mid-term revision of projects, even when the need for reform has emerged, as the process of itself seems inflexible and tends to place a high premium on on-cost, on-time spending of project funding (Dowdeswell & Watson, in press).

EU Member States and regions across Europe are shifting their health-system focus from acute care hospital-centric systems to more dispersed chronic disease management and elderly care oriented models. This is underpinned by more rapid diffusion of technologies, larger but fewer specialized centres and a squeeze on the middle-ground acute general hospitals – almost certainly leading to a process of rationalization and mergers. In part, this is due to high perceived demand on hospitals and demographics in areas such as the Basque Country (Spain) that has led to the development of pilots on telemonitoring (EUREGIO III 2010:9). Similar developments were also highlighted by regions at an Assembly of European Regions (AER) conference on financing regional health care at Lodz in March 2009, with particular attention to appropriate service development in largely rural regions (AER Social Policy and Public Health Committee, 2009).

Overall, evidence highlights further opportunities for health systems in Convergence and Competitiveness and Employment Regions to maximize health gains and reduce health inequities through direct, indirect and non-health sector investments (see Section 3.4 on capacity building). These include:

- the identification of exemplar innovation, research and technology development projects and strategies that are founded on, or contribute to, innovative research and technological advances;

- the promotion of entrepreneurship and small and medium-size enterprises (SMEs) through an emerging model of health care delivery based on PPP provision, including different forms of outsourcing, which brings into play the twin features of entrepreneurship and project/service delivery by SMEs;
- recognition of the extremely good evidence which shows that “the information society” is central to many, if not most of, these shifts (e-health and technology dispersal models, for example); and
- the relevance for employment and human resources of the potential future focus on risk assessing investment to ensure it addresses issues of improving health status.

Box 6. Case example D: Programme MURA (Slovenia)

The Pomurje region is one of the most deprived in Slovenia. The majority of indicators of economic performance are significantly below the national average. It has the lowest GDP per capita and the highest percentage of long-term unemployed of any region. Long-term unemployment is linked to the low level of education. As income, employment and education are determinants of health, with more disadvantaged populations often having higher rates of morbidity and mortality, it is no surprise that the population has relatively poor health. Life expectancy is the lowest of any region, and the number of years of life lost per 1000 people under 65 is the highest.

Programme MURA became a development priority in the regional development programme for Pomurje for 2000–2006. Financing in this period came from the Ministry of Health fund for tackling health inequities, the direct regional investments transferred through the regional development agency and endorsed by mayors in all 26 municipalities of Pomurje, and different EU funds, such as Phare and Interreg.

Programme MURA's working priorities were:

1. improve healthy lifestyles
2. increase healthy food production and distribution
3. develop healthy tourism products and programmes
4. preserve the natural and cultural heritage and reducing the ecological burden.

The lessons learnt provide practical knowledge of the challenges and benefits of the stewardship role of health systems. Of particular value to the health and equity in all policies approach are the following.

Policy development

1. Achieving policy coherence between different sectors requires that policies be aligned with broad, shared objectives that provide space for intersectoral working. Administration of finances should also permit joint working.
2. Focusing intersectoral effort requires that common priorities be identified. There is a need to focus resources on areas of greatest opportunity for health (and social) gains, which means where resources are most likely to have the greatest impact and where conditions for success exist.
3. It is crucial to consider issues of delivery and capacity (human and financial) and mechanisms for monitoring and evaluation during the policy-formation stage.

Systems for delivery

1. The establishment of clear roles and responsibilities is essential. Parties should be made accountable for their differing roles and levels of engagement.
2. Performance management systems are required. These should account for milestones, targets (at all levels of implementation), outputs and outcomes, and the monitoring and review process.

Source: Buzeti & Zakotnik (2008).

In summary, targeted investment that tackles health inequities in deprived areas or those with relatively low economic output:

- contributes to economic regeneration
- strengthens social cohesion
- increases employment prospects where matched by inclusive employment policies
- raises the skill base in regional and local labour markets.

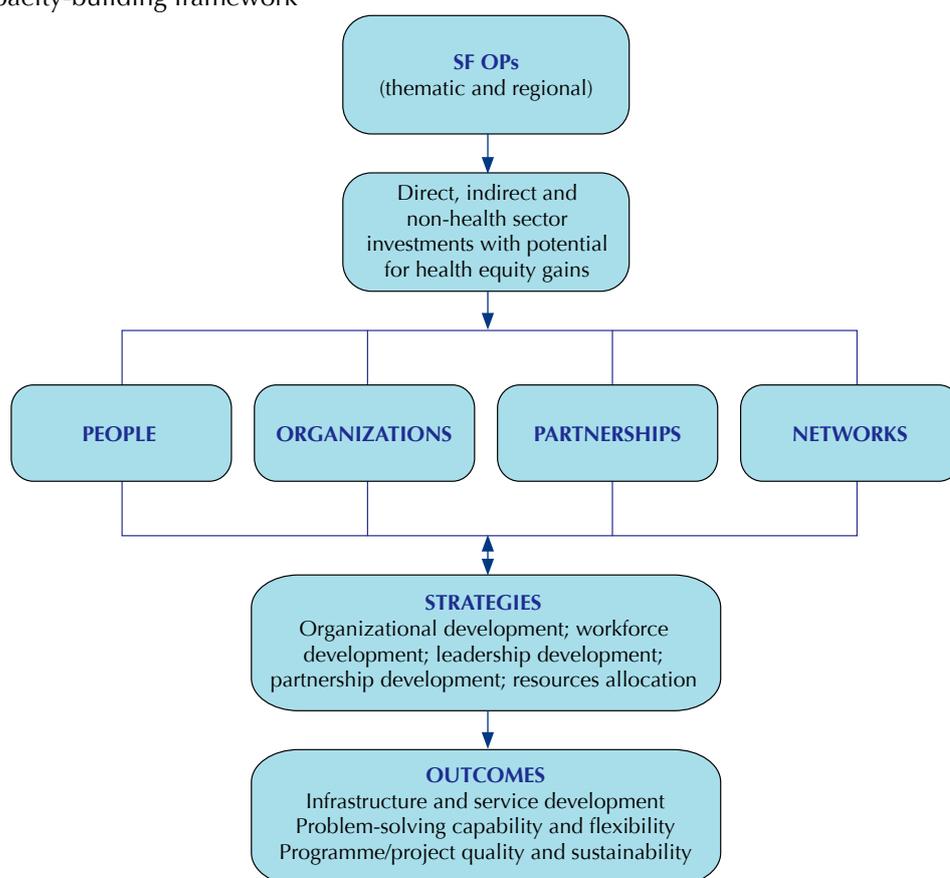
Implication 4: methods for building capacity of health staff to reduce health inequities through SF

In relation to capacity building, the SF 2007–2013 period extended the scope and eligibility for health-related projects, notably to include technical assistance (designated OPs) and exchange of best practice (such as through Interreg IVC¹⁴). However:

- other sectors have more experience of making the case for access to technical assistance funds;
- OP/ROP managing authority staff generally have little experience in health systems; and
- accessing Interreg funds to share best practice relies on a convincing focus on priorities that do not include health.

EU health systems are relative newcomers to SF and staff face a steep learning curve. To ensure the effectiveness and sustainability of investments in capacity building, the points set out in Fig. 3 could be considered.

Fig. 3. Capacity-building framework



Source: adapted from Watson (2009) and NSW Health (2001).

Building the capacity of health staff to reduce health inequities through SF cannot simply focus on workforce development (see case example E, Box 7). It needs to be nested in a broader capacity-building approach (including organizational development, partnership development, leadership development and resources allocation) that ensures sustainable capacity is achieved at system, organization, team and individual levels (Watson et al., 2005; Bowen, Harris & Hyde, 2001).

- The critical first step is to invest in capacity building of institutions (see Section 2) before funds can be effective in stimulating growth. This is especially relevant to the newer EU12 Member States.
- The issue of capacity and competency remains an issue at regional and local levels, especially in the EU12 Member States. Investment in capacity building in key RHS organizations can have a demonstrable effect on key governance issues that need to be addressed if SF are to be accessed and investments made effective and sustainable. These include transparency, accountability, equity and community engagement.

¹⁴ Interreg IVC provides funding for interregional cooperation across Europe. It is implemented under the European Community's territorial cooperation objective and financed through the ERDF. The current period runs from 2007 to 2013.

- Opportunities for, and the content of, in-country training also need attention. For example, ministry of health and RHS training courses on health, SDH and health inequities could include a module on SF. Likewise, national awareness-raising and training events on SF could include a module on health, SDH and health inequities. European web-based platforms could support the planning and delivery of such training with resources (such as modules that can be adapted to country contexts, sample facilitator notes and case studies) and be regularly updated to reflect evolution of the SF process and the latest know-how.

In summary, in the context of the SF process, capacity building is a challenge for:

1. MAs at national and regional level that might still be unfamiliar with public health systems and related agendas;
2. intermediary bodies such as national health ministries and RHS, for which the SF process from initiation to final audit remains unfamiliar and for which access to co-funding (see Section 2) remains problematic; and
3. potential beneficiaries of project funding who might not be clear about issues such as: who makes funding decisions, the criteria by which applications are assessed and whether the conditions of funding can be flexible enough to allow projects to adapt to changing circumstances (all of these elements need attention in building administrative or institutional capacity).

Box 7. Case example E: EUREGIO III — Training workshops series “Optimizing health through application of EU Structural Funds”

One of the core components of the EUREGIO III project is to develop and run a series of five initial workshops for people to learn how to apply for and use SF for health projects. The overall aim is to develop knowledge and skills to design, implement and evaluate SF investments for health and strengthen capacity to implement principles of good practice in participating Member States and regions. The objectives are to:

1. develop knowledge and competency in designing projects for measurable and sustainable health improvement, relevant for SF support, including: integrated capital and service planning and investment, health care delivery models that reflect contemporary trends and changes in health policies and systems, new perspectives on health needs assessment, and the impact of a changing economic outlook;
2. broaden awareness of the wider opportunities for SF application, including the principles of health and the economy (“health is wealth” and “health in all policies”), with particular regard to health-related investments achieving higher priority in national and regional SF operation programmes;
3. develop project management skills for implementation of SF projects that bring into play new principles of project managing for best value, sustainable life-cycle benefit and effective SF process implementation and management;
4. develop project knowledge and skills in the evaluation of SF projects, including tactical and strategic outcome assessment; and
5. enable participants to identify opportunities for, and barriers to, implementing best practice in their own countries/ settings and to develop action plans to enable them to develop successful and sustainable health infrastructures and other investment projects.

Of particular value is the opportunity for participants to be informed by the experiences of other SF health projects. Two events have already been held, drawing on local SF experience in Krakow and Berlin (Brandenburg–Nordost). In addition, participants are asked to share their experiences, challenges and learning from the SF process with access to guidance and expertise from EUREGIO III partners and others. Further events are to be held in Italy (October 2010), Liverpool (United Kingdom) (spring 2011) and Romania (spring 2011).

Master class series

The master class series takes an in-depth look at key SF health investment themes and is designed for those with some experience of using SF for health. SF beneficiaries (such as regional/local health services and regional development agencies) that are running projects and staff from OP and ROP managing authorities are targeted.

The first event, held in Budapest, focused on health infrastructure investment. Further events will be held in Bratislava (November 2010), Lisbon (spring 2011) and Stockholm (June 2011).

Source: EUREGIO III (2010).

4. Learning from current EU projects and priorities for future research

In the context of improving health equity, it is important that the learning from the findings of the CSDH and relevant projects is shared not only with policy-makers and beneficiaries, but is also available to inform the development and planning of new research, policy interventions and practice. This is not just a matter of investing

in new research. A necessary first step is to establish a process to share learning from projects such as those listed below to build an accessible knowledge base mirroring the CSDH overarching recommendations (CSDH, 2008) that can inform future research, policy and practice.

The following summary of relevant EU projects and initiatives is indicative only, but the learning they generate will help inform actions to take advantage of the opportunities identified in Section 2 and the implications for health systems covered in Section 3.

- TEENAGE (2007–2010) (<http://www.teenageproject.eu/index.php>) aims to formulate policy recommendations to prevent socioeconomic inequities linked to the health behaviour of European adolescents (relevance – Section 2, opportunity 2: using SF to improve the health of socially excluded groups; Section 3, making the case for using SF to reduce health inequities).
- ROMA-HEALTH (2007–2009) (<http://www.gitanos.org>) sought to inform the reduction of health inequities affecting the Roma community in Europe by: obtaining reliable and objective data about the social/health situation of the Roma population and the use made of health care resources available to mainstream society; identifying factors considered vital in improving the Roma situation and promote equity; and promoting synergies between the public and private spheres (such as health centres, hospitals, social organizations and public administrations) (relevance – Section 2, opportunity 2: using SF to improve the health of socially excluded groups; opportunity 3: using SF to improve health systems in Convergence Regions; Section 3: making the case for using SF to reduce health inequities).
- HealthPROelderly (2006–2009) (<http://www.healthproelderly.com/>) had a general objective of encouraging health promotion for older people through producing evidence-based guidelines with recommendations for potential actors in this field at EU, national and local level (relevance – Section 2, opportunity 2: using SF to improve the health of socially excluded groups; Section 3, making the case for using SF to reduce health inequities).
- Health Care in NowHereland (2008–2011) (<http://www.nowhereland.info/>) aims to improve the level of health protection for the people of Europe by addressing migrants' access, quality and appropriateness of health and social services as important wider determinants for health, focusing on health care services for undocumented migrants as an especially vulnerable group (relevance – Section 2, opportunity 2: using SF to improve the health of socially excluded groups; Section 3, making the case for using SF to reduce health inequities).
- PROGRESS (2007–2013) (<http://www.ec.europa.eu/social/main.jsp?catId=327>), which was set up in 2007, was established to financially support the implementation of EU objectives on employment, social affairs and equal opportunities as set out in the Social Agenda. It is designed to act as a catalyst for change and modernization in five areas: employment; social inclusion and protection; working conditions; non-discrimination; and gender equality (relevance – Section 2, opportunity 2: using SF to improve the health of socially excluded groups).
- I2SARE (2008–2010) (<http://www.i2sare.eu>) was established to produce a health profile for each region of the EU, and to create a typology of those regions and a typology of subregional territories in a selection of countries and regions. I2SARE's main objective is to assist European, national, regional and local decision-makers in developing their health policies through a better understanding of the health status of the population and of health inequities at regional and subregional level (relevance – Section 2, opportunity 1: using SF for health and equity in all policies; Section 3, engaging health systems at all levels in the SF process; making the case for using SF to reduce health inequities, how regional health systems can use SF to address SDH and health inequities).
- EURO-URHIS 2 (2009–2012) (<http://www.urhis.eu>) is developing, testing and validating a set of comparable urban health indicators (building upon the work already completed by the health indicators for the European Community project) in 30 cities across the EU using newly developed health interview surveys, mortality statistics and other routinely available data (relevance – Section 2, opportunity 1: using SF for health and equity in all policies; Section 3, engaging health systems at all levels in the SF process, and making the case for using SF to reduce health inequities).

- DETERMINE (2007–2010) (<http://www.health-inequities.eu>) aims to apply the EU and Member State shared policy competences to act on the socioeconomic determinants of health, to ensure greater awareness of the responsibility that all policy sectors, beyond the health sector, have with respect to maintaining and improving the health of EU citizens, and to gather the evidence of the benefits of greater collective investment in health (relevance – Section 2, opportunity 1: using SF for health and equity in all policies; opportunity 2: using SF to improve the health of socially excluded groups; Section 3, engaging health systems at all levels in the SF process and making the case for using SF to reduce health inequities).
- GRADIENT (2009–2012) (<http://www.health-gradient.eu>), an EC Seventh Framework Programme-funded¹⁵ research project, is mainly focused on improving understanding of which actions are effective to level up the gradient in health inequities focusing on families and children, since the greatest impact on reducing the health gradient can be achieved through early-life policy interventions and by creating equal opportunities during childhood and adolescence (relevance – Section 2, opportunity 1: using SF for health and equity in all policies; opportunity 2: using SF to improve the health of socially excluded groups; Section 3, engaging health systems at all levels in the SF process and making the case for using SF to reduce health inequities).
- Building Healthy Communities (BHC) (2008–2011) (<http://www.urbact.eu/en/projects/quality-sustainable-living/building-healthy-communities-bhc/homepage/>), funded under the URBACT 2¹⁶ programme, has a main objective of establishing a network of cities in at least six Member States participating in a transnational exchange programme for transfer of policy, planning and practice on urban health policies and to provide capacity building for professional development in the field of urban health (relevance – Section 2, opportunity 1: using SF for health and equity in all policies; opportunity 2: using SF to improve the health of socially excluded groups; Section 3, making the case for using SF to reduce health inequities and methods for building capacity of health staff to reduce health inequities through SF).
- EUREGIO III (2009–2012) (<http://www.euregio3.eu>) aims to identify and share good practice and lessons learnt for the effective use of SF for health from the 2000–2006 and 2007–2013 periods and help reduce health inequities among EU regions. It is a key resource to enable Member States and regional and local authorities to understand, develop, apply and use SF projects for health gain. In addition to providing beneficiaries with practical knowledge, its findings will also inform the mid-term review of the current SF period and planning for the 2014–2020 period (Box 8) (relevance – Section 2, opportunity 1: using SF for health and equity in all policies; opportunity 3: using SF to improve health systems in Convergence Regions; Section 3, engaging health systems at all levels in the SF process, making the case for using SF to reduce health inequities, how regional health systems can use SF to address SDH and health inequities, and methods for building capacity of health staff to reduce health inequities through SF).

In summary, as part of sharing knowledge and lessons learnt, these and other projects could, in part, be guided by the need for the monitoring of specific determinants and their health impacts, particularly in different contexts. Such monitoring should extend to policy and programmatic interventions on the wider determinants. Effectively leveraging this data will require new approaches to developing evidence-based programming that go beyond overreliance on health condition-specific indicators.

This is reinforced by the EC communication *Solidarity in health: reducing health inequities in the EU*, which states: “Consideration could be given to whether a sound monitoring of health inequalities indicators would be a useful tool to monitor [the] social dimension [of the Lisbon agenda]” (EC, 2009a:5), while the more recent EC/WHO Joint Declaration (WHO Regional Committee for Europe, 2010) also highlights the need for closer monitoring of health inequities. Such investment is essential if health systems are to better engage with SF to help reduce health inequities in ways that facilitate intersectoral working to address the SDH.

¹⁵ Known as “FP7”.

¹⁶ The URBACT II 2007-2013 Programme brings forward the experience of URBACT 2000-2006 and focuses on issues including unemployment, criminality, poverty and inadequate access to public services in urban and suburban areas. It aims to support integrated and sustainable urban development policies in Europe, with a view to implementing the Lisbon and Gothenburg strategies.

Box 8. Improving the SF process: outcomes of the meeting of EUREGIO III stakeholders, Venice, Italy, 25–26 February 2010

A EUREGIO III event for SF and health system stakeholders identified key issues that need to be addressed to improve the SF process and the effectiveness and sustainability of funded projects. The findings are relevant in considering the capacity of SF to contribute to reducing health inequities and are cross-referenced to opportunities (Section 2.3) and implications for health systems (Section 3).

- As with many funding processes, the SF process can have a significant and predisposing impact on projects, either at their initial development or subsequent submission stage. This may significantly affect priorities and focus and have unintended consequences (see implications).
- Ministries of health may encounter difficulties in integrating health and health equity-oriented objectives into policy areas and OPs that are under the control of other ministries/sectors. This possibly reflects a lack of experience in the health sector in pursuing funds in mainstream SF OPs that do not have a “health” label. Opportunities to systematically analyse, further develop the knowledge base and build capacity in the health sector towards this end could be explored (see Section 2, opportunity 1 and Section 3).
- The applications funded can depend on political need and the SF process itself, which tends towards maximizing spend instead of focusing on effect and sustainability. EUREGIO III is recommending that project applications should be able to meet pre-assessment criteria before they are assessed, including: an evidence-based rationale, relevance to regional master plans and/or national strategies, and financial sustainability once SF funding ends (see Sections 2 and 3).
- The current SF process seems designed to favour high-cost infrastructure investment with little regard to revenue implications (EUREGIO III, 2010). However, rural regions (as demonstrated by the Brandenburg and Norrbotten cases above) are showing how a better balance can be achieved (see Section 2, opportunity 3 and Section 3).
- The EUREGIO III project was partly intended to identify best practice when initially funded. There are challenges in creating evidence and documentation, including in transferring lessons from one project or area or another, given the contextual diversity across the EU (EUREGIO III, 2010; Watson, 2009) (Sections 2 and 3).
- How results can be assessed and compared given a lack of coherence between databases across the EU presents a challenge. Also, each Member State tends to use different metrics to both assess SF funding applications and to measure impact. The projects summarized in Section 4 suggest that indicators and tools exist or are in development (see Section 3).

These findings should be considered as “work in progress”. They will be regularly reviewed and updated during the course of EUREGIO III, with due consideration given to their implications for using SF to reduce health inequities.

Annex: Summary of the SF system

Under the 2007–2013 cohesion policy, the 271 regions in the EU27 are clustered into one of two objectives (Watson, 2009).

- The Convergence Objective (including regions in a “phasing-out” stage, formerly Objective 1) covers regions whose GDP per capita is below 75% of the EU average and aims at accelerating their economic development. It is financed by the ERDF, the ESF and the CF. The priorities under this objective are human and physical capital, innovation, knowledge society, environment and administrative efficiency. The budget allocated to this objective is €283.3 billion in current prices.
- The Regional Competitiveness and Employment Objective (including former Objective 1 regions that are now in a “phasing-in” stage and those that were formerly Objective 2) covers all regions of the EU territory except those already covered by the Convergence Objective. It aims to reinforce competitiveness, employment and attractiveness of these regions. Innovation, the promotion of entrepreneurship and environmental protection are the main themes. The funding – €55 billion in current prices – comes from the ERDF and ESF.

There is a third Territorial Cooperation Objective (formerly Objective 3). This builds upon previous interregional initiatives, which were originally planned to be fully incorporated into the main objectives of the SF. Financed by the ERDF with a budget of €8.7 billion, its aim is to promote cooperation between European regions and the development of common solutions for issues such as urban, rural and coastal development, shared resource management and improved transport links. The objective is divided in three strands: cross-border cooperation; transnational cooperation; interregional cooperation.

The overarching priorities at EU level are established in the community strategic guidelines (Council of the European Union, 2006). These set the framework for all actions that can be taken using the funds. Within this framework, each Member State develops its own NSRF. The NSRF sets out the priorities for the respective Member State, taking specific national policies into account.

Informed by NSRFs, two types of OPs are drawn up within Member States: national thematic OPs, such as those on innovation, and regional OPs, which reflect the needs of individual regions. ROPs were initiated for the first time in the 2007–2013 period and reflect a drive to decentralize action with the stronger involvement of regions and local players in the preparation of the programmes.

Although the SF are part of the EU budget, the way they are spent is based on a system of shared responsibility between the EC and the Member State authorities:

- the EC negotiates and approves the NSRFs and OPs proposed by Member States and uses these as a basis for allocating resources;
- Member States and their regions manage the programmes (this includes implementing the OPs by selecting individual projects, controlling and assessing them); and
- the EC is involved in overall programme monitoring, pays out approved expenditure and verifies the national control system.

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The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.



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