GUIDE FOR EFFECTIVE INVESTMENTS IN HEALTH UNDER ESI FUNDS

Developed under the project “Provision of support for the effective use of European Structural and Investment (ESI) Funds for health investments”

31 January 2015
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<tr>
<td>ACSS</td>
<td>Central Health Administration (Portugal)</td>
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<tr>
<td>CBA</td>
<td>Cost Benefit Analysis</td>
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<td>CF</td>
<td>Cohesion Fund</td>
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<td>CHAFEA</td>
<td>Consumers, Health and Food Executive Agency</td>
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<td>COP RBM</td>
<td>Community of Practice on the Results Based Management</td>
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<td>CPR</td>
<td>Common Provisions Regulation</td>
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<td>CSE</td>
<td>Central and south-eastern Europe</td>
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<td>CZK</td>
<td>Czech Koruna</td>
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<td>DG REGIO</td>
<td>Directorate General for Regional and Urban Policy</td>
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<td>DG SANCO</td>
<td>Directorate General for Health and Consumers</td>
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<td>EC</td>
<td>European Commission</td>
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<td>eHIS</td>
<td>Electronic Health Information System</td>
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<td>EHR</td>
<td>Electronic Health Record</td>
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<td>EOPPY</td>
<td>Greek National Organization for Health Care Provision</td>
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<td>ERDF</td>
<td>European Regional Development Fund</td>
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<td>ESF</td>
<td>European Social Fund</td>
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<td>ESIF</td>
<td>European Structural and Investment Funds</td>
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<td>EU</td>
<td>European Union</td>
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<td>EYTTYKA</td>
<td>Special Agency of Health and Social Solidarity (Greece)</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>GYEMSZI</td>
<td>National Institute for Quality- and Organizational Development in Healthcare and Medicines (Hungary)</td>
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<td>HDO</td>
<td>Health Development Office</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>IB</td>
<td>Intermediate Body</td>
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<td>ICT</td>
<td>Information and Communication Technology</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>MA</td>
<td>Managing Authority</td>
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<td>MC</td>
<td>Monitoring Committee</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MS</td>
<td>Member State</td>
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<td>NAOL</td>
<td>National Audit Office of Lithuania</td>
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<td>NHIFA</td>
<td>National Health Insurance Fund (Hungary)</td>
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<td>NPHMOS</td>
<td>National Public Health and Medical Officer’s Service (Hungary)</td>
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<td>Acronym</td>
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<td>NSRF</td>
<td>National Strategic Reference Framework</td>
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<td>OP</td>
<td>Operational Programme</td>
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<td>OPH</td>
<td>Operational Programme Health (Slovakia)</td>
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<td>OP HRD</td>
<td>Operational Programme Human Resources Development (Slovenia)</td>
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<td>PA</td>
<td>Partnership Agreement</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PMO</td>
<td>Project Management Office</td>
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<td>PP</td>
<td>Position Paper</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<td>SF</td>
<td>Structural Funds</td>
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<td>SME</td>
<td>Small and Medium-sized Enterprises</td>
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<td>SPMO</td>
<td>Strategic Project Management Office</td>
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<td>TO</td>
<td>Thematic Objective</td>
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<td>WP</td>
<td>Work Package</td>
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<td>ZOAST agreement</td>
<td>Agreement on organized cross-border areas for access to care</td>
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Useful definitions

**Health and health investment definition**

Community-based care refers to the spectrum of services that enable individuals to live in the community and, in the case of children, to grow up in a family environment as opposed to an institution. It encompasses mainstream services, such as housing, health care, education, employment, culture and leisure, which should be accessible to everyone regardless of the nature of their impairment or the required level of support. It also refers to specialised services, such as personal assistance for persons with disabilities, respite care and others. In addition, the term includes family-based and family-like care for children, including substitute family care and preventive measures for early intervention and family support.

Cross-border health care means health care provided or prescribed in a Member State other than the Member State of affiliation.

Day care comprises health care services delivered to patients who are formally admitted to hospitals, ambulatory premises or self-standing centres but with the intention to discharge the patient on the same day.

eHealth refers to tools and services using information and communication technologies that can improve prevention, diagnosis, treatment, monitoring and management. It includes information and data sharing between patients and health service providers, hospitals, health professionals and health information networks; electronic health records; telemedicine services; portable patient-monitoring devices, operating room scheduling software, robotized surgery and blue-sky research on the virtual physiological human.

ePrescription means a medicinal prescription, issued and transmitted electronically.

Health care means health services provided by health professionals to patients to assess, maintain or restore their state of health, including the prescription, dispensation and provision of medicinal products and medical devices.

Health care provider means any natural or legal person or any other entity legally providing health care on the territory of a Member State.

Health gain is a way to express improved health outcomes. It can be used to reflect the relative advantage of one form of health intervention over another in producing the greatest health gain.

Health inequalities mean differences in health status between individuals or groups, as measured by for example life expectancy, mortality or disease. Specifically, health inequalities refer to those avoidable and unfair differences in health that are strongly influenced by the actions of governments, stakeholders, and communities and can be addressed by public policy.

Regarding the project scope, when referring to health investments, the following areas are covered:

- Health infrastructure (facilities & equipment, organization, processes, guidelines etc.)
- Access to health care
- Health care services
- Education and training of medical personnel
- Health promotion and disease prevention measures

1 For further information on sources, see the final section of Sources – Definitions, at the end of this document.
Healthy ageing measures

Improve of health administration and capacity building, elaboration of strategic documents related to health, i.e. various studies, reform plans etc.

Medical research

**Health professional** means a doctor of medicine, a nurse responsible for general care, a dental practitioner, a midwife or a pharmacist or other professional exercising activities in the health care sector, which are restricted to a regulated profession as defined in Article 3 (1) (a) of Directive 2005/36/EC.

**Health systems** are the processes and infrastructures (legal, physical, financial and human resources) to deliver health care, prevent disease and improve health status. Health systems include not only health care but also public health measures.

**Health technology** means a medicinal product, a medical device or medical and surgical procedures as well as measures for disease prevention, diagnosis or treatment used in health care.

**Inpatient** is a patient who is formally admitted to a facility and stays overnight.

**Institutional care** is a residential care where:

- Residents are isolated from the broader community and/or compelled to live together
- Residents do not have sufficient control over their lives and over decisions which affect them
- Requirements of the organisation itself tend to take precedence over the residents’ individualised needs

**mHealth** (mobile health) covers medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices.

**Outpatient** is a patient who is not formally admitted to a facility (physician’s private office, hospital outpatient centre or ambulatory-care centre) and does not stay overnight.

**Patient** means any natural person who seeks to receive or receives health care in a Member State.

**Patient safety** means freedom, for a patient, from unnecessary harm or potential harm (medical or other) associated with health care.

**Prevention** is an integral part of the process of transition from institutional to community-based care.

- In the case of children, it includes a wide range of approaches that support family life and prevent the need for the child to be placed in alternative care.
- In the case of adults, prevention refers to a wide range of support services for individuals and their families, with the aim of preventing the need for institutionalisation.
- In relation to older people, the focus should be on preventing ill health, the loss of function, and the restoration of independence.

**Public health** shall mean all elements related to health, namely health status, including morbidity and disability, the determinants having an effect on that health status, health care needs, resources allocated to health care, the provision of, and universal access to, health care as well as health care expenditure and financing, and the causes of mortality.
**Strategic policy framework** means a document or a set of documents established at national or regional level, which sets out a limited number of coherent priorities established on the basis of evidence and a timeframe for the implementation of those priorities and which may include a monitoring mechanism.

**Sustainability** means avoiding an excessive increase in government liabilities – a burden on future generations – while ensuring that the government is able to deliver the necessary health services and to adjust policy in response to new challenges.
Introduction

The document “Guide for effective investments in health under ESI Funds” (hereinafter “the Guide”) is developed in the framework of a tender action on the provision of support to the effective use of European Structural and Investment Funds (hereinafter “ESIF”) for health investments, managed by the Consumers, Health and Food Executive Agency (CHAFEA) on behalf of the Directorate General for Health and Consumers (hereinafter “DG SANCO”), being delivered by EY.

The Guide and its supporting documents (see the list of project outputs below) are based on broad analyses of collected case studies and EY expert opinion and do not represent official European Commission documents.

The project outputs developed within the framework of the tender action are the following:

- WP 1 MAPPING REPORT ON THE USE OF EUROPEAN STRUCTURAL AND INVESTMENT FUNDS IN HEALTH IN 2007-2013 AND 2014-2020 PROGRAMMING PERIODS
- **WP 2 GUIDE FOR EFFECTIVE INVESTMENTS IN HEALTH UNDER ESI FUNDS**
- WP 3 TECHNICAL TOOLKIT FOR EFFECTIVE INVESTMENTS IN HEALTH UNDER ESI FUNDS with the following documents under the toolkit:
  - WP 3 (1) CATEGORIZATION OF THE 2014-2020 ESI FUNDS INSTRUMENTS AND MECHANISMS
  - WP 3 (2) REFERENCE CHECKLIST: ESSENTIAL AND SUCCESS FACTORS FOR CALLS FOR PROPOSALS AND FOR THE ASSESSMENT OF PROJECT APPLICATIONS
  - WP 3 (3) SET OF INDICATORS USEFUL FOR FINAL EVALUATION OF ACTIONS
  - WP 3 (4) COMPENDIUM OF (NEW) CONCEPTS AND MODELS FOR INNOVATIVE, EFFECTIVE AND SUSTAINABLE HEALTH CARE
  - WP 3 (5) MANUAL ON HOW TO PLAN, IMPLEMENT AND SUSTAIN CAPITAL INVESTMENT IN HEALTH AND HEALTH CARE
  - WP 3 (6) REFERENCE DOCUMENT ON APPRAISAL OF INVESTMENT
  - WP 3 (7) REFLECTION OF ADDITIONAL ISSUES RAISED BY MEMBER STATES

This Guide has been developed for the Managing Authorities (hereinafter also “MA”) of Operational Programmes (hereinafter also “OP”) in individual Member States (hereinafter also “MS”), Ministries of Health and other stakeholders who have an interest in the use of European Structural and Investment Funds for investment in health in the programming period 2014-2020.

The goals of the Guide are to:

- **Support** and provide recommendations for Ministries of Health and Managing Authorities on how to achieve the best results in the programming and implementation of health investment from ESIF.
- Help establish a partnership between the Managing Authorities of OPs and Ministries of Health (especially if the Ministries of Health do not act as an Intermediate Body) and inform them about their roles and cooperation possibilities towards effective investment.
Give information on lessons learned from the previous funding period and derive guidance for the programming period 2014-2020 based on it.

(i) Background to the Guide

The development of the Guide as well as the whole project builds strongly on the conclusions of Subgroup 2, a working group in the framework of the Reflection Process on modern, responsive and sustainable health systems that the EU Member States conducted in the Council from 2011 to 2013. Subgroup 2 was a group of representatives from several Member States established to share experience in preparation for the 2014-2020 programming period and building capacity for ESIF support for health. The membership in Subgroup 2 (hereinafter “SG 2”) was based on a voluntary basis.

Based on discussions, SG 2 members identified a need for better guidance for Member States to support effective use of the ESIF for health investments, mainly because:

- Public health actors in Member States are often new players in the use of ESIF and they are less informed and prepared than other sectors’ actors.
- Public health actors are not the Commission’s direct interlocutors for the ESI Funds, as there are no Operational Programmes devoted to health as such in preparation.

The results of the SG 2 work have been summarized in a document, the “Toolbox for effective structural funds investments in health 2014-2020”. This document represents, on the one hand, the policy and advocacy work undertaken within the framework of national debates on the use of ESIF for health towards the elaboration of the Partnership Agreements 2014-2020 and, on the other hand, a basic toolbox for the use of Ministries of Health and Managing Authorities with competences in health.

This project is designed to follow up and build on the results of the work of Subgroup 2. Furthermore, the Guide builds on the Policy Guide for Health Investments – European Structural and Investment Funds 2014-2020 developed by the European Commission (specifically DGs SANCO, REGIO and EMPL). The Policy Guide provides guidance for key priority areas of investment in health, pointing at suggested lines of intervention.

(ii) Structure of the Guide

With respect to the goals, the Guide is divided into three logical parts covering the theoretical background as well as practical guidance. The document covers:

- Part I: A theoretical background to the Guide

This part of the Guide focuses on the mapping of current trends in health care that delimit the areas of investment in health. Following the identification of the main determinants of health needs, the Guide provides information on how the 2014-2020 Cohesion Policy reflects health priorities and identifies areas of health eligible for funding within the new programming period.

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This part of the Guide provides a **list of health actions that could be funded from ESIF in the 2014-2020 programming period** broken down according to thematic objectives as defined in the Cohesion Policy.

- **Part II: Guidance on effectively projecting health priorities into ESIF programming and implementation process**

  The second part of the Guide analyses ESIF management structures and provides practical guidance on how to efficiently integrate the process of health investment planning and implementation into the ESIF programming and implementation process. It specifies the roles and responsibilities of the Ministry of Health and Managing Authorities in these processes of planning and implementation of health investments under the 2014-2020 Structural Funds framework.

  This part of the Guide provides practical advice to the Ministry of Health and Managing Authorities on **how to effectively cooperate and manage health investments** during each stage of the ESIF programming and implementation lifecycle.

- **Part III: Lessons learned from the 2007-2013 programming period**

  The last part of the Guide introduces a set of recommendations in critical areas identified based on analysis of a large set of case studies from the 2007-2013 programming period. Output of this phase is summarized in a table listing critical areas for efficient health investment delivery and provides practical recommendations reflecting lessons learned from the previous programming period.

  This part of the Guide identifies the **critical success factors that help deliver successful health investment outcomes** and provides a **list of recommendations** broken down according to the critical success factors identified.

- **Appendix: Case studies**

  The Appendix to the Guide presents 35 case studies, most of them original, which are referenced in the Guide and other project documents. Individual cases were identified during the mapping phase and / or national workshops and were collected with the support of the Ministries of Health (or other relevant institutions) in individual Member States who contributed by providing data. The case studies cover the main areas of planned investments in the 2014-2020 programming period (such as eHealth, transformation of health care service provision, education in health care, health prevention, and access to health care) in order to provide Member States with information regarding the goals and objectives of investments, their volume, identified success factors and the shared lessons learned. Projects and reforms are supplemented with several case studies addressing good practice examples of programming and implementation structure models from some Member States and finally with three other projects not necessarily connected to health but rather referring to good practice in the organizational / administrative set up. Original case studies are accompanied by five Euregio III Case Studies, case studies framed from two evaluation reports and some other sources referenced within individual chapters.

- The Guide is accompanied by a separate technical Toolkit, containing technical advice.
(iii) Data sources

The Guide is grounded on extensive evidence. The starting point for the development of this Guide was the results of an extensive survey among the EU Member States conducted by EY. Information and case studies collected were supplemented by the findings of some other projects conducted in this area in the past.

All the sources of information that were analysed as a background for development of this Guide are introduced below:

► Survey among representatives of Ministries of Health and / or Managing Authorities involved in structural funds implementation conducted in the majority of the EU28 countries through national EY offices.

At the beginning of the project, an extensive survey among Ministries of Health or Managing Authorities of Operational Programmes supporting health related actions in all EU Member States was conducted. Within the survey, the contractor collected a large amount of data related to health investments in the 2007-2013 programming period supported by EU SF and about the plans of public health authorities in most of the Member States for the use of ESIF for health in 2014-2020.

During the survey, which took about three months, interviews with selected contacts were conducted to discuss their experience with EU SF and lessons learned from the 2007-2013 programming period. Specific projects and practices discussed during the interviews were further developed in case studies supporting this document and recommendations involved in it.

► Results of existing initiatives on health investment

There have been several initiatives at European level examining the successfulness of health investment from Structural Funds and aiming at improving its effectiveness, efficiency and sustainability. Among them, the EUREGIO III project\(^5\) is worth mentioning as this project gathers in-depth analysis of Structural Funds used in the field of health in a number of Member States, along with the related problems. Within the EUREGIO III initiative, a number of case studies were developed. Projects that were further analysed were carefully chosen to offer relevant and important precedents and learning experiences for the future and to help relevant Member States to reflect the new challenges affecting EU Member States in the health area.

Another useful source of information is the results of The Impact of Structural Funds on Health Gains project\(^7\) that was also done for the European Commission, specifically for DG Health and Consumers (DG SANCO), and the Consumer, Health and Food Executive Agency (CHAFEA). Within the project a Guide to Health Gains from Structural Funds was developed. This guide demonstrates how non-health related investments such as transport, environment, infrastructure, research, agriculture, education, training, energy and social and economic development could generate health gains.

\(^5\) In cases where the Ministry of Health was not involved in the implementation of Structural Funds and / or did not have the necessary detailed information, authorities managing the relevant OPs were further addressed/interviewed to complete the picture on health investments in the Member State.

\(^6\) Available at: [http://www.euregio3.eu/](http://www.euregio3.eu/)

\(^7\) Available at: [http://www.healthgain.eu/](http://www.healthgain.eu/)
► **Further sources** include the e-Health Impact study, sources related to Slovakian OP Health (evaluations), the report on Health Equity and Regional Development in the EU, European Observatory on Health Systems and Policies and its studies on cross-border cooperation in health care and other sources.

► **National workshops carried out under the project**

The Guide and other supportive documents were updated with comments and good practice examples collected through workshops in 12 Member States that were selected according to their previous as well as planned use of EU Funds for health.

► **EY experience with SF EU programming and implementation** process and with public strategic work

Our EY team has extensive experience of providing advisory related to SF EU programming and implementation, from which a number of recommendations have also been drawn.

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Part I: Context of ESIF health investments
1 Challenges for European health systems

The EU Health Strategy addresses four main challenges for current health systems in Europe, i.e. (i) an ageing population, (ii) an increase in chronic diseases, (iii) a greater demand for health care, and (iv) the high cost of technological progress. These challenges together lead to an increased demand for health care services and causes the public health expenditure to grow thus creating pressure on the sustainability of current health systems.

Apart from the above mentioned, there are other challenges Member States are facing. The main challenges of today’s health systems in Europe cover the following aspects:

- Inefficiency and unsustainability of current health care models due to increasing demand for health care
- New types of health issues (aging population, surge in lifestyle diseases, back problems and other musculoskeletal disorders, mental diseases, chronic diseases)
- Inequalities in access to and use of health care services. Disparities exist along territorial, demographic and social dimensions (i.e. age, ethnic origin, geographic areas and socioeconomic status)
- Emergence of new types of care and approaches to treatment
- Lack of health care professionals and staff due to their ageing and high levels of migration.

It is a general consensus at the level of the European Commission as well as at the level of individual EU members that today’s health systems and models need to be adapted and transformed to efficiently address the challenges. The recent economic slowdown has reinforced the necessity to reform and modernize those systems.

The following categories of investments in health are recommended by the European Commission to ensure sustainable health systems and support achieving the objectives of Europe 2020:

- **Investments in cost-efficiency** and reconciling fiscal consolidation targets with the continued provision of sufficient levels
- **Investments in people’s health** as human capital, helping to improve the health of the population in general and reinforcing employability, and thus making active employment policies more effective, helping to secure adequate livelihoods and contributing to growth
- **Investing in reducing health inequalities** contributes to social cohesion and breaks the vicious spiral of poor health contributing to, and resulting from, poverty and exclusion.

The EU can help Member States to design reforms and improve the efficiency of health systems. Apart from the EU Health Programme addressing the objectives to (i) contribute to innovative and sustainable health systems, (ii)
increase access to better and safer health care for all EU citizens, (iii) promote good health and prevent diseases by addressing the risk factors, and (iv) protect people from cross-border health threats; **the EU's Cohesion Policy and its funds are also powerful instruments to help Member States invest in sustainable, innovative and reformed health systems**, in people’s health for employability and in reducing health inequalities.\(^\text{16}\) The Commission proposals for the 2014-2020 programming period provide the support of the Cohesion and Structural Funds to the Member States’ investments in health. Health is also included in most of the thematic objectives of the Common Strategic Framework.

With respect to the Commission staff working document Investing in Health, accompanying the Communication "Towards Social Investment for Growth and Cohesion – including implementing the European Social Fund 2014-2020" and the Commission proposal for a regulation laying down common provisions and creating a common strategic framework, the ESIF should co-finance investments in health by the Member States that follow a coherent, strategic policy approach by:

- **Investing in health infrastructure fostering a transformational change in the health system**, in particular reinforcing the shift from a hospital-centred model to community-based care and integrated services
- **Improving access to affordable, sustainable and high-quality health care**, in particular with a view to reducing health inequalities between regions and giving disadvantaged groups and marginalised communities better access to health care
- **Supporting the adaptation, up-skilling and life-long learning of the health workforce**
- **Fostering active, healthy ageing** to promote employability and employment and enable people to stay active longer on the labour market.

The following chapter analyses health funding potential under the EU Cohesion Policy in the 2014-2020 programming period in greater detail.

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2 Health funding potential in the 2014-2020 programming period

In 2014-2020, health remains eligible for financing under the European Structural and Investment Funds (ESIF). Health is recognized as a value necessary to achieve growth, employment and social inclusion, which represent the goals of the strategy Europe 2020, towards which all actions financed from the Cohesion Policy shall contribute. Moreover, the health sector itself is a sector with growth and employment stimulation potential. In the context of the ageing population in Europe and the growing demand for health and care services, the sector will generate a number of jobs, including jobs for a highly qualified workforce. It also stimulates research and innovations and development of new technologies.

Considering health as an eligible area, ESIF might provide an important resource for Member States towards achieving strategic health objectives, transforming services and enabling health to make a significant and measurable contribution to regaining economic stability, boosting competitiveness and growth and improving quality of life.

2.1 Funding principles of ESIF

The Cohesion Policy and ESI Funds in the 2014-2020 programming period are underpinned by four key principles:

► Programming: The programming principle expects that each programme is developed through a collective process involving authorities at European, regional and local level, social partners and organisations from civil society.

► Partnership: The partnership principle states that the Cohesion Policy funds multi-annual national programmes aligned on EU objectives and priorities.

► Additionality: The principle of additionality states that financing from the ESIF may not replace national spending by a Member State.

► Concentration: The concentration principle has three dimensions: concentration of efforts, concentration of resources and concentration of spending.

For a detailed description of the funding principles and mechanisms (delivering the Europe 2020 strategy goals contributing to thematic objectives; coordination of synergies and complementarities; ex-ante conditionalities; thematic concentration; result orientation; and performance reserve based approach), please refer to WP3 (1) Categorization of the 2014-2020 ESI Funds instruments and mechanisms.

With respect to the focus of this Guide, two of the above-mentioned principles are further detailed: (i) the principle of additionality to demonstrate the variety of resources available to fund health care, and (ii) the principle of concentration to explain the funding objectives to follow through the use of ESIF.

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2.1.1 Principle of additionality

In line with the principle of additionality, ESI Funds shall not replace the national funding, but should be complementary to it. Therefore, with respect to the principle of additionality, ESI funding of health shall always be based on national public health priorities, and shall combine a variety of financial sources. These can include:

► National sources (from state and/or regional budgets) earmarked directly for health care as well as sources for other policies with a potential health impact, i.e. education, research, digital agenda, administration efficiency etc.
► Private sources leveraged through Public Private Partnerships
► Community programmes such as Horizon 2020, LIFE or COSME
► Other sources (i.e. research grants, other public funding mechanisms such as European Economic Area funds and Norway Funds).

2.1.2 Principle of concentration

Member States shall concentrate support on interventions that bring the greatest added value in relation to the European Union strategy for smart, sustainable and inclusive growth. The principle of concentration therefore states that ESI Funds shall support a limited number of priorities embedded under 11 thematic objectives defined in Article 9 of the Common provision regulation:

1. Strengthening research, technological development and innovation
2. Enhancing access to, and use and quality of, ICT
3. Enhancing the competitiveness of SMEs
4. Supporting the shift towards a low-carbon economy in all sectors
5. Promoting climate change adaptation, risk prevention and management
6. Preserving and protecting the environment and promoting resource efficiency
7. Promoting sustainable transport and removing bottlenecks in key network infrastructures
8. Promoting sustainable and quality employment and supporting labour mobility
9. Promoting social inclusion, combating poverty and any discrimination
10. Investing in education, training and vocational training for skills and lifelong learning
11. Enhancing institutional capacity of public authorities and stakeholders and efficient public administration

Required concentration of the investment priorities corresponding to the thematic objectives varies according to the Fund and the level of development of a region:

23 Thematic concentration is adjusted in Article 4 of both ESF and ERDF regulation.
For ESF interventions, at least 20% of the total ESF resources in each Member State (at national level) shall be allocated to the thematic objective 9 (promoting social inclusion, combating poverty and any discrimination). In addition, Member states shall concentrate at least 80% of the ESF allocation to each Operational Programme on up to five of the ESF investment priorities for more developed regions, 70% for the transition regions and 60% for the less developed regions. Priority axes for the implementation of social innovation and transnational cooperation are excluded from the calculation of the ESF thematic concentration percentages.

For ERDF interventions, the thematic objectives and the corresponding investment priorities to which the ERDF may contribute shall be concentrated as follows:

- In more developed regions, at least 80% of the total ERDF resources at national level shall be allocated to two or more of the thematic objectives 1, 2, 3 or 4. Furthermore, at least 20% of the total ERDF resources at national level shall be allocated to the thematic objective 4.
- In transition regions, at least 60% of the total ERDF resources at national level shall be allocated to two or more of the thematic objectives 1, 2, 3 or 4. Furthermore, at least 15% of the total ERDF resources at national level shall be allocated to the thematic objective 4.
- In less developed regions, at least 50% of the total ERDF resources at national level shall be allocated to two or more of the thematic objectives 1, 2, 3 or 4. Furthermore, at least 12% of the total ERDF resources at national level shall be allocated to the thematic objective 4.

In line with this principle, and in line with the above-mentioned challenges of current health systems, the funding of health activities from ESIF should be targeted at the achievement of two underlying objectives:

- The cost-effectiveness and sustainability of health systems through their adaptation and reform
- The mitigation of inequalities in health status and in access to health care: increasing access to health services with particular attention to inequalities between regions and social groups, especially those affected by social exclusion and at risk of poverty.

### 2.2 Health funding potential under thematic objectives and investment priorities of the 2014-2020 Cohesion Policy

Under the 11 thematic objectives (listed above), the Fund-specific Regulations define the scope of support from ERDF and ESF, and list the investment priorities. Health is specifically recognized under the following investment priorities:

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► **ERDF investment priorities** in the area of health are specifically recognized under thematic objective No. 2 – Enhancing access to, and the use and quality of ICT, thematic objective No. 3 – Enhancing the competitiveness of SMEs and thematic objective No. 9 – Promoting social inclusion, combating poverty and any discrimination.

► **ESF investment priorities** with relation to health are specifically defined under thematic objective No. 8 – Promoting sustainable and quality employment and supporting labour mobility - and again under thematic objective No. 9 - Promoting social inclusion, combating poverty and any discrimination.

The DG SANCO Policy Guide for health investments under ESIF 2014-2020 identifies more funding possibilities. With respect to this document which has been developed by DG SANCO for desk officers from DG REGIO and DG EMPL in the context of the preparation and implementation of European Structural and Investment Funds, the 2014-2020 programming investments in health are eligible under seven of the eleven TOs - thematic objectives No. 1, 2, 3, 8, 9, 10 and 11.

Another point of view is also possible. If one searches for potential health gains – even through non-health investments – health gains might be achieved and / or health care entities could benefit even from non-health investment priorities (under thematic objectives No. 4, 5, 6 and 7). Adopting this approach, health-related investment potential could be identified under each thematic objective.

The following text presents indicative health measures that could be funded from ESIF in the 2014-2020 programming period. For the purpose of this Guide, two groups of investment actions based on their linkage to health are further reflected:

► **Direct health investment actions** cover investments made under thematic objectives 1, 2, 3, 8, 9, 10 and 11, which are directly relevant for the area of health.

► **Indirect health investment actions** covering investments under thematic objectives 4, 5, 6 and 7, which are not directly relevant for the area of health; however, some health related actions can still be supported.

It should be stressed that irrespective of the classification (i.e. direct or indirect), investment actions to be selected for funding have to always be based on a national or regional strategic policy framework for health. Such a strategy being in place is an ex-ante conditionality for ESIF investment in health, and any investment shall correspond to the national or regional needs and priorities identified in the health strategy.

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29 The concept of direct and indirect health investment actions is an approach developed by EY for the purpose of this Guide and does not reflect any official Commission terminology or standpoint.

30 Thematic objectives 2, 3, 8, 9 and 11 explicitly include health interventions as key priorities for ESF and ERDF.
2.2.1 Direct health investment actions

Within the concept developed for this Guide, direct investments:

► Are directly targeted at health care issues and reforms
► Are reflected in key programming documents, i.e. in Partnership Agreements and Operational Programmes
► Relevant Ministries of Health are usually formally involved in their implementation

In the text below, seven thematic objectives are described in detail under which, according to the ERDF and ESF Regulations and DG SANCO Policy Guide for Health Investments, investments in health can be supported. These are thematic objectives 1, 2, 3, 8, 9, 10, and 11. For easier orientation, the health interventions are split into ERDF and ESF.

A. ERDF investment priorities

ERDF investment priorities in the area of health are recognized under thematic objectives No. 2 – Enhancing access to, and use and quality of ICT, No. 3 – Enhancing the competitiveness of SMEs and No. 9 – Promoting social inclusion, combating poverty and any discrimination. Health related investments could be also identified under thematic objective No. 1 – Strengthening research, technological development and innovation, although health is not explicitly covered in this objective.

► Thematic objective No. 1

Actions which might be financed through thematic objective No. 1 should support innovation in health, health products and services in those cases where health innovation is one of the areas of the specialization strategies of Member States.

► Thematic objective No. 2

One of the investment priorities set in thematic objective No. 2 is the strengthening of ICT applications for e-health. The actions to be funded under this thematic objective include various e-Health solutions compatible with EU standards ensuring the (cross-border) interoperability of IT systems, improvement of IT Tools for coordination of responses to health threats or development of ICT based solutions and services for the needs of an ageing population.

► Thematic objective No. 3

Within objective No. 3, ERDF investments should support SMEs' businesses in the area of health, (e.g. wellness or 'age-friendly' businesses), including senior start-ups and entrepreneurship.

► Thematic objective No. 9

Within objective No. 9, one of the investment priorities includes investing in health and social infrastructure, which contributes to national, regional and local development; reducing inequalities in terms of health status, promoting social inclusion through improved access to social, cultural and recreational services and the transition from institutional to community-based services. The specific interventions to be funded cover investing in health and social infrastructure in order to support specialization and concentration of hospital care, deinstitutionalization and the strengthening of primary care.
B. ESF investment priorities

ESF investment priorities related to the area of health are specifically defined in thematic objectives No. 8 – Promoting sustainable and quality employment and supporting labour mobility, No. 9 - Promoting social inclusion, combating poverty and any discrimination and No. 11 – Enhancing institutional capacity and ensuring an efficient public administration. Furthermore, selected ESF health investment actions can be financed under thematic objective No. 10 – Investing in education, skills and lifelong learning despite the fact that health is not explicitly mentioned in this objective.

► Thematic objective No. 8

Within objective No. 8, health actions shall be supported under the investment priority on active and healthy ageing, and potentially under the investment priority focused on support of labour mobility. The investments to be supported include promotion of healthy life style and disease prevention and measures related to healthy and safe working conditions.

► Thematic objective No. 9

Within thematic objective No. 9, ESF shall, according to one of the investment priorities, enhance access to affordable, sustainable and high-quality services, including health care and social services of general interest. The actions to be financed cover promotion of active involvement of patients and their empowerment and actions aimed at access of marginalized communities to health care and improvement of health status of these groups.

► Thematic objective No. 10

Investments in health under thematic objective No. 10 should support Member States’ actions in relation to the formal education and lifelong learning of health care professionals. Thematic objective No. 10 might also support the development of curricula for training health workers or school curricula to sensitise students / pupils for healthy lifestyles.

► Thematic objective No. 11

Within thematic objective No. 11, the actions shall support improvement of health sector administration efficiency under the investment priority Investment in institutional capacity and in the efficiency of public administrations and public services at the national, regional and local levels with a view to reforms, better regulation and good governance.

2.2.2 Indirect health investment actions

Within the concept developed for this Guide, indirect investments:

► Are not directly targeted at health care, i.e. health institutions are not considered as main beneficiaries, but entities active in health sector might be eligible to apply for funding from them

► Might contribute to fulfilment of national strategic objectives and positively influence public health and

► Relevant Ministries of Health usually have no formal competencies in implementation of this group of investments.

The thematic objectives 4, 5, 6 and 7 are not directly relevant for the area of health; however, some health related actions mentioned below can be still supported from ERDF.
Thematic objective No. 4

Within thematic objective No. 4 – Supporting the shift towards a low-carbon economy in all sectors, actions focused on improving the energy efficiency of healthcare facilities, low-income communities and the elderly or actions reducing the use of domestic solid fuels (coal and wood) can be supported.

Thematic objective No. 5

Under thematic objective No. 5 – Promoting climate change adaptation, risk prevention and management, investments concentrated on disaster prevention, creation of early warning systems and water efficiency in health care buildings can be financed.

Thematic objective No. 6

Within thematic objective No. 6 – Preserving and protecting the environment and promoting resource efficiency investments in waste sector management to support protection from dangerous medical waste actions that reduce the potential health risks of contaminated sites can be supported.

Thematic objective No. 7

The actions to be supported under thematic objective No. 7 – Promoting sustainable transport and removing bottlenecks in key network infrastructures include investments that improve connectivity and mobility to enhance access to health services, develop safety levels of transport networks to gain health benefits. Further, investment actions for greener infrastructure to reduce obesity and create healthier lifestyles, particularly for the youth can be financed.

The scheme below provides an indicative list of health actions under thematic objectives for the 2014-2020 programming period. It shall serve all of those to whom this Guide is addressed to raise awareness about possible health actions under the individual thematic objectives. It is nevertheless only an indication and it does not seek to give the Member States a full and comprehensive list of eligible health investment under ESIF. It is based on the Commission Policy Guide for health investment under ESIF 2014-2020, the Toolbox for effective SF investment in health 2014-2020 developed by Subgroup 2 on health investment, fund-specific rules, discussions with Member States and experts’ recommendations.

<table>
<thead>
<tr>
<th>TO No.</th>
<th>Thematic objective</th>
<th>Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Strengthening research, technological development and innovation</strong></td>
<td>ERDF</td>
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<tr>
<td></td>
<td>► Enhance innovation in health</td>
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<td></td>
<td>► Support research in development of new detection methods and treatments</td>
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<td></td>
<td>► Stimulate collaborative research in rare diseases</td>
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<td></td>
<td>► Support research and related IT infrastructures including support to health systems</td>
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<td>2</td>
<td><strong>Enhancing access to, use and quality of information and communication technologies</strong></td>
<td>ERDF († indirect ESF investment under TO 8-11)</td>
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<tr>
<td></td>
<td>► Strengthen ICT applications for e-Health</td>
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<td></td>
<td>► Set up e-Health solutions compatible with EU standards ensuring the (cross-border) interoperability of IT systems</td>
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<td></td>
<td>► Support the use of a uniform electronic health care information system, electronic prescription system, patient electronic medical records, telemedicine and telecare</td>
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<td></td>
<td>► Create a legal basis for e-Health (including quality standards / certification for applications and data management, data protection)</td>
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<td></td>
<td>► Improve IT Tools for the coordination of responses to health threats</td>
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<td></td>
<td>► Support the development of ICT based solutions and services for needs of an ageing population and empower users to use them to remain active and independent for longer</td>
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<td>3</td>
<td><strong>Enhancing the competitiveness of SMEs</strong></td>
<td>ERDF</td>
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<tr>
<td></td>
<td>► Promote awareness among SMEs of “white sector” business opportunities and know-how</td>
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<td></td>
<td>► Support SMEs' businesses addressing the needs of old people, or 'age-friendly' businesses (e.g. providing personalised care, assisting in functional physical or cognitive decline, improving old people’s health literacy), including senior start-ups and entrepreneurship</td>
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<tr>
<td></td>
<td>► Encourage private and public enterprises to play a larger role in public private partnerships in 'age-friendly' areas</td>
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<tr>
<td>4</td>
<td><strong>Supporting the shift towards a low-carbon economy in all sectors</strong></td>
<td>ERDF</td>
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<tr>
<td></td>
<td>► Stimulate energy efficiency of health care facilities</td>
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<tr>
<td></td>
<td>► Assist low-income communities and the elderly with energy efficiency improvements</td>
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<tr>
<td></td>
<td>► Support actions to help reduce the use of domestic solid fuels (coal and wood) which create indoor air pollution and negatively affect health</td>
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</tr>
</tbody>
</table>
### 5 Promoting climate change adaptation, risk prevention and management

- Support investments in risk prevention and management, including protection, preparedness, response and recovery that have a positive impact on human health
- Support the creation of early warning systems and health care investments for disasters and climate-related events and adaptation
- Support water efficiency in health care buildings to reduce water scarcity
- Stimulate investments to reduce the flooding of health care facilities

### 6 Preserving and protecting the environment and promoting resource efficiency

- Invest in waste sector management to support protection from dangerous medical waste
- Increase actions that reduce the potential health risks of contaminated sites

### 7 Promoting sustainable transport and removing bottlenecks in key network infrastructures

- Improve connectivity (e.g. through infrastructure) and mobility to enhance access to health services
- Enhance safety levels of transport networks to gain health benefits
- Support greener infrastructure to reduce obesity and create healthier lifestyles, particularly for the youth

### 8 Promoting employment and supporting labour mobility

- Support adequate and qualified health workforce in all areas through adaptation and training and promotion
- Support labour mobility and measures to enhance the attractiveness of the health professions to improve access to health care in rural and remote areas
- Stimulate active and healthy ageing measures
- Promote healthy life style and disease prevention
- Supporting healthy and safe working conditions and prevent work-related injuries
9 Promoting social inclusion and combating poverty

- Enhance access to affordable, sustainable and high-quality services, including health care and social services of general interest
- Promote actions reducing inequalities in terms of health status. Support active inclusion improving employability (including integrated pathways combining various forms of employability measures and modernization of social protection systems)
- Support actions integrating marginalized communities in terms of health access and preventive health care
- Support specific actions targeting people at risk of discrimination and people with disabilities to increase their labour market participation
- Promote transition from institutional to community-based services (deinstitutionalization of long-term care, after care and mental care, home care strengthening)
- Strengthen ambulatory services and primary care
- Support specialization and concentration of hospital care
- Promote active involvement of patients and their empowerment

10 Investing in education, skills and lifelong learning

- Enhance access to lifelong learning, upgrading the skills and competences of the workforce training – eHealth, new treatment and diagnostic methods
- Support tertiary education delivering a workforce sufficient in numbers as well as in qualification, reflecting the shortages of certain specializations (i.e. General Practitioners)
- Promote flexible pathways between health care education and training and between education and work

11 Enhancing institutional capacity and ensuring an efficient public administration

- Support actions to increase efficiency of health administration in particular to design and deliver health system reforms and increase its efficiency, quality and sustainability
- Enhance actions leading to cross-border cooperation of Member States in the area of health

Sources: DG SANCO Policy Guide for health investment under ESIF 2014-2020 (specifically TO 1, 2, 3; 8 – 11); Toolbox for effective SF investment in health 2014-2020; Guide to Health Gains from Structural Funds – Funding Themes (specifically TO 4 – 7); Regulation (EU) No 1301/2013; Regulation (EU) No 1304/2013.
Part II: Guidance on effective projecting of health priorities into ESIF programming and implementation
The Guide has been developed at the time when programming for the period 2014-2020 has already reached its mature phase. The main strategic priorities for funding from ESIF have been outlined in the Partnership Agreements between individual Member States and the European Commission, and Operational Programmes are near to be finalized and adopted in most of the Member States.

With regard to this, this section of the Guide is not aimed at helping the Member States to establish Operational Programmes and intervention logic, but to provide them with practical guidance on how to effectively use relevant Operational Programmes to finance the health priorities envisaged under national health strategies.

Using of ESI funding has its specifics and Ministries of Health or other relevant authorities covering national health agenda (hereinafter uniformly referred to as Ministry of Health) need to respect these specifics when aiming to implement health investments under ESIF. The following scheme illustrates the process of investment planning and implementation and integrates it in the process of ESIF programming and programme management and implementation.

Scheme 2 Break-down of an effective process of health investment implementation under ESIF
With respect to the current stage of the strategies’ development and even the level of development of the key ESIF programming documents, the focus of this part of the Guide is limited to the phase of the implementation of health investments through Operational Programmes that could still be addressed by the Ministries of Health and Managing Authorities to support the effective funding of health priorities under ESIF. Preceding phases, if reflected, are described only to provide complete picture and background.

However, as strategic planning has been addressed by several countries during workshops organized within this project in selected Member States, basics of strategic management (principles of strategic planning and public health strategy development) have been further developed under WP 3 (7) Reflection of additional issues raised by Member States. For more details about the topic, please see the document.
3 Model roles of the Ministry of Health in programming and implementation of health priorities under ESIF

Varying from country to country, in general, there are four models of possible involvement of the Ministry of Health in the implementation of ESIF in Member States:

► **Ministry of Health as a Managing Authority** of an Operational Programme focused purely on health with a wide range of competencies associated with the management of ESIF. Based on our mapping analysis *(to see detailed results, please refer to WP 1: Mapping report)* this case will most likely not exist in the 2014-2020 programming period, and therefore this concept is not further developed in the Guide.

► **Ministry of Health as an Intermediate Body** within one or more Operational Programmes that are to some extent focused on investments in health. This is quite often model, especially in Central and South-Eastern European (CSE) countries. Ministry of Health takes some of the competencies of Managing Authority, thus still being able to manage the focus of support under the given Operational Programme(s).

► **Ministry of Health as a beneficiary** of funding from ESIF Operational Programmes. Within this role, the Ministry of Health applies for funding from one or more Operational Programmes. Project applications that the Ministry submits go through a standard selection process.

► **Ministry of health as a coordinator of funding of health from ESIF among existing Operational Programmes and institutions involved in ESIF implementation.** The core of this role of the Ministry of Health lays in identification and coordination of ESIF funding opportunities and providing a subject-matter expertise to Managing Authorities of Operational Programmes more or less directly addressing health sector priorities where the Ministry of Health is not directly involved in implementation structure.

This role of the Ministry of Health slightly transcends the ESIF context, but it is recommended to ensure effective implementation of ESIF opportunities for health as well as complex health priorities under ESIF (under legal conditions and with respect to Europe 2020 as well as national strategic framework, including Partnership Agreement).

The models are further introduced below.

(i) **Ministry of health as an Intermediate Body**

This model allows for **direct involvement of the Ministry of Health in the programming and implementation process.** It can be particularly advantageous if health represents an integrated part of the Operational Programme, which shall serve to provide additional resources to deliver a part of the national public health strategy. In this case, the **Ministry of Health should be able to execute direct influence on the design and delivery of OP** (or its part relevant for health), which is what the model of Intermediate Body allows for.

In the role of an IB, the Ministry of Health can directly participate in the preparation as well as implementation of an OP – it can communicate with the applicants and beneficiaries directly (leading to increased efficiency of communication and programme delivery), it can manage the calls for proposals and bring its expertise into project administration. Importantly, it might also have a direct overview of the contribution of ESIF to achievement of national health strategy goals.

The model of Intermediate Body, on the other hand, **imposes requirements on a sufficient quality of administrative and managerial capacities** at the Ministry of Health. The expertise of the Ministry of Health shall lie not only in the medical field, but also in the field of project management, financial management, public procurement and administration *(see more on these aspects in part 3. of this Guide).* It also increases the
fragmentation of OP management; therefore the benefits always need to be weighed against the possible negative impacts. The role and competencies of the Ministry of Health as an IB also have to be defined accordingly, as the scope of competencies of an Intermediate Body can range from vast implementation to purely administrative powers. **The role of an Intermediate Body and delegated competencies shall be formally specified in the Delegation Agreement.** It shall always be adjusted to suit the necessary model and the measures to be supported from the OP.

(ii) Ministry of Health as a beneficiary

The same conditions and rules apply to the Ministry of Health in the role of a beneficiary, as to any other beneficiaries under the given OP. The main specific of this model is that the **Ministry of Health has quite limited options for influencing the design and delivery of a given Operational Programme and thus even the focus of the OPs support.**

In the role of a beneficiary, the Ministry of Health is responsible for the preparation of a project application and, if the application is selected for granting, also for the project implementation. During the project implementation, the Ministry of Health is bound by specific OP requirements and rules. Among others, periodical reporting on project progress (monitoring reports) to the Managing Authority / Intermediate Body could be mentioned as well as the rules for assessing eligibility of expenditures or procurement rules for projects funded from ESIF.

Being **directly involved in project planning and the implementation** of specific investments, the Ministry could utilize its expertise in a given field of investment. Moreover, ensuring relevant project management, as well as administrative capacities to successfully implement the investment(s) and meet all requirements put on beneficiaries to avoid cuts in subsidies provided, is also essential.

In some countries, the **Ministry of Health** is expected to conduct both roles: being an Intermediate Body for some OP(s) and a beneficiary under other OP(s). In this case, an aspect to consider is the exclusion of conflict of interests, i.e. there has to be segregation of duties between the IB and the beneficiary if both in one organization. Typically, the role of the Intermediate Body or expert advisor to applicants and the one of a project applicant and beneficiary would be executed by different departments. Interdepartmental cooperation is to be exploited to make the project a success; however this cooperation cannot cause any bias.

(iii) Ministry of Health as a coordinator of funding of health from ESIF

The list of possible direct and indirect health actions under the thematic objectives of 2014-2020 Cohesion Policy presented in the chapter 2.2 indicates that health-relevant issues could be addressed by a variety of Operational Programmes. **To ensure health care sector will take advantage of ESIF opportunities, the Ministry of Health shall identify health-relevant funding opportunities and actively support transformation of such opportunities in relevant projects.** This is reflected by the role of Ministry of Health as a coordinator of funding of health from ESIF.

This model role of the Ministry of Health reflects the following two aspects:

- **Support to health sector to implement relevant opportunities under ESIF**
  
  The Ministry of Health shall conduct a comprehensive mapping / analysis of Operational Programmes implemented in the Member State and identify all health-relevant funding opportunities in accordance with requirements of the programmes. If this is conducted still in a programming phase, identified possibilities shall be categorized with respect to their complexity and effect on health system. In case of the complex issues or investments with a greater impact on the system, the Ministry of Health shall promote itself to a role of an Intermediate Body or beneficiary (if possible). When this is not possible and / or in case of remaining funding opportunities, the **Ministry of Health shall initiate discussion with the Managing Authorities of OPs...**
on identified direct and indirect health investment opportunities to raise their awareness and ensure that the Ministry of Health or health institutions are not excluded from relevant calls.

When conducted in later stages, the principles remain the same. The Ministry of Health shall analyse all the existing OPs and their investment priorities to identify possible relevance of supported actions for the health system and health institutions, with the aim to support absorption capacity among health institutions. This might be a case of an OP related to environment supporting insulation of public / private facilities or energy-efficiency of public institutions. Even though not directly addressing health institutions, e.g. hospitals and other facilities might be interested in this opportunity to improve operational cost-efficiency with a support of ESIF. Operational Programme(s) focusing on education might address actions supporting greater cooperation of universities with private or public institutions, under which medical schools could support enhancing of training opportunities for their students with the final effect on the quality of education and medical staff coming from these schools. However, eligibility of health institutions shall be checked with the Managing Authority of relevant OPs before any follow-up action is taken.

Being aware of the full range of funding potential for the health system, the **Ministry of Health shall inform and mobilize health sector institutions to apply for funding under relevant calls and coordinate the targeting of investments in line with the strategic health priorities.** Via this approach, the Ministry of Health not only supports utilization of ESI Funds and fulfilment of health priorities, but also supports the Managing Authorities of relevant Operational Programmes to build sufficient absorption capacities.

**Support effective implementation of ESIF in the health care sector**

As already mentioned, health-relevant issues could be addressed by a variety of Operational Programmes and the Ministry of Health will probably not be integrated in the programming and implementation structure of all of them. Even then, the Ministry of Health should be to some extent engaged in designing, preparation and negotiations with the OP, and in the implementation phase in the preparation of calls for proposals and evaluation of project applications with possible impacts on health or health system. This is particularly important role in countries where the Ministry is not acting as an Intermediate Body for OPs directly addressing health issues. In such cases, the coordinator shall intensively support MA or relevant IB in the areas addressing health issues.

The Managing Authorities of the relevant OPs are experts in fund management and in the relevant field of the OP’s primary focus. But the public health strategy lies within the **Ministry of Health which should act as a coordinator and subject-matter expert with relation to health investment from any source of funding, including ESIF.** The importance of engaging the Ministry of Health in the programming process on the use of ESIF stems also from the requirement for a more result-oriented use of the ESI Funds in the 2014-2020 programming period laid down in the Common Provisions Regulation. In order to meet this requirement, **investment into health has to be co-designed and regularly evaluated through cooperation between the Managing Authority and the Ministry of Health.**

In practice, this role shall be effectively accomplished by the Ministry of Health through providing an expertise in designing of calls under various OPs where health issues are concerned, during project applications assessment and during monitoring of projects performed by health care institutions (administrative control, on the spot control). Involvement of the Ministry of Health in evaluations could also be recommended.

Regardless of the extent of the level of engagement of the Ministry in implementation, it is recommended to support such a role via a formal written document (i.e. a memorandum) between MoH and the relevant Managing Authority.
The roles introduced above, i.e. Intermediate Body responsible for implementation of health priorities under ESIF, Beneficiary responsible for development and implementation of a project using ESIF money and the role of Coordinator responsible mainly for utilization of the ESIF health funding potential and coordination of these efforts to efficiently support realization of strategic goals might be (and often are) simultaneous; however, the roles need to be clearly separated, and to be in competency of various departments / units. The roles and competencies of each department / unit need to be properly defined. However, as the agenda within these roles might overlap, mechanisms for cooperation and coordination between these departments within the Ministry of Health shall be present to achieve the full potential of this structure. Therefore, if referring in the further text to some of the roles, it is referred to a specific department at the Ministry of Health with competencies designated to it within the role it is referred to.

In general, without consideration of the models of involvement, the **Ministry of Health should be integrated into the monitoring committee of OP (under which health care investments will be supported)**, which role is defined in Article 47 of CPR. 32 Monitoring committee is set up in agreement with the Managing Authority and composed of representatives of the relevant Member State authorities and Intermediate Bodies, and relevant stakeholders in particular policy area.

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4  Effective involvement of the Ministry of Health in various stages of ESIF programming and implementation

4.1  Programming of ESIF

The principles of programming under the EU Cohesion Policy for the period 2014-2020 are defined in the Common Provisions Regulation (CPR), mainly in Art. 27 and Art. 96.33

Each programme shall set out a strategy for the programme’s contribution to the strategy Europe 2020 for smart, sustainable and inclusive growth consistent with this regulation, the fund-specific rules, and with the content of the Member States’ Partnership Agreement.

Operational Programmes consist of **priority axes**, each of which corresponds to a thematic objective and comprise one or more of the **investment priorities** of that thematic objective, as defined in the fund-specific regulations. The Member States have therefore only a limited possibility with regard to the definition of their Operational Programmes, as the priority axes shall be defined based on the given list of thematic objective, set in CPR34 (Art. 9) and filled with investment priorities defined for each thematic objective by ERDF / ESF specific regulation. They can only choose relevant investment priorities from the list.

**The final goal** which shall be achieved by an investment priority shall be expressed through a **specific objective**. A specific objective is defined by Art. 2 of CPR35 as a result of which an investment priority or Union priority contributes there with a specific objective is then expressed in one or a few **result indicators**.

As the programming process is generally well known to the Managing Authorities and other officials involved in the management of ESIF; and as it is not the primary focus of this Guide, the general information is not further developed. The above description of its main steps shall only provide the background for the further text on projecting health investment into this process.

► Effective involvement of the Ministry of Health in the programming phase

As explained above, the strategy development and programming phases will not be explored in such a detail. However, a few principles of effective involvement of the Ministry of Health in the programming phase are mentioned below.

Within the phase of programming, the key role of the Ministry of Health is to ensure transposition of relevant health priorities in the programming documents. This involves:

► The Ministry of Health shall be included in the process of the Partnership Agreement development and shall see to it that the strategic health priorities are reflected in the strategy through which the Member State shall contribute to achieving the Europe 2020 goals.

► The Ministry of Health shall identify which priorities from the national public health strategy are in line with the thematic objectives and investment priorities supported under the set Operational

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Programmes, and shall actively participate in negotiations with the relevant Managing Authorities on investing in health.

4.2 Implementation of ESIF

As Operational Programmes have already been drafted, the main potential for influencing the use of ESIF for health investment lies within the implementation phase. This chapter targets the main areas where cooperation of the Managing Authorities and MoH could be effective in terms of establishing stable pillars for efficient use of ESIF for health investments.

4.2.1 Calls for proposal & selection process

The first step through which the ESIF investment can be directed into health projects within the implementation phase is through preparation and publication of calls for proposals.

To help direct funding into health, the Ministry of Health should take the following actions:

- Negotiate with MA to make health projects eligible under the relevant calls for proposals
- See to it that the relevant calls for proposals are defined in a way which allows for funding of projects leading to accomplishment of the health sector strategy objectives through fulfilment of the specific objectives of the Operational Programme, and contributing to achievement of the results
- Get involved in the process of setting up project eligibility and selection criteria in calls oriented on health sector to make sure the supported projects will be of high quality and will add to sustainable and cost-efficient solutions
- Build absorption capacity among the health sector beneficiaries and beneficiaries with potential impact on the health sector, inform them about possible areas of funding and provide them with assistance to improve the quality of their project applications in health aspects
- Ensure the quality health care projects are selected. If MoH is not directly involved in implementation, health care experts shall support relevant MA / IB within the project applications evaluation phase

For more information on the process of management of calls for proposals and applications assessment, please refer to WP 3 (2) Reference checklist for successful management of calls for proposals and project applications assessment.

Once the calls are published, it is time for funding applicants to plan the project and develop project application with respect to the requirements of a specific call.

Specifics of various roles of the Ministry of Health (presented in chapter 2.3) within the process of designing of calls for proposal and evaluation of project applications are mentioned below.

- Ministry of Health as an Intermediate Body

  If the Ministry of Health is an Intermediate Body, some of the above mentioned steps will probably be under its direct responsibility, e.g. publishing of calls for proposals and / or the evaluation and selection process. MoH shall ensure that relevant experts in the field of supported actions (might refer to internal and even external sources) are engaged in the process of setting up the calls and project application assessment.
As an Intermediate Body, the Ministry shall provide authorized and transparent support to funding applicants, within the limits of its delegated powers and under the supervision of the Managing Authority. The support to applicants can take the following forms:

- Awareness raising among applicants about the health priorities and the possibilities of receiving funding
- Information sharing and advice through workshops and seminars
- Guidelines and templates to make the application process and project preparation as easy as possible

The goal of this support is to ensure that projects proposed for funding have the necessary quality, i.e. (i) are consistent with the programme rules and rules specified in the call for proposals, (ii) contribute to the achievement of a given specific objective (iii) are financially sustainable, (iv) will have a real health contribution, i.e. will contribute to the health priorities stated in the health care strategy.

**Ministry of Health as an applicant for funding**

In this role, the Ministry of Health itself acts as an applicant for funding. This can be the case for projects of strategic importance, i.e. complex health system reform or the implementation of e-Health. These projects are usually projects of major importance and should be prepared with close attention. Following dimensions are to be considered:

- Set up of quality project management and administration capacities
- Realistic timetable of actions, taking into consideration possible delays caused by time-demanding procurement process and other decision processes
- Cost-benefit analysis or other form of project effectiveness assessment.

**Ministry of Health as a coordinator of funding**

Among others, the main task within this stage is to increase the awareness of the Managing Authorities about the health sector funding possibilities and to ensure that the health sector entities are not excluded from the relevant calls. Further support could be offered to the relevant Managing Authorities / Intermediate Bodies MoH establishes connection with. Competencies of the Ministry of Health towards OPs managed by other institutions shall also be defined in some formalized document (e.g. a memorandum).

Within this role, while not being officially involved in the programme management and administration structure, the Ministry of Health should also play an active role with regard to providing support to applicants from the health sector developing project applications. Compared to the role of Intermediate Body, MoH could support applicants through direct consultations if there is a clear distinction between the departments responsible for implementation of ESIF (IB) and department(s) executing the coordinator’s role. Through the support to beneficiaries, MoH might increase the quality of proposed projects and control their contribution to health objectives. The support can also take on the forms described above, despite the fact that it is done on a more informal basis outside the official implementation structure. With regard to this, the Ministry of Health shall focus its advice on the health aspects of the proposed projects.

The goal of this support shall be to ensure projects proposed for funding (i) will have a real health contribution, i.e. will contribute to the health priorities stated in the health care strategy, (ii) are financially sustainable in relation to operating costs and the cost of treatment, especially with relation to the sustainability of the health care system.
While the Ministry can at the same time act in either of the roles described above, an aspect to consider is the exclusion of conflict of interests, i.e. strict segregation of duties especially of the role as IB and a beneficiary. Typically, the role of an Intermediate Body or expert advisor to applicants and the one of a project applicant and beneficiary would be executed by different departments. Interdepartmental cooperation is to be exploited to make the project a success; however this cooperation cannot cause any bias.

4.2.2 Project implementation

In this process, aspects addressed in the Guide section on the key success factors (Part III of this Guide) have to be reflected, depending on the role played by the Ministry of Health in the implementation structure. As the role of the Ministry of Health can differ from being an Intermediate Body to having only a consulting expert role, or even to being a beneficiary, the following text is divided to reflect the different position of the Ministry of Health.

► Ministry of Health as an Intermediate Body

During the implementation phase of OP, the Ministry of Health as IB executes responsibilities delegated to it by the Managing Authority (defined in the Delegation Agreement). Such activities are related to the monitoring of projects, their control, communication with beneficiaries, approval of requests for payment etc. Moreover, depending on the scope of delegated competencies, it can organize periodic workshops for beneficiaries to disseminate information, provide guidance and share experience.

► Ministry of Health as a beneficiary

The Ministry of Health bears the responsibility for successful project implementation in accordance with the Grant Award and delivery of its actions. This includes a vast scope of project management activities. The Ministry shall use its internal health matters expertize, as well as expertize of project management capacities and legal experts. All advice presented in regular communication with stakeholders, capacity and partnership building and sustaining, legality of tender actions, and investment sustainability are also to be applied to the role of the Ministry of Health as a beneficiary with regard to projects of strategic importance.

► Ministry of Health as a coordinator of funding of health from ESIF

As already indicated, competencies of the Ministry of Health towards OPs managed by other institutions shall be defined in some formalized document (e.g. a Memorandum). The MoH shall aim to ensure:

► Being informed about the health projects and projects with potential health gains receiving a support from ESIF

► Playing the role of a consultant for both the Managing Authority and beneficiaries on the health related aspects

Again, its role can be foreseen in the regular dissemination of information, expert guidance and health issues related to the advisory link to procurement, evaluation etc.
4.2.3 Evaluation & monitoring

Another stage, in which the Ministry of Health can be present in influencing the effectiveness of health investment under ESIF, is the process of evaluation and monitoring. According to Art. 56 of CPR, the Managing Authority shall ensure that evaluations, including evaluations to assess effectiveness, efficiency and impact, are carried out for each programme on the basis of the evaluation plan. It is an ongoing process, described in more detail below in the section 6.6 of this Guide, in which the Ministry of Health can play an important role.

Regardless of the role played by the Ministry of Health in the OP implementation structure, it should be engaged in the monitoring and evaluation of health measures supported through ESIF. It should evaluate the health gains achieved by the implemented projects and the progress on the way to national health strategy. As described in Articles 47-49 of CPR, it can do so in the monitoring committee where the Ministry of Health should be present either through its role of Intermediate Body or as the coordinator and subject-matter expert (it refers to the monitoring committees of OPs directly or indirectly addressing health gains). The aim of this committee is to monitor implementation of the programme and progress made towards achieving its objectives through observation of financial data, indicators, milestones and qualitative analysis. It also examines all issues that affect performance of the Operational Programme. Involvement of MoH in the monitoring committee needs to be approved by the Managing Authority.

For the monitoring and evaluation of ESIF supported actions, the Managing Authority defines a set of indicators within the Operational Programme. These programme-specific indicators together with common indicators, financial data and quantified target values should be set out in annual reports on implementation of the programme in the previous financial year which are to be submitted to Commission annually from 2016 to 2023 including (Article 50 of CPR). The Ministry of Health can provide data or enable the collection of data to monitor these indicators, but the evaluation of health actions should not be limited to the compulsory set of indicators defined at the Operational Programme level. It can be recommended that the Ministry of Health uses a set of health indicators and evaluation for the purpose of assessment of a real health impact and progress towards the national health objectives.

For more information on the indicators for final evaluation of actions, please refer to WP3 (3) set of indicators useful for evaluation of actions in health, and to the European Core Health Indicators website available at http://ec.europa.eu/health/indicators/echi/index_en.htm.

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Part III: Analysis of the 2007-2013 programming period
5 Lessons learned from the 2007-2013 programming period

The following chapter guides its readers through the results of the analysis of health investment in the 2007-2013 programming period, and the recommendations developed based on an abstraction of lessons learned from the past successful and even unsuccessful practices. This part of the Guide aims to provide its readers with practical advice on how to support efficient implementation of ESIF for health projects and how to successfully manage these projects.

5.1 Analysis background

The information this analysis builds on has been collected through extensive mapping conducted across the EU Member States, interviews with representatives of the Ministries of Health and / or other institutions responsible for implementation of health investments co-financed from EU SF and information gathered during workshops in selected Member States.

When talking about the effectiveness of health investments under ESIF (but being applicable on any investment), there are two levels determining effectiveness of investments under ESIF.

1. At the very top, it is the implementation structure of ESIF in each country itself. Ineffective set up might cause problems in the implementation phase, and therefore limit the ability of ESIF to efficiently support the aimed sectors or national priorities.

2. Then there comes the implementation of ESIF, respectively development and implementation of the specific investments within the ESIF structures and in accordance with the ESIF rules.

These are areas of the main causes of investment inefficiencies that could be identified in each phase of the investment lifecycle.

As the document is being created at the stage when ESIF implementation structure has already been set up in all Member States, greater attention and emphasis is given to the second level, i.e. implementation of health investments. Nevertheless, being possibly a source of information and experience when preparing for the 2014-2020 programming period, the good practices in ESIF programming set up are also reflected in the text below.

5.2 Main barriers to effective implementation of health investments under ESIF resulting from analysis of the 2007-2013 case studies

The analysis aimed to identify good and bad practices affecting health investment success. Before presenting the results, it is essential to first define what is understood by successful investment in the context of ESI funding and this Guide, and categorize the main causes of investment inefficiencies that the analysis identified or confirmed.

39 Twelve countries were selected to participate in the project dissemination phase: Bulgaria, Croatia, Czech Republic, Estonia, Greece, Hungary, Latvia, Lithuania, Poland, Portugal, Romania and Slovakia. The dissemination covers tailor-made support delivered to the selected Member States through national workshops and support networking and experience sharing between the Member States through delivery of two regional workshops.
Successful investment is one that:

► Significantly contributes to fulfilment of agreed objectives
► Has at worst minor negative unintended effects
► Its objectives are consistent with social needs and priorities
► Produces the intended long-term benefits

Below specific examples of practices identified during the analysis of health related case studies threatening successfulness of health investments are presented:

i. Implementation structure of ESIF

► Number of Operational Programmes developed and implemented without setting of appropriate coordination mechanisms
  ► High risk of duplications in selection of the investment priorities, or even supporting mutually excluding investments under OPs in competencies of different institutions
► Complicated system of ESIF implementation and overlapping competencies
  ► Lack of clarity for potential beneficiaries lowering absorption capacity
  ► Inconsistencies in interpretation of rules at different implementation levels
  ► Inconsistencies in on the spot controls and audit findings
► Insufficient involvement of the Ministry of Health or other institution responsible for health system in the programming phase / implementation phase in case of implementation of significant health care investments
  ► Exclusion or low involvement of the Ministry of Health in the programming of Structural Funds at the national level significantly limits the ability of the Ministry of Health to project its main strategic priorities in the programming documents.

ii. Investment / project level

► Absence of the strategic context, respectively a link between national strategies and the specific investment(s) and project integration
  ► Overlooked necessity of developing related capacities (infrastructural investments not matched by necessary development of human capital)
  ► Led only to a short-term easing of problems rather than to a solution of the problems (investments in old fashioned models)
  ► Solved only a part of the problem causes
► Not all relevant stakeholders involved in investment planning and implementation
  ► Wrong strategic investment set up

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Unacceptance of relevant stakeholder groups

- Poorly defined competencies and responsibilities of partners (investment planning as well as implementation phase)
  - Critical delays in key decision making / realization

- Insufficient capacities on the side of MoH / MAs
  - Inefficient investment planning and management
  - Non-transparent and ineffective evaluation of applications (relevance, impact evaluation, sustainability)

- Decision-making based on insufficient / not relevant information sources, poor project planning
  - Inaccurate evaluation of project necessity
  - High risk of inaccurate financial planning and estimations of resources necessary

- Non-existing / outdated guidance and policies on managing and evaluation of the SF health projects
  - Non-transparent decision and evaluation processes

- Inefficient procurement
  - Inefficiencies in project expenditures
  - Critical delays in key activities

- Improper appraisal of investments sustainability
  - Higher demands on resources resulting in unsustainability of solutions supported

These individual inefficiency causes at both levels are further addressed in the following text. Logic of the text above is followed, therefore first addressing the set-up of the ESIF implementation structure. More attention is given to the investment level, where the specific cases and individual recommendations how to avoid unsuitable practices and provide examples of good practices (where identified) are presented. As the Ministry of Health might (and in most cases probably even will) act as an Intermediate Body as well as a beneficiary, both points of view are reflected in the following text.

Individual case studies gathering good as well as bad practices are presented in the Appendix to this report.
5.3 Principles of effective implementation structure of ESIF

This chapter provides its readers with information summarizing the main lessons learned and barriers to effective implementation of the health priorities under ESIF and some examples of latest developments and good practices in this field.

5.3.1 Lessons learned deriving from analysis of the 2007-2013 period practices

The main issues at the ESIF implementation level were:

► Complex implementation structure with many OPs and bodies involved

The models of ESIF implementation structure varies from country to country. In the 2007-2013 programming period, complicated orientation in funding possibilities, as well as the related administrative burden lying on beneficiaries, were often seen as a barrier for effective implementation of ESIF.

From what has been seen, many Member States have proceeded to simplify the ESIF implementation structure – in terms of the number of OPs and implementing bodies as well as the total number of institutions involved in the structure itself. In this area, Baltic countries could serve as a good example [for more details, see case study 1 in the Appendix to this report].

In the Baltic countries, i.e. Estonia and Lithuania, only one Operational Programme covering all the thematic objectives of relevance for each country has been developed. In the programming period 2007-2013, these countries employed different model of three OPs, but afterwards came back to the one-OP-model when preparing the 2014-2020 programming period. The reasoning was simple - they have proved that the implementation structure with only one OP is easier to manage, and easy to follow for beneficiaries. As there is only one Managing Authority, it usually delegates competencies to the Intermediate Bodies, in this case the relevant ministries. In these model structures, the Managing Authority is mainly responsible for development of unified rules and guidelines for a proper implementation of ESIF and projects financed from ESIF, while the Intermediate Bodies are mainly responsible for operational tasks. Reduction of number of OPs down to one could be also seen in Slovenia.

Implementation structure with only one Operational Programme, i.e. with one Managing Authority and relevant ministries involved as the Intermediate Bodies have the following main benefits:

► Eliminating duplication of investments (supported priorities)
► Introducing standardized rules and principles in implementation of all priority axes
► Involving limited number of bodies in implementation structure and makes the coordination easier
► Introducing standardization across priority axes
► Limited number of implementing bodies significantly lowers administrative burden lying on beneficiaries.

The model introduced could not be efficiently implemented in any of the Member States. It is more suitable for smaller countries and would probably not work as well in Poland for example, with many self-governing regions and amounts of funds managed. Nevertheless, examples of other countries limiting numbers of Operational Programmes and simplifying complexity of the ESIF implementation system might be found – at this place the Czech Republic could be mentioned.

► Insufficient involvement of the Ministry of Health or other institution responsible for the health system in the programming and implementation phase in case of implementation of significant health care investments
If there are any health priorities to be addressed by the Partnership Agreement and key programming documents, it is essential to involve the Ministry of Health in the programming and implementation process. The level of involvement and the strength of mandate given to the Ministry of Health differ from country to country. In general, the more competencies in the programming and implementation phases the Ministry of Health has, the more focus on the health priorities that can be expected in a given Member State. In Slovakia, strong political support for health care issues enabled creation of an OP solely dedicated to health issues. The Ministry of Health in the role of the Managing Authority obtained large competencies in the programming as well as implementation phases. Considering the feedback of Slovak representatives, the following facts showed to be helpful for successfulness of health reforms and their implementation through ESIF:

- MoH was directly involved in the programming process with a strong mandate of the Managing Authority
- MoH thus directly participated in negotiations with EC representatives which enabled the Ministry to enforce critical investments and directly address any comments from EC
- Concentration of health issues under one OP enabled the Slovak Ministry of Health to roof the investments and reforms implemented.

The example shows also one important thing. Political backing is essential for the ability of the Ministry of Health to transpose its main strategic priorities in the programming documents. The stronger the political backing is, the stronger the position or mandate in the programming and implementation phase is achievable.

### 5.3.2 Recommendations for effective health strategy development

Below, general recommendations together with indication of the subject responsible are summarized. At this stage, the Ministry of Health is not directly addressed, as it is usually not in a position to affect this level directly.

(i) **Simplify the ESIF implementation structure**

*Role of the National Coordination Body*

- Develop reasonable number of Operational Programmes providing ESIF support. This approach is in line with the principle of concentration and makes it easier for the beneficiaries to understand the structure and areas supported by the programmes.
- Reasonable number of institutions involved in the implementation of OPs developed also makes the system more clear for the beneficiaries and even for bodies directly involved in the ESIF implementation.
- Also unification of guidelines and funding rules might lower the administrative burden lying on the beneficiaries.

(ii) **Involve the Ministry of Health and health stakeholders in the ESIF programming and implementation in case of OP with significant health care actions**

*Role of the National Coordination Body, designated Managing Authorities*

- Involve the MoH and health stakeholders in development of the programming documents (PA, OPs) and setting priorities for funding from ESIF so that health issues are not played down and the principle of partnership is met.
- Invite the relevant subject-matter experts in the field of health to the monitoring committee of OP, if the programme is addressing health actions / actions with potential health gains.
► Give the Ministry of Health adequate mandate to be involved in implementation of the health priorities funding and to coordinate the health investments supported by ESIF during the implementation.

► Encourage partnership building among the health stakeholders in order to enable mapping and coordination of the health investments, support synergies and prevent duplications of the supported actions.
5.4 Principles of effective implementation of health investments at various stages of investment lifecycle

The findings at the investment level address various stages of investment lifecycle. When talking about investment lifecycle, it addresses the following stages:

1. Strategy development [i.e. identification of health needs and priorities that shall be addressed; development of action plans for implementation of each priority]

2. Capacity building / ensuring [i.e. ensuring of relevant capacities for a proper planning and implementation of the health priorities and specific investments fulfilling the priorities; or relevant capacities to ensure an efficient allocation of the ESIF sources (if the MoH acts as an Intermediate Body)]

3. Partnership building [i.e. involvement of the relevant partners and stakeholders essential for implementation of the strategic priorities under ESIF]

4. Financial planning [i.e. detailed investment planning in terms of financial, HR and other resources, schedule of actions, identification of critical processes, risks etc.; if the MoH acts as an Intermediate Body, then also setting up of application assessment process ensuring selection of only realistic and effective projects / investments fulfilling selected health priorities ]

5. Procurement management [i.e. planning and management of purchases from the third parties that are essential to deliver planned investment outcomes]

6. Monitoring and evaluation [i.e. at the investment level this stage addresses monitoring of project implementation with respect to project plan, taking corrective actions if necessary; at the strategy or programming level, this stage addresses evaluation of achievements in the area of fulfilling the strategic / programme priorities and taking corrective actions if necessary]

7. Sustainability of investment [i.e. the ability of the investment to produce expected benefits even after the termination of financial support from EU SF / ESIF]

The above mentioned investment lifecycle identifies the stages essential for ensuring the effectiveness of these investments, especially in the context of ESIF.

The text below focuses in greater detail on the critical success factors in each stage of the investment life-cycle. Based on the identified practices causing investment inefficiencies as well as the collection of practices that might be considered as good practice examples, the recommendations addressed to the Ministries of Health reflecting the critical aspects of each stage of the investment process, and delimitating the responsibilities of the Ministry of Health in the process, have been developed.

For each of these seven areas, the lessons learned identified based on extensive analysis of projects implemented in the 2007-2013 programming period are described first, followed by a set of recommendations supporting effective go-through all stages of the investment lifecycle as introduced above. As the Ministry of Health might execute different roles in different stages, main recommendations are broken down according to the specific role of the Ministry relevant for each stage (for more details about the roles, see chapter 3). Moreover, internal and external subjects relevant for successful execution of the recommendations addressed are indicated.
5.4.1 Strategy development

The existence of the national strategy for health should precede any investment measures to ensure the investment is aimed at solving public health problems and/or at improving health care sector, contributes to set objectives and has a real value added. This has also been reflected in the health specific ex-ante conditionalities defined by the European Commission.  

Strategy development can be seen as a process through which needs, goals and actions to achieve them are defined in a coordinated manner with a set time framework, taking into account the limited amount of available resources and the socio-economic and legislative context. Needs assessment should be seen as a primary step when developing a strategy together with proper mapping of the existing health infrastructure.

5.4.1.1 Lessons learned deriving from analysis of the 2007-2013 practices

i. Lack of real public health strategy

Public health strategy should be developed as a complex tool which is widely accepted, interconnected with other existing public strategies, has clear objectives and realistically outlines how to achieve them.

Existence of the public health strategy is defined as a thematic ex-ante conditionality for ESIF investment in health. This requirement for a strategy shall not be replaced by ad hoc strategic efforts offering only independent solutions for individual problems, without a broader context, synergies and complementarities and without supporting evidence for impact of the planned interventions. Such partial strategic planning can nevertheless often be seen with regard to the use of ESIF.

The main impacts of insufficient strategy development can be the following:

- Resources are not focused on priorities
- Occurrence of duplicities and overlapping of funding
- Investment does not generate any tangible results, i.e. there are no health gains and no improved cost-efficiencies of the health sector
- Unsustainability of the investment
- Lack of the project progress or project disruption in the case of changes in the political environment

While countries with health care strategies often addressed the implementation of more or less systemic solutions in the areas of health reflecting the main challenges, the current health care systems are facing and focused on sustainable solutions of the problems. Countries without a strategic framework very often addressed mainly investments in underfinanced infrastructure as the main priority.

Under existing strategies, the infrastructural investments were closely connected to the reform of health services in various areas, e.g. inpatient care, outpatient care, ambulatory services earning together significant improvements in the health system as a whole. For example in Hungary, the needs for investment into the development of unified central eHealth were derived from the Semmelweis Plan for the Rescue of Health Care, a professional concept of the Ministry of Health [for more details on the Hungarian eHealth solution, see case studies 4 and 5 in the Appendix to this report]. Another example of a systemic solution could be found in Lithuania where the optimization of the

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infrastructure of psychiatric health care services was based on a strategic document with a clear vision of what needs to be done [for more details on the Lithuanian optimization of psychiatric health care services, see case study 21 in the Appendix to this report] or Greece, where investments in secondary care infrastructure were simultaneously accompanied by the development of an appropriate primary care network [for more details on the Greek primary care reform, see case study 17 in the Appendix to this report].

On the other hand, limited effectiveness of investments missing a broader strategic context could be demonstrated through the examples of the Czech Republic and Poland. Both countries’ main priorities in the 2007-2013 programming period lay in modernization and reconstruction of hospital infrastructure and modernization of existing and / or procurement of new equipment in hospitals. Although both types of investments improve the quality of health care services, they do not address cost-efficiency issues or problems that make the current systems unsustainable in the long-term.

ii. Sensitivity of strategies to changes in political representation

Previous experience also shows that strategies are often sensitive to changes in leading political representatives. As strategies are often being developed for a period longer than a four-year term, a change in governing political parties could be anticipated. A long-term strategy shall therefore not be developed as a political document reflecting the priorities of the governing party, but shall involve the whole political spectrum. Another aspect limiting the sensitivity of health strategy to changes in political representation is involvement of all relevant stakeholders that will be affected by the strategy in the strategy development process so that they adapt it as their own. Hungarian case study could also be used to demonstrate the possible effects of insufficient involvement of relevant stakeholders in the process of key strategic documents development [for more details on the Hungarian experience, see case study 3 in the Appendix to this report].

iii. Lack of coordinated action

At various levels of management and for different types of care

As the example of Hungary (which was the largest spender of SF on health care) shows, strategy alone could not ensure effective investments. Implementation of strategic priorities needs to be coordinated at various levels and in between various types of care [for more details on the Hungarian experience, see case study 3 in the Appendix to this report]. This problem is relevant for all Member States, but especially for those where health care is managed from different levels and coordination is not properly set. It is undeniably correct that different levels of care shall be managed from different levels of public administration, with the primary care being managed in regions, while concentrating specialized care above regional level to maximize its quality and cost-efficiency. However, the coordination between these levels shall always be present.

The problem can be better described with a specific example. In most of the new Member States and some of the old Member States with stronger regional disparities, one of the strategic priorities consists of improvement of the regional hospital infrastructure. Another priority concerns the strengthening of the primary care sector to reduce the unnecessary treatment in hospitals. If these priorities are each part of a different strategy (i.e. one is managed at regional level, while the other one at national level) and are managed in an uncoordinated manner, this could result in directing funding into two potentially uncomplimentary investment goals. While the first one aims at the improvement of hospital infrastructure, the second one aims at reducing hospital care. Despite the fact that both goals are important, they have to be delivered in compliance, i.e. the improvement of regional hospital infrastructure shall mean its optimization, including possible reduction of bed capacities, reflecting the increase in cases which can be treated in ambulatory primary care. It is worth adding, that both these infrastructure investment goals shall be matched by clinical guidelines development, which would delimit the scope and competencies of primary care to put the strengthening of primary care into practice.
Absence of coordination in between various levels, especially between national OPs and regional OPs, and between regional OPs could also lead to duplication in investments. In the Czech Republic, Regional Operational Programmes have been criticized for ineffective use of ESIF sources, mainly because of the absence of coordination mechanisms in between the regional OPs themselves as well as between regional OPs and national OPs sometimes targeting the same issues. The issue applies to health investments as well. The Czech Republic was criticized by the European Commission for duplicities in health investments implemented under the European Structural Funds. The main problem was that national as well as regional OPs often addressed similar infrastructural investments and modernization of health care facilities, but these investments were not coordinated. While national OP aimed at more complex solutions in area of improvement of the quality of health care, regional OPs supported investments in hospitals in their region without a broader concept. As a result, specialization of hospitals was more a question of the ability of the hospital management to successfully apply for regional / national money rather than a result of coordinated development fulfilling a strategic concept. Together with absence of any strategy in the area of secondary care infrastructure development, many investments have been found as inefficient or unsustainable.

The analysis shows two possible ways to improve coordination of health investments between various levels or types of care. In the Czech Republic, for the programming period 2014-2020 the regional issues have been merged under one Operational Programme called the Regional development Operational Programme. In Poland, with a quite similar structure of OPs and problems with coordination between national and regional investments, regions have kept their independence, but a set-up of an appropriate coordination mechanism between national OPs and those regional ones is one of the main issues in the negotiations in between Poland and the EU. In line with this, a practical set-up and responsibilities of a so called Steering committee gathering the representatives of MoH and regional representatives responsible for regional health issues is being developed.

The examples of the Czech Republic and Poland might indicate possible ways how to address inefficiencies caused by a split of topics between national and regional levels. Every concept has its specifics, but both show a way to ensure coordination of investments in countries with autonomous regional units in line with the requirements of the 2014-2020 programming period.

► At cross-regional, interregional and cross-border level

Even though the health strategies are developed as national or regional ones, this does not mean that the coordinated action should stop at this level. Neighbouring regions and countries shall always consider each other’s strategies to avoid duplicities and profit from the synergic effect. The cooperation can lead to a significant improvement in health access while reducing the costs. However, during the 2007-2013 programming period, there has been a lack of engagement by the public health sector in many regions and countries to unlock this potential.

For illustration, two neighbouring regions should not both develop an oncology centre (unless there is a strong reasoning for that), but shall cooperate and merge their funds to create only one centre accessible for both regions, and provide for the exchange of information with regional general hospitals and general practitioners in each of the regions.

The same considerations shall apply to the cooperation of neighbouring countries, which can efficiently cooperate with regard to health care provision and infrastructure development. This is of particular importance in remote border areas which are distant from the centres in their countries, as well as in densely populated areas on

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42 Setting up coordinated measures to improve access to health services and reducing inequalities in terms of health status is emphasized in thematic ex-ante conditionalities for ESIF investment in health
Due to the historical development of borders in Europe which does not always copy the population’s settlement or natural borders and sometimes divides cities and urban areas, this concept is of particular importance. Examples of successful cross-border cooperation include sharing hospital infrastructure and specialized treatment centres, shared emergency medical services and cooperation of medical specialists. Successful cross-border cooperation was set up in the region of Ardennes located in border areas both in France and Belgium guaranteeing the French patients from the sparsely populated region the access to specialized health care in a Belgian hospital [for more details on the French-Belgian cooperation, see case study 30 in the Appendix to this report].

The projects of cross-border cooperation can be funded from cross-border Operational Programmes between two neighbouring countries as well as be part of transnational or interregional programmes (i.e. INTERREG).

For more information on Transnational and Interregional Cooperation, see WP 3 (1) Categorization of the 2014-2020 Instruments and Mechanisms, and for more information on cross-border care, see WP 3 (4) Compendium of concepts and models for innovative, effective and sustainable health care.

► At different fund level

In order to ensure an effective model of funding in the area of health investments it is vital that the Member States concentrate on coordination of different ESIF, but also on coordination of ESIF with possible other funding sources. Other sources include national funding sources and community programmes (in the area of health especially community programmes Horizon 2020 and the 3rd Health Programme).

One of the most important rules set in the 2014-2020 Cohesion Policy is the focus on integrated funding. The aim of this principle is to improve coordination of the funds to avoid overlaps and to create synergies. In addition, the Cohesion Policy emphasizes implementation of the new cooperation instruments to achieve integrated development (i.e. community-lead local development, integrated territorial investment, integrated sustainable urban development). In comparison to the 2007-2013 programming period, the 2014-2020 Cohesion Policy allows actions financed by ERDF, ESF and CF to be combined either at a programme or an operation level.

Coordination of funding can help ensure more effective interlinking of actions in order to address problems. For illustration, activities comprising investments to be financed from different funds such as medical equipment and training for staff to operate the equipment, could be supported under one multi-fund project. It is necessary to mention that the simple cross-financing approach combining ESF and ERDF funding used widely in the 2007-2013 period will not be in most cases sufficient during the new programming period and is, according to the common provisions, considered as complementary to multi-funding schemes.

For more information on integrated development, see WP 3 (1) Categorization of the 2014-2020 Instruments and Mechanisms.
5.4.1.2 **Recommendations for the Ministry of Health for effective health strategy development**

Strategy development shall precede or eventually run simultaneously with the ESIF programming, providing input information for development of key programming documents (Partnership Agreement and Operational Programmes). Therefore, so far the process has reached the point where possible sources of funding are identified and assessed, the roles of the Ministry of Health in programming and implementation of health priorities under ESIF (*identified and described in chapter 3*) are not applicable. Therefore, the recommendations below are mostly addressed to a department, unit or any formation mandated to develop and maintain health strategic document(s) at the Ministry. Where the process gets to the point at which potential of ESIF support is assessed, relevant role of a coordinator of funding of health from ESIF as identified in chapter 3 of this document is further examined.

(i) **Develop an overarching public health strategy**

*To be coordinated with: specialized departments within the Ministry of Health providing subject-matter expertise, health stakeholders*

- Map the health infrastructure and identify priority issues and needs of the health sector in your country. These should reflect the current situation of the country, of the neighbouring regions and countries, as well as new trends, which may transform into issues in the future. An example of these can be the ageing of the population, territorial inequalities in access to health care, increase in psychiatric problems, or musculoskeletal problems – all of which decrease the employability of citizens and pose a burden on social systems.

- Define long-term goals which respond to the priority needs

- Define major actions to achieve these goals and decide on their sequence and timing

- Adopt a patient oriented approach which has public health at its centre

- Support the identified needs and actions leading to objective achievement with evidence, including examples of good practice

(ii) **Coordinate the strategy-making process to make the strategy broadly accepted, relevant and valid**

*To be coordinated with: government, regional and national public authorities, health stakeholders*

- Identify all relevant stakeholders: government, regional and local authorities, health care experts, medical staff and professionals, social experts, general public, educational institutions, universities, enterprises, NGOs, partners from neighbouring regions and countries.

- Engage identified stakeholders in the process of strategy preparation: prepare stakeholders’ consultation process, get their input and feedback and validate the strategy with them regularly.

- Get to know all existing strategies and strategies under development with health sector impact prepared at various levels:
  - EU strategies (i.e. Social Investment Package, part of which is a working document on Investing in Health, which establishes the role of health as part of the Europe 2020 policy framework, and EU health strategy)
  - National or regional health strategies
  - Regional and local development strategies, in which health themes are addressed
  - Cross-border cooperation strategies
  - Education and employment strategies
Strategies on cooperation between enterprises and universities, and on research and innovation

Other

(iii) Ensure a balanced and complementary approach to maximize investment effects

To be coordinated with: specialized departments within the Ministry of Health providing relevant expert insight, health stakeholders

- Make sure the strategy for different types of health care is coordinated and complementary. Strategies for hospital network development have to be in compliance with the strategy for primary care strengthening as well as with the strategy for the creation of highly specialized treatment centres, so that the strategy does not create dual overlapping structures. For this reason, it is important to have the one overarching health care strategy mentioned above, which brings all elements under one strategy.

- In the strategy, balance infrastructure development plans with skills development. All creation of new infrastructure and acquisition of new equipment should be supported by corresponding investment into human resources development and complementary actions such as prevention campaigns to ensure maximum benefits from the investment and its sustainability.

(iv) Identify financial resources and select priorities to be financed from ESIF

To be coordinated with: relevant department at MoH conducting the role of a coordinator of funding of health from ESIF

- Make an estimation of resources necessary to implement the strategy and achieve its objectives.

- Consider possible sources of funding (available volumes of funding / eligibility of costs):
  - National and regional sources
  - ESIF
  - Other EU sources such as community programmes Horizon 2020 and Health Programme
  - European Economic Area Funds and Norway Funds
  - Financial instruments (also outside ESIF)
  - Private sources (PPPs, private capital)

- Assess compliance of strategic health priorities with the Cohesion Policy thematic objectives and investment priorities and identify those priorities, the support of which is eligible under the relevant thematic objectives.

Coordinator of funding of health from ESIF

(v) Get engaged in the programming process and OP implementation

To be coordinated with: National Coordination Body, other ministries involved in programming, strategy development unit

- Once the selection is made, the Ministry of Health shall be engaged in drafting the Partnership Agreement and selected Operational Programmes in order to allow for funding of health priorities from ESIF.

- As the Ministry of Health, negotiate with the Managing Authorities of relevant Operational Programmes about funding the selected priorities from their OPs allocation.
Ensure national co-financing or co-financing from other sources to support those complementary priorities, which cannot be financed from ESIF to avoid incompleteness of action.

For more information and guidance on principles of public strategies development and implementation, please refer to Toolkit, part 7, **WP 3 (7) Reflection of additional issues raised by Member States.**
5.4.2 Capacity building / ensuring

Other issues identified in the analysed case studies and confirmed by EY’s experience relate to quality and the adequacy of administrative and expert capacities involved in the management of OPs as well as to the capacities of applicants for funding and beneficiaries. These issues have a direct impact on (i) the amount of resources paid out and certified and on (ii) the quality of the funded projects.

5.4.2.1 Lessons learned deriving from analysis of the 2007-2013 practices

i. Lack of qualified human resources for efficient implementation of strategic priorities and related investments at the Ministry of Health

Being responsible for the implementation of strategic priorities, the Ministry of Health has usually been acting as an Intermediate Body and in specific cases of investments of strategic importance also as a beneficiary.

Both these roles are highly demanding on human resources capacities. Being responsible for implementation of investments of strategic importance is highly demanding especially on quality management capacities. Being an Intermediate Body responsible for allocation of ESIF funding to investments and projects fulfilling health strategic priorities is even more demanding on qualified people. The specific level of delegation of responsibilities of the Managing Authority to the MoH as an Intermediate Body differs from country to country. But in most cases the MoH were responsible for setting up calls for proposals, assessment of project applications and selection of projects to be financed, monitoring of projects’ progress and conducting on-the-spot controls of supported projects. Being an Intermediate Body has therefore been demanding not only on the qualifications of the staff, but also on the numbers of capable employees.

Ministries of Health (unfortunately as many other ministries in the role of IB) have therefore been facing a challenge of how to attract and keep qualified people with regard to the usual level of salaries in public administration. Failure in this effort is often accompanied with the following symptoms:

- Inadequate knowledge of Operational Programme rules and lack of project management skills
- Inadequate skills in financial management, resource leveraging and public private partnership (PPP) projects management
- Lack of experience with health strategies implementation and system reforms accomplishment
- High fluctuation rate of employees

The main effects of a lack of qualified capacities could be identified in limiting the quality and value added of the supported projects, potentially also causing projects’ / investments’ ineligibility. This was seen mainly in some of the new Member States, where the majority of projects were targeted on investment into infrastructure modernization and equipment procurement rather than on development and implementation of health systems reforms and system efficiency improvement.

A positive example of how to deal with this challenge could be found in Slovakia. In Slovakian OP Health (2007-2013 period), technical assistance was used to attract and keep quality human resources and to enable to reimburse the labour cost of staff responsible for the OPH implementation that in general exceeded the remuneration of other state administrative staff. Technical assistance could be used even to support capacities of Intermediate Bodies, which is important as in 2014-2020 there will be most probably no Ministry of Health in the role of Managing Authority. Nevertheless, the use of Technical Assistance for reimbursement of employees within the implementation structure shall be properly planned and balanced with investments in educational activities.
Designating the majority of technical assistance resources to increasing the salaries of staff responsible for implementation of the OP significantly limiting staff education activities and exchange of experience (cooperation) with foreign partners was one of the main issues addressed in the mid-term evaluation of the OPH 43 [for more details about Slovak OP Health and its evaluation, please refer to case study 2 in the Appendix to this report].

Another example of how to attract and retain qualified staff is provided by the development of regional branches of CzechInvest – an organization of the Ministry of Industry and Trade of the Czech Republic - which acted as an Intermediate Body for an OP supporting business and innovation [more details about the CzechInvest project can be found in case study 35 in the Appendix to this report]. Four success factors were identified:

► A feeling of belonging of the employees in the regional branches
► Direct personal contacts between the project beneficiaries and the staff of IB
► Well designed and professionally implemented system of central management methods, providing employees with backup and support and allowing for the exchange of best practice
► The strategy for the recruitment of staff which recruited people from business who understood the world of the beneficiaries

ii. Lack of information and guidance for applicants

Another source of the inefficiencies of health investments stem from inadequately informed applicants. The main barriers on this side identified during our analysis could be summarized as follows:

► Insufficient knowledge of health relevant strategy objectives within the OP among health sector entities
► Lack of transfer of information about publishing a call for proposals targeted at health issues among potential health sector applicants
► Insufficient support of applicants in the phase of project preparation and implementation

Lack of information about funding and guidance for applicants can cause insufficient absorption capacity and does not stimulate investment in strategic areas identified by the public health strategy. As a result, ESIF allocation earmarked for health investment might be drawn on projects without real results and impacts towards the achievement of strategic health objectives. In the situation of insufficient applicants’ guidance, applicants with experience in drawing ESI funding but possibly low experience with health projects implementation are more likely to be successful in the projects selection than health care provider institutions. Then, importance of the quality of a project itself is lowered which is not desirable. Lack of experience among applicants was one of the main challenges for example during the optimization of the health care infrastructure in Lithuania [for more detailed information, see case study 15 in the Appendix to this report].

Ministries of Health usually aim to provide relevant information to potential beneficiaries and project applicants on their webpages. Some of the Ministries of Health provide further support to beneficiaries through workshops and training activities addressing e.g. effective project management skills development or principles of effective procurement (Latvia). In Hungary, a particular project aimed at the provision of the support and information to

potential beneficiaries has been implemented in order to ensure absorption capacity and help improve optimal use of available resources. [For more details on the Hungarian project, see case study 6 in the Appendix to this report].

The above-mentioned CzechInvest regional branches case study confirms that when the potential beneficiaries were supported in their regions through workshops and a helpline with well-qualified staff, the quality of projects elaborated in cooperation with the regional branches of CzechInvest was significantly higher than those project proposals that did not receive advice. This case study also shows that the capacity building of administrators and the capacity building of applicants and beneficiaries are interconnected [for the whole case study description, please refer to case study 35 in the Appendix to this report].

5.4.2.2 Recommendations for the Ministry of Health for effective capacity building

Further in the text, main recommendations broken down according to model roles of the Ministry of Health within programming and implementation of health priorities under ESIF (as identified and detailed in chapter 3) relevant for this stage are introduced.

► Intermediate Body

(i) Pay the attention to the development of relevant and skilled capacities

To be coordinated with: Managing Authority, specialized departments within the Ministry of Health providing relevant subject-matter expertise

► Ensure the MoH has qualified and skilled capacities for ensuring the competencies designated to the Ministry of Health by Managing Authority, e.g.:

► Experienced project and financial managers responsible for selection and monitoring of projects and eventually performance reviews

► Sufficient administrative capacities supporting processing of administrative tasks stored on beneficiaries as well as stored on the Ministry of Health towards Managing Authority / EC

► Sufficient expert capacities involved in calls preparation and assessment of project applications

► Sufficient capacities to efficiently support beneficiaries under calls managed by the Ministry of Health

For the purpose of capacities building, technical assistance should be used more extensively. Following Article 58 of CPR, on the initiative of the Commission, the technical assistance may be used to support (among other):

► Institutional strengthening and administrative capacity-building for the effective management of the ESI Funds

► Strengthening of national and regional capacity regarding investment planning, needs assessment, preparation, design and implementation of financial instruments and the dissemination of good practices in order to assist Member States to strengthen the capacity of the relevant partners


45 Partners as defined by Art. 5 of the CPR.
(iii) Build absorption capacity among aimed beneficiaries
To be coordinated with: Coordinator of funding of health from ESIF

► Educate beneficiaries through workshops and dissemination of information
► Provide applicants and beneficiaries with clear rules and enable them to consult these rules with designated person at the Ministry of Health (establish a contact point etc.)

Beneficiary

(iii) Ensure skilled capacities supporting effective implementation of strategic health projects
To be coordinated with: e.g. the strategy unit, other specialized units, such as procurement unit or project management office (if established)

► Develop experienced project and financial managers capable of preparing and implementing complex programmes as well as efficiently planning and implementing strategic projects
► Develop sufficient administrative capacities to meet all the requirements and rules that are concerned if ESIF support is used

Coordinator of funding of health from ESIF

(iv) Pay attention to the development of relevant and skilled capacities
To be coordinated with: specialized departments within the Ministry of Health providing relevant expert knowledge

► Ensure the MoH has qualified and skilled capacities capable of supporting:
  ► Managing Authorities and other Intermediate Bodies in the area of health expertise where relevant and communication with beneficiaries
  ► Beneficiaries in project planning and project application development

(v) Build sufficient absorption capacity among potential beneficiaries
To be coordinated with: Intermediate Body

► Inform health care providers and entities active in the area of health about existing funding possibilities, and open calls for proposals
► Actively analyse the needs of potential applicants and provide them with guidance in order to help them submit quality project applications and deliver measures focused towards the health strategy objectives achievement
► Educate beneficiaries through workshops and dissemination of information
5.4.3 Partnership building and management

As referred to in Article 5 of the CPR and in accordance with the multi-level governance approach, Member States should involve a wide range of partners in the preparation of Partnership Agreements, and progress reports and throughout the preparation and implementation of Operational Programmes, including through participation in the monitoring committees for programmes. In general, the partnership principle implies close cooperation between public authorities, economic and social partners and bodies representing civil society, including environmental partners, community-based and voluntary organizations, at national, regional and local levels.

The analysis of case studies stressed how important it is to involve partners in the process of programming, implementation, monitoring and evaluation of Operational Programmes and to manage the relationship with partners throughout the whole investment lifecycle.

The reasoning for involvement of relevant partners in programming of ESIF implementation structure has already been discussed in chapter 5.3 Principles of effective implementation structure of ESIF, and importance of stakeholders’ identification and engagement during the strategic development phase has been addressed in the previous sub-chapter (chapter 5.4.1. Strategy development). The partnership principle might, however, be applied also throughout the whole investment (project) lifecycle, especially in case of large, system projects where it is desirable to have more parties included. Key success factors for effective partnership building are discussed below in further detail.

5.4.3.1 Lessons learned deriving from analysis of the 2007-2013 practices

Problems the public authorities responsible for health investment delivery faced in analysed case studies could be generally divided into two groups:

- Insufficient involvement of relevant partners in development of health programmes, especially investments with great impact on health system and stakeholders (hereinafter referred only as investments)
- Shortcomings in management of partners during the subsequent phases of the programme or investment lifecycle
  - Insufficient partners consultation process set-up
  - Set-up of rigid decision-making structure, i.e. structure based on consensus of all involved partners, which delayed the project delivery
  - Unclear roles and responsibilities of involved partners

These problems were present i.e. in the Slovenian eHealth implementation project, where the consultation process among different stakeholder professional groups did not translate to clear, anticipated and well understood contractual arrangements among stakeholders. The chosen consultation and project management approach of consensual decision-making has been met with difficulties while engaging important stakeholders such as the IT


48 Definition according to the Commission delegated regulation of January 7, 2014 on the European code of conduct on partnership in the framework of the European Structural and Investment Funds. Available at: http://ec.europa.eu/social/BlobServlet?docId=11350&langId=en
industry, the Medical and Pharmacy Chambers. [For more details on the Slovenian eHealth project, see case study 7 in the Appendix to this report].

Cooperation among different institutions and stakeholders is especially needed when implementing eHealth solutions such as electronic health records as emerged in Hungary, where the inter-institutional cooperation was successful, and in Romania, where the main lesson learned lies in the focus on partnership building [for more details on the Hungarian eHealth solution, see case study 4; for more details on the Romanian experience, see case study 11 in the Appendix to this report].

- The main risks related to insufficient involvement of partners in health investments planning and subsequent implementation, are the following:
  - Strategies and specific investments bounded to the strategies developed without a wide consensus among partners proved to be vulnerable with a high risk of refusal from stakeholders targeted by it. Programmes and investments that did not have support across the political spectrum were likely to be discontinued in case of political representation changes during investment implementation.
  - Even intensive collaboration with experts in the given field might not ensure selection of the best and most effective solution for its use in practice. Failure to involve medical staff and the general public as partners may limit desired impacts of the investment and/or some groups of beneficiaries from receiving programme outputs.

Main risks related to poor management of partners during investment lifecycle were the following:
  - Misunderstandings, lack of clear responsibilities of each stakeholder group, bureaucratic procedures in the cooperation set-up might lead to significant delays in realization of the investment.
  - Poor partners’ management and delays in investment realization could not only affect a project’s positive contribution but also a project’s entitlement to obtain funds from ESIF.
  - Lack of a coordinated management function causes inefficiencies in a way that projects addressing various levels of care provision are not complementary and may lose (at least partially) their benefits [lesson learned derived from case study 3 in the Appendix to this report].

5.4.3.2 Recommendations for the Ministry of Health for effective partnership building

Considering lessons learned from the 2007-2013 programming periods and the specifics of the 2014-2020 period, main recommendations broken down according to model roles of the Ministry of Health within programming and implementation of health priorities under ESIF (as identified and detailed in chapter 3) relevant for this stage are listed below.

- Coordinator of funding of health from ESIF
  (i) Build partnerships within the ESIF implementation structure

  Recommendations for the coordinator aim at building of partnerships at the level of Operational Programmes. As a coordinator of health investments under ESIF, the Ministry shall build partnership with Managing Authorities or Intermediate bodies of various OPs supporting health-relevant investments, apart from those managed by MoH as an Intermediate Body.

  - Ministry of Health shall be involved in the Monitoring Committee at least of those OPs that has been designed to support health priorities, even in cases of OPs where the Ministry has not gained formal
competencies in their implementation. However, to efficiently deal with the role of coordinator of health investments under ESIF and in line with principle of partnership, involvement in Monitoring Committee even of those OPs, that do not directly address health priorities, but are addressing investments relevant for health care sector, could also be recommended. This needs to be initiated by the Ministry and negotiated with the Managing Authorities of relevant OPs.

- The Ministry of Health shall also aim to establish a cooperation platform for the Ministry of Health and MAs and IBs of such Operational Programmes. The Ministry of Health might support MAs/IBs with capacity building among health sector beneficiaries, subject-matter expertise in various stages of the call for proposal development and evaluation of project applications and even during implementation process (specific forms of cooperation of MoH as a coordinator and MAs/IBs are addressed in relevant chapters below). On the other hand, MAs/IBs shall provide the Ministry with information about planned calls, beneficiaries from health sector and the projects supported and overall information relevant for monitoring of progresses in the health sector.

It should also be recommended to support achieved partnerships with a formal written document specifying forms and extent of mutual cooperation between MoH and other relevant institutions.

**Beneficiary**

(i) Identify relevant partners (meaning important stakeholders) through transparent procedures

*To be coordinated with: Intermediate Body, department expected to be responsible for overall coordination of funding of health from ESIF and strategy unit*

- Think about all possible parties that could be involved in investment designing, planning and implementation and assess roles and responsibilities of the partners with respect to their importance for the investment successful realization introducing transparent assessment criteria.
- Identify partners that are critical for investment successful realization and invite them to the project management structures. Define transparent cooperation and communication rules for stakeholder and partners not directly involved in investment management structure to be followed during further stages.
- Follow the ESIF and OP specific rules regulating partnership at the project level.

(ii) Designate a person responsible for partner management, i.e. a coordinator responsible for engagement of all relevant partners and stakeholders, their ongoing coordination and solving any issues that might arise

*To be coordinated with: department expected to be responsible for overall coordination of funding of health from ESIF*

- The coordinator shall be active in both the phase of strategy development and subsequently in the phase of investment implementation. He shall be given sufficient competencies and shall have the authority needed to manage various partners and groups of stakeholders, as well as deep knowledge and understanding of the investment and role and responsibility of each of the partners.
- In case the partners’ consultation process comes to an impasse, engage a mediator to unblock the process to avoid unnecessary project delays.

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49 Respectively, department responsible for investment planning and implementation.
(iv) Learn to understand individual partner’s and groups of stakeholders’ needs

To be coordinated with: the coordinator nominated based on previous recommendation

► The purpose of the partnership building and management is to accommodate needs of all relevant stakeholders through the planning and implementation of important investments. In order to achieve this goal, understanding the partners’ needs is a key to success.

(v) Introduce a formalized system for cooperation among partners, which will be consensually adopted, and follow the procedures systematically

To be coordinated with: the coordinator, partners involved in investment management structures (steering committee etc.)

► Clearly delimit the roles and responsibilities of each of the partners / stakeholders
► Involve the partners continuously and have all major decisions approved from their side
► Decide on the decision-making process: consensus is recommended for major decisions, but might be a rigid option for the day-to-day decision-making process. When choosing other than consensual methods, bear in mind the need for wide acceptance of your steps.
► Define the consultation, communication and exchange of information system, consult the partners on a regular basis and keep them informed.
► Adopt a schedule of partners’ consultations in sufficiently advanced time so that all partners can plan to attend the consultations and disseminate the outcome of the consultation to ensure up-to-date information for all partners.

Three cases illustrate successful usage of some of the above-mentioned recommendations at both programming and project level:

► In Hungary, the methodology for the public consultation on the National Strategic Reference Framework (NSRF) was set up following recommendations from civil society organizations. About 4000 partner organizations, including trade unions, NGOs, representatives of business, education and science, were invited to advice on the orientation of the NSRF and OPs. The general public was also invited to comment on the documents via a webpage. [For more details, see case study 3 in the Appendix to this report].

► In Mecklenburg-Vorpommern, Germany, the monitoring committee was responsible for all EU Funds for the 2007-2013 programming period. It was composed of high-level representatives from the private sector (trade unions, employers, small enterprises, chambers, farmers, environmental and social welfare associations). It met frequently, five to six times per year. The monitoring committee had a real say in decision-making on proposed projects, and the public and private partners had the same number of votes. 50

► In Greece, mental health reform has been implemented since 1997. The implementation was challenged by the initial reactions of local communities whose support was, however, necessary for

50 Example of the good practice in Germany is retrieved from Best practices as regards implementation of the partnership principle in the ESI Funds’ programmes, EC document accompanying Commission Delegated Regulation on the European code of conduct on partnership in the framework of the ESI Funds. Brussels: January 7, 2014. Available at: http://ec.europa.eu/regional_policy/what/future/pdf/preparation/2_staff_working_document_en.pdf
success. Yet, over the years the situation improved resulting in positive evaluation regarding the sufficiency of the coordination and allowing the accomplishment of the reform. [For more details on the Greek mental health reform, see case study 21 in the Appendix to this report].
5.4.4 Financial planning

Especially in the context of ESIF, the need for proper investment planning with an emphasis on financial planning supported by detailed evidence and selection of a suitable method for the appraisal of investment reasonability and rationality is often stressed. This has been reflected in the Cohesion Policy ex-ante conditionalities set-up. The health-related ex-ante conditionality criteria include having a budget and monitoring framework to accompany the strategic policy framework in health. The framework should outline available budgetary resources on an indicative basis and a cost-effective concentration of resources on prioritized needs for health care. Having a budgetary framework for health is a critical factor and a prerequisite for the early and efficient definition of the type of investments required towards a cost-effective, sustainable and accessible health system.

Financial planning is not a one-off activity carried out only once in the planning process. It is an ongoing and continuous activity that starts – if properly conducted – already at the early stages of strategy development. Even though methods and detail of assessments differ in each stage of the process, i.e. from strategy through investment priorities development down to specific project development, general principles of financial planning shall be applied in all stages introduced.

When referring to the development of a financial plan at the strategic level, the following shall not be left out:

► Development of a strong needs assessment to ensure the priorities address the real needs of the health care sector and population
► Identification of possible alternatives and selection of the most efficient option for strategic investment / project realization (determination of the most cost-effective investments)
► Prioritization of investments
► Identification of possible sources for funding (public sources, ESIF, private sources)

Having identified investment priorities, the next stage of financial planning expects development of a strong business case for each investment priority, which covers:

► Assessment of investment necessity in an overall strategic context
► Evaluation of investment value and sources of funding
► Detailed project economic appraisal (estimations of realistic costs, economic appraisal, modelling of expected operational costs etc.)

For more guidance on effective development and implementation of investment priorities and investment projects, please refer to Toolkit, part 5, WP 3 (S) Manual on how to plan, implement and sustain capital investment in health and health care.


The above-mentioned stages enable the Ministry of Health to identify the specific investment needed to deliver health priorities addressed in the strategy.

- In the context of ESIF, some of the investments will be ensured by the Ministry of Health itself in the role of a beneficiary. Other investments will be implemented through individual projects managed by responsible department with MoH in the role of an Intermediate Body. Financial planning in the context of possible roles of MoH in ESIF implementation structures covers: development of a detailed business case for the specific investment / project (as a project applicant / beneficiary)

- Evaluation of business cases (as a part of a project application) for projects applying for funding (competency of MA, respectively MoH, when acting as an Intermediate Body with project applications assessment competency)

5.4.4.1 Lessons learned deriving from analysis of the 2007-2013 practices

Based on the research and interviews with the representatives of the Ministries of Health and Managing Authorities, the main problems could be seen in the area of insufficient detail that the projects were developed by beneficiaries on the one hand and in the selection of such projects for funding by managing authorities on the other hand. The main underlying causes that need to be addressed are as follows:

- Insufficient needs assessment often causing projects to not be justified by the real needs and not supporting strategic priorities, even if they were developed.

- Unrealistic budgeting caused either by lack of evidence or by inappropriate use of techniques for financial planning and investment appraisal.

- Incorrect evaluation of project applications for funding where even project applications with the two above-mentioned problems were accepted for funding.

The selection of applications process shall be set in a way to lead to rejection of projects with any of the above mentioned insufficiencies. This could be mentioned as one of the most important success factors ensuring that the ESI Funds would be implemented efficiently and support investments that contribute to fulfilling the goals of the Europe 2020 strategy. The set-up of the selection process is primarily the responsibility of the Managing Authority, but its outcome is also to a large extent dependent on the human factor in the project preparation and applications selection process. The capacity building is, therefore, closely linked to the successful outcome of the financial planning phase.

On the side of the Managing Authorities / responsible Intermediate Bodies, the main causes of inefficiencies in the project selection process could be tracked in:

- Lack of expertise when assessing technical aspects of health and health care projects

- Improper setting of evaluation criteria

For more guidance on the success factors for calls for proposals and project applications selection process, please refer to Toolkit, Part II: WP 3 (2) Reference checklist for successful management of calls for proposals and project applications assessment.

Concrete implications of the above-mentioned inefficiencies led in general to:

- Project costs overruns which might seriously threaten implementation and the project sponsor’s ability to even finish the project
► **Failures to achieve expected benefits** that were expected to contribute to the fulfilment of national as well as European strategic objectives

► **Problems with project sustainability** in two possible ways:
  - In cases where the operational costs during the sustainability phase were not planned for or identified properly or proved to be significantly higher than amounts budgeted
  - In cases where the needs assessment considered only current health needs without considering possible changes or were not developed at all

Both options ultimately affect the financial sustainability of projects implemented under ESIF

It is apparent that the bigger the investment, the more serious the impacts of improper investment planning could be. As the Ministry of Health might take on the position of a beneficiary, i.e. institution responsible for project planning and implementation, as well as the position of grant provider (Intermediate Body), recommendations included in the next chapter will reflect both of these roles.

5.4.4.2 **Recommendations for the Ministry of Health for efficient financial planning and project selection**

Further in the text, main recommendations broken down according to model roles of the Ministry of Health within programming and implementation of health priorities under ESIF *(as identified and detailed in chapter 3)* relevant for this stage are detailed.

► **Beneficiary**

Based on the analysis and discussions with representatives of several Ministries of Health and Managing Authorities, the recommendations on how to improve the financial planning of health projects in the programming period 2014-2020 would be the following:

(i) **Process a detailed and comprehensive needs assessment to ensure investment appropriateness and sustainability**

*To be coordinated with: strategy unit, specialized departments within the Ministry of Health providing relevant expert knowledge, health stakeholders*

► When conducting a needs assessment, do not focus only on current needs, but **involve long-term prognoses of key factors** to ensure long-term sustainability of the solution that will be developed based on the results of the needs assessment.

When searching for a good practice example of a properly conducted needs assessment, it is possible to refer to one of the EUREGIO 3 case studies from Kymenlaasko Region in Finland *[for more details, see case study 22 in the Appendix to this report]*. This study shows the approach to a needs assessment conducted in the above-mentioned region, based on which a new integrated regional model of care delivery was developed. Among good practice examples that could be identified, is the involvement of long-term projections estimating the development of the population and their needs in terms of decades, not just years. The 30 years projection pointed to significant changes in population structure that would cause financial unsustainability of the health care provision in the region. Based on the results, a large reform of health service delivery has been developed and is currently being implemented step-by-step. The benefits of integration of long-term projections in the needs assessment process shall be clear – the approach supports innovativeness and shall ensure the improvement of health care services that would be sustainable in the long-term. Both significantly contribute to effective utilization of money used from EU SF as well as from national funds.
► Develop comprehensive **cause and consequence analysis** based on data gathered to properly identify causes that need to be addressed when aiming at change of the status. Do not stop until reaching a certainty of being able to identify causes rather than symptoms.

► Pay sufficient attention to identification of possible solutions and their examination to ensure **selection of the most efficient way how to address a need**.

► **Involve techniques of investment appraisal in selection process** and ensure selection of an appropriate appraisal method.

Various techniques and methods supporting selection of the most efficient solution exist, but not all could be appropriately applicable when assessing health care projects. This can be demonstrated on an example of the most popular method, i.e. Cost Benefit Analysis (CBA). This method is quite popular among beneficiaries and even project evaluators because of its relative simplicity.

Assessment techniques are always based on comparing cost of investments with potential benefits of the investment. CBA attempts to value the consequences of investments in monetary terms so as to make them commensurate to costs. CBA therefore assumes that all benefits can be expressed in monetary terms. When talking about health care investments, conversion of benefits to monetary terms might not always be possible. As a result of this, many cost-benefit analyses conducted in practice are more restricted than other types of appraisal and are limited to a comparison of those costs and consequences that can be easily expressed in monetary terms. It is obvious that this “limited” approach could significantly compromise the quality of the results. CBA is therefore not recommended to be used as a sole source for decision making in case of complex or large-scale investments.

*For guidance on the use of the investment appraisal methods in health, please refer to the Toolkit, part 6: WP3 (6) Reference document on appraisal of investments.*

(ii) **Clearly set the main principles of financial planning and require their systematic application**

*To be coordinated with: financial department or project management office (where applicable) in internal structure of MoH*

► Identify and assess costs related to solutions analysed within needs assessment (as mentioned above)

► After selection of specific solution, review and refine the initial estimates, in compliance with the following principles:

  > Assess the financial needs to achieve project objectives realistically, taking into account the operational and maintenance costs

  > Require use of evidence-based approach, i.e. support your financial estimates with existing similar project costs and calculations or validate your estimates with relevant experts

  > Apply metrics and benchmarking to gain evidence that financial goals established are realistic

► Monitor the financial performance data periodically to be able to identify any possible problems in time

(iii) **Ensure capacities with adequate knowledge and expertise in the field of financial planning of health projects and health investment appraisal methods through the capacity building process**

*To be coordinated with: specialized departments within the Ministry of Health providing relevant expert knowledge, if appropriate external expert capacities*
► Build relevant capacities at the Ministry of Health

Ensuring relevant capacities might be achieved in two ways:

► Attract experts with a knowledge of financial planning and management in health
► Adequately develop the skills and competencies of current staff

► The adequate quality capacities might require a high initial investment, but are crucial to successful mastering of the financial planning.

Experts with a good knowledge of the financial management of health projects are rare in many of the new Member States. This situation could be improved with the help of ESIF that can also provide funding to train or support the necessary capacities.

► Intermediate Body

(iv) Set criteria for project application evaluation and selection to ensure only financially realistic, achievable and cost-efficient projects are supported (if this competency was delegated to IB)

To be coordinated with: Managing Authority, specialized departments within the Ministry of Health providing relevant expert knowledge

► Ensure experts with relevant expertise as described above are in charge of the set-up of relevant indicators / criteria to be used for the evaluation of project applications and selection of projects
► Ensure that the evaluators assessing individual project applications also have adequate experience and knowledge
► Set up relevant evaluation (quality assessment) criteria. While setting the quality assessment criteria for health focused projects, it is recommended to include the following aspects (as applicable with regard to the nature of the supported actions):

► Impact of the project on cost-efficiency and sustainability of health care systems
► The project’s capacity to reduce inequalities in health status and access to health care
► The effectiveness of the project: the capacity of the project’s results to contribute to the programme’s specific objective, which is to be achieved through the call
► The need for the project, i.e. project relevance in relation to the current situation in an area (country, region)
► Project efficiency, i.e. “value for money”. The aim of the criterion reflecting this aspect is to select projects where the costs incurred generate maximum value added.
► Project economy, i.e. “budget of the project”. The aim of this criterion is to assess whether the budget is reasonable with relation to the outcomes of the project.
► Feasibility of the project: The feasibility of the project indicates the applicant's ability to successfully implement the project through the solution provided in the proposal and to maintain it.
► Consistency with horizontal principles (as defined in Articles 5, 7 and 8 in the Common Provisions Regulations)\textsuperscript{53}

For more detailed recommendations and guidance on the selection of criteria for the assessment of health related project applications, please refer to the Toolkit, part 2: **WP3 (2) Reference checklist: essential and success factors for calls for proposals and for the assessment of project applications.**

► **Choose a suitable assessment model** with regard to the type of projects at which the call is targeted:

► Choose **the single step assessment model** if the call is aimed at a large number of smaller, easier to prepare projects.

► When referring to health related projects, these include calls aimed at purchasing standard medical equipment and other infrastructure projects of a smaller scale, the training and education of medical staff, preventive campaigns and projects in the field of healthy aging.

► Choose the **two steps assessment model** if the call is aimed at large projects and projects, where preparation costs are high (i.e. innovative and pilot projects), and if communication between the Managing Authority and applicants regarding the project is important for increasing its quality.

► When referring to health related projects, this includes large infrastructure projects and e-health projects which are part of the health care system’s reform and projects in the field of medical research and innovation, the preparation of which is linked with significant costs and resources engagement.

► As a part of the project assessment and selection process, assess the risks associated with its implementation

For more detailed guidance on the effective process of project applications assessment reflecting the specifics of health related projects, please refer to the Toolkit, part 2: **WP3 (2) Reference checklist: essential and success factors for calls for proposals and for the assessment of project applications.**

► **Coordinator of funding of health from ESIF**

► Coordinate the availability of relevant experts from MoH to support the Managing Authorities or Intermediate Bodies of OPs if calls addressing health-related issues are (to be) opened

► Support applicants from health sector with:

► Providing consultations on specific issues related to project financial aspects and business case development

► Educate beneficiaries in financial planning effective practices

5.4.5 Procurement management

Procurement means the acquisition of goods and services from a third party, which has been awarded a contract through a process of bidding, based on the tender specifications.

5.4.5.1 Lessons learned deriving from analysis of the 2007-2013 practices

The procurement process has proved to be one of the key aspects influencing the implementation of the Structural Funds in all areas of funding, including health. In the 2007-2013 programming period, erroneous procurement was the major problem, causing ineligibility of expenses and project delays in many countries. Beneficiaries (as contracting authorities) have gained important experience with public procurement over the past programming period, however past examples show that all contracting parties have repeatedly had problems with procurement administration and awarding contracts.

Errors in the public procurement process have had the following impact:

- Ineligibility of expenses
- Delays in project implementation and in some cases even cancellation of a project
- Disruption of project implementation and possible loss of unrecoverable funds
- Additional costs (fees for legal advisors, sanctions, additional personal costs)

Examples show that the main problems in the procurement process in health sector are also linked to:

i. Technical specifications of the tender

These have to be specific enough to allow for the proposals to meet the contracting authority’s requirements and to be comparable in terms of scope and quality, but not discriminatory. When implementing, for example, a large project directed at purchase of new equipment, its quality, technical parameters, complementarity with other equipment, availability of after-sales services, guarantee etc. should be defined in the technical specifications as specifically as possible. However, the specifications cannot be discriminatory and cannot be limited to one potential supplier or brand, thus excluding competition.

ii. Scope of the tender and estimated value

When deciding on the scope of the tender, it is important to include all of the related items so as to avoid subdivision of contracts to lower its estimated value. Such subdivisions are often used to exclude the contract from the scope of the EC Directive on procurement. On the other hand, the contract should not be defined too broadly, combining unrelated items, so as not to exclude potential smaller and specialized suppliers from the competition.

Both the above stated problems push the contract prices above the market prices, thus causing inefficient spending.

iii. Contract award criteria (lowest price / economically most advantageous bid)

These should always be defined in relation to the tender, and should be specified as unambiguously as possible to avoid any area for a preferential course of action.

The ways in which a large project implementation can be delayed by problems related to procurement processes is demonstrated by the Slovenian project on eHealth implementation “eZdravje” [for more details on Slovenian
experience, please see case study 7 in the Appendix to this report. This project was co-financed by the Operational Programme Human Resources Development (ESF) and the procurement process for contracts awarded in the framework of the OP followed the rules set in the provisions of the OP HRD. A central problem associated with the relative lack of progress of eZdravje was identified in the process of designing, issuing public tenders and awarding project contracts.

At the start of the project, the Ministry of Health led the preparation of tenders for this project including technical specifications. These tenders were then required to be submitted for approval to the Managing Authority.

IT companies and other stakeholders found tenders to be of too large a scope, lacking clear specification, and focusing on a single technology to deliver services. Smaller companies felt unable to contest one particular tender deemed important to the project, despite their involvement in the pre-stage consultation. This tender was legally challenged and was then withdrawn. In another example, the MoH received written complaints about a tender because it was thought to be too narrowly specified.

An example of good practice in mitigating erroneous procurement could be found in the Czech Republic. In the 2007-2013 programming period, the Ministry of Health (in the role of IB) reviewed the tender specifications of all projects funded from the Integrated Operational Program (IOP) before their publishing. Reviewing the process, as well as technical aspects of the planned tenders, the Ministry of Health was able to significantly reduce the numbers of findings and penalties imposed on beneficiaries (related to the tender specification) because of erroneous procurement. Despite these measures performed by the Czech Ministry of Health, erroneous procurement in health investments and projects in the Czech Republic has been often addressed by the EC.

The review of project tender specifications of large projects is a practice highly demanding on available and capable capacities, even with a quite limited number of projects. When facing a lack of capacities or dealing with a large number of projects supported, it is recommended to set a threshold above which the tender specifications will be conducted.

Delays in project implementation may have negative impact on project budget as the price of contracted services or medical equipment may rise. The difference between financial allocation for individual services / equipment in the original project budget and the real price can put beneficiaries into the situation when they are short of the project budgets. [For an example of such situation, see Lithuanian case study 15 in the Appendix to this report].

5.4.5.2 Recommendations for the Ministry of Health for effective procurement management (with the focus on tender documents)

Further in the text, main recommendations broken down according to model roles of the Ministry of Health within programming and implementation of health priorities under ESIF (as identified and detailed in chapter 3) relevant for this stage are introduced.

► Intermediate Body

(i) Support the Managing Authority in defining clear, concise and unchanging programme-specific rules

To be coordinated with: Managing Authority

Being primarily in responsibility of MA, aim to support the following:

► Aim at defining easy-to-follow programme specific procurement rules bound by national legislative which is in compliance with the EU directives. The programme specific procurement rules shall be set up in order to facilitate the procurement process and make it
Take enough time to prepare tender action, capacities, pipeline or shortlist of operations at the beginning of the programming period.

- **Add on a minimum of additional requirements** on top of those set by the national procurement law. Ideally, only rules concerning the contracts awarded outside the scope of the procurement act and small-scale contracts should be defined. These should be **based on the procurement act** with possible simplifications, and should by no means introduce any new concepts different from the ones defined by the procurement act (i.e. if a procurement act does not allow for restricting the number of contestants by means of drawing lots, this should not be introduced by programme specific rules, even for contracts outside the procurement act scope to avoid any confusion).

- **Avoid frequent changes in procurement rules.** If it is in competency of an Intermediate Body, define the rules in such a way that they will not require frequent changes and the basic principles remain valid. Any planned changes to the procurement law (i.e. adoption of new EU public procurement directives) shall already be taken into consideration.

- Rules should be **specific**, but they should be **detailed only to a level** which will **not prevent** the use of **common sense** and will not impose unnecessary requirements and duties.

(ii) **Provide administrative support to beneficiaries acting as a contracting authority**

*To be coordinated with: Managing Authority, internal and external subject-matter experts in the field relevant to the tender*

- Provide sufficient guidance in the form of explanatory guidebooks, templates, tutorials and trainings.
- Consider ex-ante reviews of tender specifications — many mistakes can be eliminated in the early stages, thus reducing the ineligible expenditure. However, such a set-up requires sufficient administrative capacity in order to avoid delays in the tendering process, and there is also the risk of unclear responsibility delimitation between the contacting authorities and the administrator.

(iii) **Beneficiary**

*To be coordinated with: Intermediate Body, relevant department at the MoH conducting the role of a coordinator of funding of health from ESIF, subject-matter experts in the field relevant to the tender, procurement / legal department*

- Ensure sound preparation of tender specifications (transparent, non-discriminatory and ensuring equal access) and tendering procedures ensuring compliance with all requirements of national procurement law and programme specific rules
- Engage health care experts as well as experts from other fields relevant to the tender, i.e. IT experts and engineers, in preparation and to review the technical specifications
- Carefully decide on the tender scope – avoid subdivision of related items into separate tenders, but do not link large contracts with various components into one tender without allowing for presenting bids for parts of the tender, so as not to exclude specialized and smaller suppliers
- Set the estimate value in an evidence-based manner, supported by market research and evidence of usual market prices

**Coordinator of funding of health from ESIF**
(iv) Support health-sector beneficiaries with procurement

To be coordinated with: internal and external subject-matter experts in the field relevant to the tender, Intermediate Body within the MoH and/or Managing Authorities or Intermediate Bodies of OPs addressing health-relevant issues

► Provide beneficiaries with expert consultations on procurement issues and/or mediate contacts on relevant experts who might support beneficiaries in procurement set up and administration.
5.4.6 Monitoring & evaluation

**Monitoring is an essential** part of investment / project implementation as well as of an OP. It is a tool for observing whether intended outputs and results (i.e. values of defined indicators including financials) are delivered and whether the implementation process is on track.

Evaluating has a more complex function, as it not only observes, but assesses and draws conclusions and recommendations. Monitoring and evaluation are tightly connected, as monitoring is essential tool for gathering of data for evaluation purposes.

As suggested by the European Commission Guidance on monitoring and evaluation, these two tools represent a continuous process, the basic function of which is to:

- Help to deliver the investment (i.e. project) in an efficient manner
- Assess whether a programme has produced the desired effects and reasons why or why not

The first function should help focus the investment measures more directly on the priorities. It should control whether or not the investment is in line with the underlying strategic documents, whether it responds to identified needs, whether the mechanisms and principles of synergies, complementarities and concentration are followed.

The second function is relevant mostly during the implementation and after. It should answer the question of whether the public intervention had the intended effect, whether the effect had the intended extent and why or why not it had such an effect as the intended one.

Monitoring & evaluation requirements for ESIF Operational Programmes are **defined by the Cohesion Policy legislation**. The CPR sets the common provisions for monitoring and evaluation in Art. 54-57, and further in Art. 110-114. Moreover, the European Commission Guidance Document on monitoring and evaluation can be used by the Member States for better understanding of monitoring and evaluation.

This chapter is, however, **not primarily focused on ESIF requirements on the monitoring and evaluation of Operational Programmes**, for which guidance exists, but aims to show the usefulness of both monitoring and evaluation also at the level of individual health initiatives or investments, and show that it can **lead towards increased effectiveness of health investment and more accountability for health actions**.

### 5.4.6.1 Lessons learned deriving from analysis of the 2007-2013 practices

Monitoring as such serves to collect essential data on investment progresses and achievements and is essential source of information for further evaluation. Experience of Member States shows how important it is to select relevant indicators for monitoring of health investments. Selection of irrelevant indicators, i.e. indicators that were not able to capture progress achieved properly and level of fulfilment of investments goals, was one of the often problems in health projects identified. Not only selection of improper indicators, but also too vague or unclear definition of indicators significantly limiting effectiveness of this tool and consequently also aimed added value of evaluation, was an issue addressed by participants on the Czech workshop. A good practice example can be tracked

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in Lithuania, where additional and secondary indicators are applied and used for evaluating the changes in quality and accessibility of health care services and in order to analyse the implementation of investment objectives in separate invest fields and means. [For more detail and the list of indicators, see case studies 15 and 20 in the Appendix to this report].

To support Ministries of Health in selection of proper indicators for monitoring of health investments, a list of relevant indicators for the main categories of health investments has been developed. For more details and the list itself, please see WP 3 (3) Set of indicators useful for final evaluation of actions.

As already mentioned, evaluation is a more complex function building on data and information gathered through monitoring and assessing the information. Evaluation could therefore be an effective tool for achieving systemic improvements. The main problems, often addressed during national visits, were the insufficient quality of evaluators. Participants also expressed their opinion, that there is often not a good understanding of the real aim of evaluations. Evaluation should be predominantly used as an opportunity to identify weaknesses of the program / investment and should help the relevant authorities to adopt corrective actions. The experience of participants is that evaluations are often a formal tool not being followed by any improvements.

Analysis also shows that evaluation is often seen very narrowly as something to be conducted in line with the Cohesion Policy legislation to assess performance of OPs. Nevertheless, evaluation itself has potential for broader utilization. It can be used as a management tool to evaluate areas of OP where MA might see opportunities for improvement (e.g. evaluation of implementation structure, evaluation of the system of indicators or evaluation of administrative burden). The evaluation results might then lead to redefining the evaluated areas and streamlining of the system organization.

When properly conducted, evaluation might also improve the quality of public investments. Evaluations of health interventions are especially gaining in importance, as measures such as prevention and health promotion and community-based care, the effect of which cannot be measured in pure numbers through changing values of indicators, become more widely supported.

A good practice in the field of evaluations of preventive programmes can be shown in the example from Poland.\(^56\) The study evaluated the effectiveness of four preventive programmes, and came with strengths, weaknesses and best practice solutions of each of them, which can be used in future project on prevention. [Please see case studies 26-29 in the Appendix to this report for more details].

To sum it up, the main risks related to insufficient monitoring & evaluation with regard to ESIF investment could be seen in the following areas:

- Untargeted support or support of measures, which do not lead to objective achievements
- Inner inconsistency of supported measures
- Lack of progress towards the objectives
- Insufficient drawing of allocation and insufficient pay-out (spending)
- Undrawn allocation at the end of the financing period

\(^{56}\) PSBD grupa WYG: Ocena skuteczności wybranych programów profilaktycznych w ramach Poddziałania 2.3.1 PO KL (Assessment of the effectiveness of selected prevention programs within measure 2.3.1 of OP Human Capital) – English executive summary. Available at: http://www.zdrowie.gov.pl/aktualnosc-2-2112-Raport_ewaluacyjny__Ocena_skutecznosci_wybranych_programowprofilaktycznych_w_ramach_Poddzialania_231_PO_KL.html
The risks are mainly caused by deficiencies of monitoring & evaluation set-up:

- Lack of data, or data of insufficient quality, to monitor progress made
- Unclear definitions of indicators and resulting inconsistency in data, which makes it impossible to evaluate the real impact of the intervention
- Inconsistency of indicators when a linkage between project indicators and programme indicators is missing
- Insufficient concentration of resources on priorities and unclear definition of priorities

On the other hand, correctly carried out and well utilized monitoring and evaluation could serve for following purposes:  

- Evidence-based policy tool
- Accountability and management information tool
- Lessons learned and recommendations
- Verification of theories and assumptions behind policies and actions

### 5.4.6.2 Recommendations for the Ministry of Health for effective monitoring and evaluation

Further in the text, main recommendations broken down according to model roles of the Ministry of Health within programming and implementation of health priorities under ESIF (as identified and detailed in chapter 3) relevant for this stage are introduced.

**Intermediate Body**

(i) Support the Managing Authority in selection of relevant and unambiguous indicators for monitoring purposes of health actions  

*To be coordinated with: Managing Authority, internal and external subject-matter experts in the field of investment focus*

The indicators have to be relevant with regard to the specific objective for which they are set and express the progress achieved in relation to its fulfilment. They also have to be unambiguous, meaning their definition has to be clear and has to allow a uniform interpretation. Preferably, the definition should be consistent with the definition used by the European Commission – for health indicators, see for example DG SANCO European Community Health Indicators.  

- An example of an ambiguous indicator is “the number of people who received training”, if the “training” is not further specified in any way. Such an indicator can result in incomparable and unreliable data, as people who have increased their qualification through an accredited course as well as people who received half-day training of minor importance could be counted.
- Another example is “the number of new jobs created”, if it is not specified that these have to be expressed as a number of full-time equivalent jobs.

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58 DG SANCO: European Community Health Indicators. Available at: [http://ec.europa.eu/health/indicators/indicators/index_en.htm](http://ec.europa.eu/health/indicators/indicators/index_en.htm)
Many indicators will have to be based on the data collected by health care providers and stemming from the self-assessment of patients. In order to get comparable and valid data, the indicator should be defined as specifically as possible.

For more information on indicators, see WP 3 (3) Set of indicators useful for final evaluation of actions.

(ii) Support the Managing Authority in set up of monitoring rules and framework for whole lifecycle of the Operational Programme

To be coordinated with: Managing Authority

► Clear rules for beneficiaries, including defining periodicity of monitoring reports submitted by beneficiaries and required content and form of monitoring reports etc. shall be developed.

► ICT systems might significantly contribute to efficiency of handling with data reported by beneficiaries for monitoring purposes. Such system might, apart from enabling beneficiaries to submit monitoring reports electronically, also evaluate information inserted, monitor developments of key indicators on the level of a call or whole OP and/or monitor beneficiaries’ compliance with the set rules and dates etc.

► Timing and periodicity of the Pre on-the-spot controls shall be planned. Initial schedule might support effective control of the projects, limiting cases where the control is conducted at the end of the project only to meet formal requirements and rules set.

► Monitoring of developments of key indicators on an ongoing basis shall also be ensured and shared between the Managing Authority of OP and MoH to ensure essential inputs for monitoring at the programme level.

(iii) Support the Managing Authority in setting up evaluation plan required by Art. 114 CPR

To be coordinated with: Managing Authority

The European Commission Guidance Document on Monitoring and Evaluation presents which elements should the evaluation plan include. These include, among other:

► Indicative list of evaluations to be undertaken, their subject and rationale

► Methods for evaluation and their data requirements

► Provisions that data will be available and collected

► Timetable

► Human resources to be involved

► Training plan (optionally).

At this stage, the Managing Authority of an Operational Programme, from which investment in health is funded, shall include the Ministry of Health to verify the relevance of evaluation methods related to the

health area, discuss the data availability and decide also on inclusion of health experts in the evaluation process.

The evaluation plan shall be approved by the monitoring committee, as defined by Art. 47-49 of CPR. The monitoring committee shall be composed of relevant representatives of Member State authorities, which should also include the Ministry of Health representatives for OPs, under which health investment is to be funded.

(iv) Support the Managing Authority in evaluation  
To be coordinated with: Managing Authority

- Coordinate with the Managing Authority in defining a specific objective for each evaluation study to make it clear what the evaluation shall assess. Specific objectives can be used e.g. to evaluate the effectiveness of a programme, and to indicate best practices that can be used in the future.
- Based on that, a decision on the methods to be used needs to be made – basic methods for evaluation can include a basic set of evaluation questions, statistical methods for data evaluation, requirements on evidence supporting conclusions, etc. Other methods for soft projects can include surveys or in-depths interviews with programme target group.
- Establish a system through which the evaluation results could be used to serve the intended purpose.

(v) Support improving quality of evaluations through capacity building of evaluators  
To be coordinated with: Managing Authority, coordinator of health funding under ESIF

- Support knowledge sharing and networking of evaluators with health-related expertise
- Provide for their systematic education, not just ad hoc trainings

(vi) Beneficiary

(vii) Ensure compliance with the monitoring rules set by Managing Authority/Intermediate Body  
To be coordinated with: Intermediate Body

- Identify all the duties you have with respect to reporting to IB and designate a person responsible for monitoring duties.
- Ongoing monitoring of key project indicators shall be also used for proper project management. Information shall be assessed and evaluated on an ongoing basis also internally.

Coordinator of funding of health from ESIF

(viii) Support the Managing Authorities/Intermediate Bodies in selection of relevant and unambiguous indicators  
To be coordinated with: Managing Authorities and Intermediate Bodies of OPs addressing health-relevant issues, internal and external experts in the field of investment focus

The selection and definition of indicators is primarily the responsibility of the Managing Authority, nevertheless, the Ministry of Health and health care experts should be invited to help design relevant indicators for specific objectives in the health care area, or under which health care and health gains are

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This is important to ensure that the indicators are relevant, measurable, and that it will be possible to collect reliable and robust data.

(ix) Support the Managing Authorities/Intermediate Bodies in evaluation where investments supported target health care entities

*To be coordinated with: Managing Authorities and Intermediate Bodies of OPs addressing health-relevant issues, internal and external experts in the field of investment focus*

► Ensure qualified capacities at the Ministry of Health that could support the Managing Authorities or Intermediate Bodies of OPs which address health-relevant issues. MoH representatives could support these subjects with a specific health expertise relevant for proper evaluation.

(x) Gather data about health-relevant investments and projects across the ESIF implementation structure

*To be coordinated with: Intermediate Body, strategy unit, MAs/IBs of OPs supporting health-relevant issues and investments*

The coordinator of health investments under ESIF shall gather relevant information and data about health-relevant investments across all OPs. Concentrated data could provide the Ministry of Health with relevant background for monitoring of health sector development and for periodic evaluation of health strategy and possible updates of this key document.

(xii) Use evaluations also for assessment of health strategy, health programmes and individual large projects

*To be coordinated with: Intermediate Body, beneficiary*

Evaluations of Operational Programmes are required by the Cohesion Policy legislation (CPR, Art. 54). However, in order to improve effectiveness and quality of health investment, evaluation conducted also at a lower level is recommended; that is parts of Operational Programmes fully devoted to health and large health projects.

► As the Ministry of Health, schedule evaluations of public health strategy, and when participating in a design of large health investment projects and programmes, plan for evaluations of these projects and programmes.

► The quality of evaluators should be enhanced through the capacity building process.

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5.4.7 Investment sustainability

Sustainability can be defined as the ability to maintain operations, services and benefits during the projected life time of an investment. Sustainable investment can be therefore also defined as an investment which is financially sustainable even after the funding has been ceased, so that it maintains its effects.

Project sustainability is set as a requirement by the Cohesion Policy legislation and has to be ensured in order to maintain the eligibility of the funding. In relation to investing in health, sustainability, however, has to be taken into account also in another broader sense. Sustainability of investment has to be seen as contributing to sustainability of health systems. Such an investment is sustainable only if it is:

- Viable in the long term
- Not imposing increased burdens on public budgets
- Corresponds to the current trends in health care and reflects the trends and needs in population and its health status

Under this concept, investment sustainability means sustainable investment, leading to improved cost-efficiency.

Investment in health does not, however, mean only investment in infrastructure, but also in other sustainable concepts represented by ‘soft investment’. These concepts include the development of clinical, treatment and prescription guidelines, prevention measures, the promotion of healthy lifestyles and patient empowerment, support for active and healthy ageing measures and care deinstitutionalization.

5.4.7.1 Lessons learned deriving from analysis of the 2007-2013 practices

The main problems related to the sustainability of health care projects can be described as following:

- The treatment costs for using the new techniques and equipment are too high to be paid for by the public health insurance and the investment does not yield the intended health benefits.
- There is insufficient pool of patients with health status requiring treatment with a new, and thus often more expensive, equipment (occurs when regional hospitals provide care in the same field of expertise instead of specializing).
- The medical personnel are not trained properly to use the new equipment and techniques.
- Investment does not reflect the current trends in health care, i.e. less need for acute and intensive care, but more need for long-term and follow-up care with regard to the ageing population and transition to more community-based care.
- Little attention is given to promotion and prevention measures, which nowadays account for a minimum of health investment, but have an important potential in terms of savings and lowering health expenditure related to cure and treatment of existing health problems.

In relation to health care investment sustainability, evidence is given in the following examples:

- In Finland, a positive example can be found. The government realized that due to the specific demographic situation, the population over 75 years of age will double by 2030, thus causing the current health system to be financially unsustainable. With the help of ERDF funding, an innovative and far reaching health reform model has been developed. The goal is to save at least 10% in current operating costs of the acute hospital service and deliver a ‘care for the elderly’ service for double the numbers at present but with no increase in operating (staff) costs.
The key components of the reform are to:

► Integrate special / acute and primary care and some social services
► Reorganize service structures within hospitals to improve effectiveness and efficiency
► Rebuild age care residential accommodation to provide better support and promote healthy ageing
► Improve rehabilitation services
► Invest in illness prevention wherever possible

[For more details, see case study 22 in the Appendix to this report]

► In Latvia, a voucher system has been established from which cooperating hospitals, which specialize in a branch of medicine that the other regional hospitals do not provide, can benefit. This system reduces the costs for equipment, ensures sufficient pools of patients which require the treatment, thus ensuring the rateability of the investment, and contributes to a better quality of specialized care in one place where specialized human resources are concentrated [For more details, see case study 16 in the Appendix to this report].

5.4.7.2 Recommendations for the Ministry of Health supporting investment sustainability ensuring

Further in the text, main recommendations broken down according to model roles of the Ministry of Health within programming and implementation of health priorities under ESIF (as identified and detailed in chapter 3) relevant for this stage are introduced.

► Intermediate Body

(i) Support the Managing Authority in selection only of projects that are supported by needs assessment and sufficiently demonstrate long term solution

To be coordinated with: Managing Authority, relevant internal and external subject-matter experts

► Sufficient demonstration that the investment reacts on needs and possible inefficiencies in health care on a national or possibly regional level shall be required.

► Trends in the area the investment targets and evaluate whether the investment sufficiently deals with this trend and thus ensure long-term solution of the need addressed shall be taken into account.

For more details, please see chapter 5.4.4.2 Recommendations under the chapter 5.4.4 Financial planning.

This approach would ensure the link between the unsatisfied needs and investments and thus sustainability of the investments even after the 5-year period required for projects supported by ESIF.
(ii) Support the Managing Authority in selection and implementation only of projects that represent the most effective and useful solution of the need

To be coordinated with: Managing Authority

► Application of adequate assessment methods to assess future operating costs of investment actions needs to be ensured.

► Assessment of whether the operating costs can really be covered by other sources of funding after the ESIF support is ceased (e.g. by public health insurance) shall be conducted. If not, the investment should not be supported without further investigation into its future funding.

► Assessment of expected health outcomes against the costs shall also take place when considering investment sustainability.

(iii) Support sustainability through ensuring that also sustainability in terms of availability of qualified and adequately trained human resources is being assessed

To be coordinated with: Managing Authority

► Lesson learned from the previous programming period which has been quite intensive on ‘hard’ projects mainly in the area of infrastructure modernization and development is that such investments (e.g. in infrastructure and equipment needs) need to be coupled with ‘soft’ investment in human resources in order to gain additional value and synergy from the used funding.

A well-managed combination of hard and soft investment could also be seen in the Slovenian ‘ezdravje’ case study [for more details, see case study 7 in the Appendix to this report]. The project has featured the delivery of three system modules, parts of the national electronic Health Information System – eHIS. These were the national health information exchange telecoms network, the national eHealth portal, and national Electronic Health Record – EHR. Additional deliverables include also an education and training programme for health care professionals on using newly developed eHealth services. Without such training, it would be much slower and more difficult to implement the modules and achieve their widespread use.

(iv) Support prioritization of investment actions according to their sustainability

To be coordinated with: Managing Authority

► ‘Sustainability’ shall be included in project selection criteria when designing the calls for proposals.

► Preferential approach towards projects, which have impact on improving sustainability and cost-effectiveness of health care systems, i.e. projects that will encourage hospitals to specialize and concentrate, and cooperate with other hospitals in other areas of medicine, shall be adopted.

► The following projects shall be promoted:

  ► Introduction of systems monitoring and measuring health care effectiveness
  ► Reduction of unnecessary use of specialist and hospital care, especially acute care, and improving primary health care services
  ► Health prevention and promotion
  ► Adopting health care guidelines and standards

► Beneficiary

(ii) When developing the project, put emphasis on proper project planning to ensure project sustainability
To be coordinated with: Managing Authority, respective relevant Intermediate Body

- Put emphasis on the project planning phase and develop a strong case study to prove project efficiency and sustainability
- Develop and implement only sustainable solutions
- Monitor the project even for internal purposes and take corrective actions whenever necessary

- Coordinator of funding of health from ESIF

(v) Monitor health investments and their compliance with updated strategies

To be coordinated with: relevant department in the role of IB, Managing Authorities and Intermediate Bodies of other OPs addressing health-relevant issues

- Monitor health needs and their development on an ongoing basis and update strategic documents based on up-to-date data
- Discuss latest developments with MAs of OPs supporting health issues to ensure that the calls announced reflect the latest situation
- Monitor implemented health investments and their compliance with trends and up-to-date strategies; in case of significant divergences:
  - Discuss with the beneficiary possible corrective actions
  - In case MoH is the beneficiary, discuss with the relevant department the necessary corrective actions and inform project manager on the side of the relevant MA / IB
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Subgroup 2 sources:


Definitions:

► Community-based care, Institutional care, Prevention:


► Cross-border health care, Health care provider, Health professional, Patient:

► Day care, Inpatient, Outpatient:


► eHealth:


► ePrescription:


► Health care, Health systems, Health technology, Strategic policy framework:


► Health gain:


► Health inequalities:


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A. ESIF programming & implementation structure

1. Lithuanian programming period set up

Introduction of the implementation structure

Lithuania has only one national Operational Programme for the 2014-2020 programming period. The Programme consists of 10 thematic priority axes following European thematic objectives and two technical assistance axes. The Operational Programme for the European Union Structural Funds’ Investments in 2014-2020 thus sets a well arranged, easy to follow and logic user interface and puts Lithuania among more advanced countries in the 2014-2020 programming period preparation.

There is one Managing Authority giving general rules and a framework; various investment priorities are implemented by other ministries, where e.g. MoH is an Intermediate Body responsible for implementation of health care related investment priorities. The EU Support Division stays apart from the official MoH structures to avoid problems with any conflict of interest when MoH is also a beneficiary.

Similarly, there is only one controlling authority concerning European funding, the National Audit Office of Lithuania (NAOL).

Reasoning & main contribution of the model

After the experience with three Operational Programmes in the 2007-2013 programming period, Lithuania went back to the concept of only one OP covering all the investment priorities. A sole national OP better suits the needs of a smaller country such as Lithuania (and the same holds for the rest of the Baltic countries). It provides transparency of the processes associated with European funding and sets a more user-friendly environment for potential beneficiaries, who face less bureaucratic obstacles finding all areas under one responsible authority. Also synergies across various agendas are more easily reachable.

The State Control (NAOL) which is a supreme government audit institution (accountable to the Seimas – the Lithuanian Parliament) contributes, through possessing exclusively the right to carry out an audit of the ESIF financing, for transparency of the controlling mechanism. Given the fact that NAOL possesses exclusively the right to carry out an audit of the ESIF financing, this set-up prevents contradictory conclusions of different controlling authorities which increases overall reliability of the system. Furthermore, it eliminates needless obstacles imposed on the beneficiaries under control which, therefore, can be fully focused on their primary agenda.

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1 Data compiled from public sources and information provided during the national workshop within this project.
2. Evaluation of the effectiveness and quality of the Slovak Operational Programme Health – impacts of the OP and its implementation, the programming period 2007-13

Source of funding
ERDF

Identification of the project
The desired outcome was to answer the main evaluation questions defined by the Managing Authority:

► What progress has been made in the OPH physical implementation at the level of its individual priority axes?
► What progress has been made in the OPH financial implementation at the level of its individual priority axes – is there a real risk of a financial resources loss resulting from the failure to meet the n+3, respectively n+2 rules?
► Is there an implementation system established in accordance with the OPH strategy?
► Have measurable indicators been defined at the project level in accordance with the Programme indicators?
► Does the OPH Monitoring Committee fulfil its tasks efficiently and in terms of the Statute and Rules of Procedure of OPH MC?
► Is the cooperation of OPH MA and MC sufficient, is the principle of partnership observed?
► Are the Technical Assistance financial resources used efficiently?
► To what extent and in what way do the Technical Assistance resources contribute to the efficient OPH implementation?

Project description
The Operational Programme includes indicators at the level of the global objective and priority axes, 28 indicators in total.

Indicators at the level of the individual measures (75 in total) are presented in the Programme Manual. For the purposes of monitoring the implementation of projects supported, MA has defined 44 project indicators included in the official Code list of project indicators administered by the Central Coordination Body. The limited number of the Programme and project indicators properly reflects the close thematic focus of OPH where – besides the Technical Assistance priority themes – the support is linked only to one priority theme (Healthcare infrastructure). At the same time, the relatively low number of indicators improves the comprehensiveness of the indicators system and reduces the requirements of its management and updating.


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Need for the implementation of the project

The evaluation has been intended to evaluate the effectiveness and quality of the Operational Programme Health implementation up until 31 December 2009 and formulate relevant recommendations for the OPH Managing Authority, respectively the OPH Monitoring Committee.

The strategy chosen respects the current trends in development of the healthcare systems in Europe where efficient, quality, and available healthcare is placed at the top of healthcare systems.

Project outcomes

The physical progress achieved in the OPH implementation and its priority axes by the end of 2009 can be considered adequate for the status of the financial resources contracting and drawing. With regard to the fact that by this date only 24 projects had been implemented, including the Technical Assistance projects, the effects of interventions supported could not become evident in a more significant way.

Upon the data provided by OPH MA it can be stated that the financial progress achieved in the OPH implementation is satisfactory. Within the Operational Programme, an amount of more than €125 million was contracted which constitutes a 42.55% rate of contracting of the total ERDF and SB allocation to the Programme. 100% of the allocation to the Priority Axis 3 Technical Assistance is contracted through two projects for the entire programming period. Allocation to the Programme is expected be fully contracted in 2 years.

The Operational Programme Health implementation system in the programming period of 2007 to 2013 shows compliance with the Programme implementation strategy chosen focused on investment in the healthcare infrastructure relevant for the Group 5 diseases. The setting of the system as a whole meets the requirements of the efficient and effective implementation strategy by MA. Moreover, the ability of the individual components (aspects) of the implementation system to support the strategy implementation through two thematic priority axes, respectively demand-oriented and national projects can be considered positively.

Upon the analysis the compliance between measurable indicators at the Programme and project levels is considered sufficient. In the case of most indicators it is possible to identify direct relations of project indicators to the next Programme level - the level of measures. The interconnection was assessed on the basis of the monitoring subject and the definitions of indicators. The availability of definitions for all indicators being used in the OPH context is positively evaluated since they are missing in most NSRF programmes.

Success factors identified

► In the process of the Programme preparation and definition of individual management and implementation processes MA has managed to sufficiently reflect the strategy needs within: institutional provision, programming, publishing of calls for submission of applications for grants, evaluation and selection of projects, monitoring and evaluation.

► In order to efficiently administer the set of project indicators the Central coordination Body has created a Code list of project indicators and defined procedures of entering new project indicators in the code list.

► A significant share in the positive state can be assigned to the ability of MA to provide adequate administrative capacities with a minimum staff turnover. An important aspect in this context is the ability to attract and keep quality human resources. The Technical Assistance resources enable to reimburse the labour cost of staff responsible for the OPH implementation that in general exceed the remuneration of other state administration staff.
The positive aspects contributing to the Monitoring Committee operation efficiency include the MC staff stability where so far a minimum number of MC members have been replaced, as well as high attendance of the MC members at its meetings.

**Challenges / problems during the implementation**

- Insufficient basic strategic framework for transformation of the Slovak health system
- Insufficient efficiency of the Monitoring Committee and lower human resources quality
- Shortcomings of the compliance of indicators which in particular relate to various definitions at the project and Programme levels

**Lessons learned / best practice**

- The basic strategic framework for transformation of the Slovak health system was insufficient. This caused the objectives and strategy of the Operational Programme to be rather vague and general. It limited the potential of systemic changes in the health sector.
- Measurable indicators in general serve for beneficiaries to manage the project by monitoring the progress achieved in comparison to the target values planned, which at the same time provide Managing Authorities with complex information on the state of implementation of individual projects. A functional system of measurable indicators should ensure interconnection and compliance of the programme and project levels.
- Shortcomings of the compliance of indicators relating to various definitions at the project and programme levels constituted a real risk of collection and presentation of inconsistent data. A clear definition of indicators and methodology of their collection should eliminate the basic risks connected with the collection of inconsistent data.
- Limited or marginal monitoring of committee performance negatively influenced the progress in the programme implementation.
- Evaluation of activities in the area of information awareness has not been the subject of the monitoring. OPH information activities should be evaluated in the context of the needs of target groups in the following periods.
- Cooperation between MA and MC focused on the provision of the programme quality implementation requires a certain intensity of contacts and communication between partners. The SF and CF Management System requirement of holding at least one MC regular meeting per calendar year constitutes a minimum intensity of cooperation.
- The Priority Axis 3 Technical Assistance shall serve to support the efficient and effective programme implementation and its strategy.
- The reimbursement of labour cost of the staff involved in the OPH management and implementation significantly contributed to the provision of sufficient administrative capacities and their stabilization.

**Introduction to the case study**

Hungary was the biggest consumer of Structural Fund resources for health infrastructure investment purposes in the EU budget period of 2007-2013 (approximately €1.3 bn. allocated over the 7 years).

Most of the time, projects had double funding; the majority funding came from Structural Fund resources, the minor part came from self-contribution from the applying agency (mostly municipalities). The source of funding was represented mainly by ERDF, but ESF was also involved.

Action plans belonging to regional Operational Programmes were located around two components. One component A was aimed at the development of primary care by establishing local „health centres“, while the other one, component B, dealt with the development of independent outpatient centres at a micro regional level. These two components could be found in each region with the exception of the Central-Hungarian Operational Programme.

**Scope of the case study**

A huge consumption of resources by Hungary represents an experimental approach from the part of EU decision makers through higher or lower Structural Fund commitment to health infrastructure investments in the future based on evaluation of the experiences.

Due to the economic downturn, Structural Fund projects represented the only substantial development resources in the reconstruction of Hungarian health services.

The amount disposable for the 7 year period of the elements is €11.5 million. The total budget of the 2007-2008 Action Plan was €747.58 million. The 2009-2010 Action Plan does not stipulate the planned spending schedule. For the elements of further periods €122.56 million will remain between 2009-2010, that is 16.39% of the total, this way a little more than 81% payment can be realized by the end of 2010.

The Central-Hungarian region does not count as a convergence region from 2007, so the amount and the extent of the support is much more limited than in the other six regions.

Due to the availability of a long-term health insurance reimbursement database there is a unique opportunity to develop the evidence base for capacity or patient pathway planning.

**Challenges / problems during the implementation**

- Lack of broadly accepted and well-known strategy
- Lack of political stability
- Strategic planning and the health policy development process were threatened by political ideology
- Ignoring sustainability factors and previous modelling in the time of preparation and implementation, excess improvising
- Lack of coordination between relevant institutions and even at project level
- Bureaucracy related to the Structural Fund resources access

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▸ Limited expert capacities

**Lessons learned**

▸ Lack of strategic planning resulted in a spending driven approach and in preference for projects lacking an evidence base.

▸ Insufficient attention was given to health gains, so the development resources did finance rather only efficiency gains achievements.

▸ Lack of a coordinated management function caused inefficiencies in a way that the projects addressing various levels of care provision are not complementary and lose (at least partially) their benefits.

▸ Limited expert capacities at all levels endanger the achievement of funding objectives.

▸ Widely accepted strategy would have helped to overcome political instability without major disruptions in the development and implementation process.

▸ Significant degree of bureaucracy for the applicants and beneficiaries caused reduced transparency, generated dependence on external consultants and caused additional expenses.

▸ Imbalance between the magnitude of infrastructure investments and the development of human resources reduced the benefits of the investment.

▸ Insufficient coordination of Structural Funds projects and other development efforts also limited the potential effect.
B. Reforms & projects in the area of health

eHEALTH CONCEPTS

Various eHealth concepts appear among investment priorities throughout Europe either as complex solutions or in the form of individual projects. Below several investments are addressed varying in size and from different Member States. For illustration, complex IT development has recently been launched in Hungary supported under ERDF with the aim of building a functional National Health Information Technology System. The solution consists of three main parts: (i) national unified central solutions, (ii) electronic certified public registries, and (iii) inter-institutional information systems, which are presented below as case studies seven to nine. These are followed by several projects from Slovenia, Estonia, Romania and Sweden, including topics such as the statistical and validation module, electronic patient health record, electronic prescription, telehealth and other.

4. Development of IT systems ensuring central, inter-institutional dataflow, introducing national unified central solutions (Hungary)∗

Source of funding
Social Infrastructure OP [ERDF], Research and Technology Innovation Fund [national fund]

Complex project description
The main aim of the project implemented under the Social Infrastructure OP is to establish the interoperability in terms of teleconsulting, resource allocation and inter-institutional data exchange of institutions providing care. A unified central solution should be reached by:

► Creating an event catalogue
► Implementation of online patient pathway monitoring
► Creating the possibility of digital autonomy and professional registry-based data collection
► ePrescription development

Need for the implementation of the complex project
The initial need for this investment was the achievement of savings through implementation of inter-institutional eHealth services at national level like electronic health record sharing, ePrescription, etc. The identified needs were derived from the Semmelweis Plan for the Rescue of Health Care from June 2011∗ and therefore based on a strategy.

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* Data provided by the National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI) in Hungary.

Individual projects under the investment

► Electronic health record catalogue and sharing
► ePrescription
► eReferral & eAppointment
► Digital Autonomy
► Digital Teleconsultation (Radiology)
► Innovative Data Representation
► Registry-engine

Coordination of the projects contributing to the reform

The consortium is led by the GYEMSZI EU Project Office in cooperation with the eHealth Programme Bureau at the Ministry of National Resources (which also covers the health agenda).

Indicators

► Connectibility of health information systems - 90% - 1 year from finish
► Message types handled by the central system - 25 - at finish
► Accessibility of electronic health record catalogue elements - 90% - 1 year from finish
► eReferrals / all Referrals - 30% - 1 year from finish
► Parallel teleconsultation capability - 2000 - 2 years from finish
► Registries using the new registry engine - 10 - at finish
► ePrescription / all prescription - 50% - 2 year from finish

Length of the reform implementation

January 2014 – June 2015 (September 2015)

Success factors identified

Given the fact that the project is still ongoing, only limited information regarding any evaluation is available. Nevertheless, an obvious success factor is the inter-institutional cooperation.

Challenges / problems during the implementation

► Timing of the project portfolio
► Possible changes of institutional backgrounds

Lessons learned / best practice

The initial phase of the implementation proved that strong state-level coordination is needed. When implementing projects aimed at the use of patient data, legislation support is indispensable.
5. Development of electronic certified public registries and a sectorial portal (Hungary)

Source of funding
Social Infrastructure OP + Central Hungary OP [ERDF], national budget

Complex project description
The main objective of the project was to establish the catalogue of certified sectorial basic data and its registry, which would become the central and authentic basic data source for the information, account and report systems of sectorial institutions, as well as an indispensable tool for accessing the sector’s certified public basic data. In order to create unified sectorial data management and to eliminate redundancy and ambiguity, exclusive data owners with primary responsibilities for certain data circle will be designated. By creating the validator functionality, the data content of the most important reports used in the sector (according to the basic data and rules of the sectorial portal) will be reviewed, standardised (unified) and transferred to the appropriate institution for processing. The bureaucratic procedures and systems of the managing institutions (National Health Insurance Fund – NHIFA, National Public Health and Medical Officer’s Service – NPHMOS, professional registries etc.) receiving the sectorial reports will only change so as to rationalise the data structures used in the sectorial reporting system.

Need for the implementation of the complex project
The need behind this investment was to achieve savings through renewal, consolidation and analogue publication/access of databases, lists, registries, etc. through establishment of a secure national eHealth network. The project responded to needs addressed in the Semmelweis Plan (i.e. a professional concept of the Ministry of National Resources).

Individual projects under the reform
- National e-Health infrastructure development
- Identity & Access management
- Data Transfer
- Data Validation

Coordination of the projects contributing to the reform
The consortium is led by the GYEMSZI EU Project Office in cooperation with the eHealth Programme Bureau at the Ministry of National Resources (which also covers the health agenda).

Indicators
- Number of published lists / registries
- Number of validated and transferred records

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6 Data provided by the National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI) in Hungary.

Percentage of connected care providers

**Length of the reform implementation**

February 2013 – December 2014 (proposed September 2015)

**Success factors identified**

Given the fact that such a complex project requires collaboration and inputs from all involved parties, the key success factor identified was the inter-institutional cooperation.

**Challenges / problems during the implementation**

- Timing of the project portfolio
- Possible changes of institutional backgrounds

**Lessons learned / best practice**

Strong state-level coordination and legislation support proved to be key practices enabling successful implementation of complex projects, especially when many different institutions are involved.

**6. Establishment of regional, functionally integrated inter-institutional information systems (Hungary)**

**Source of funding**

Social Infrastructure OP [ERDF], Research and Technology Innovation Fund [national fund]

**Project description**

The objective of the project is to facilitate the implementation of funds for the development of local IT infrastructure and enable involvement of as many health care institutions as possible. Connecting to the central system induces requirements from the local infrastructure, so the goal is to launch mutually coordinated development activities to help improve the quality of services provided to citizens through the optimal use of available resources. Therefore, the current project develops the requirements for institutions implementing the funds and supervises their fulfilment. The total budget of the project is separated from the Social Infrastructure Operational Programme and from the Research and Technology Innovation Fund in the consortium led by GYEMSZI.

**Need for the implementation of the project**

This project was designed to support the National Health Information Technology System in the form of securing full scale use of central services by endorsing care providers in their need to improve their IT infrastructure to be able to access the central system.

**Indicators**

- Number of connection capable inpatient institutes
- Number of connection capable outpatient institutes

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8 Data provided by the National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI) in Hungary.
Number of institutes capable of horizontal data flow
Percentage of connection capable inpatient capacity
Percentage of connection capable outpatient capacity

**Length of the reform implementation**

April 2014 – September 2015

**Challenges / problems during the implementation**

- Timing of the project portfolio
- Possible changes of institutional backgrounds

**Lessons learned / best practice**

Strong state-level coordination is needed to ensure involvement of health providers in the numbers pledged in the indicators.

7. National eHealth project “eZdravje” in Slovenia

**Source of funding**

OP Human Resources Development [ESF]

**Identification of the project**

The project aims to include facilitating information access for all health care professional groups and citizens, improving planning and management of health care infrastructure and services, and promoting the citizens’ active role in managing their health and healthcare.

**Project description**

The project is understood as an integral part of Slovenia’s health care reform, a highly politicized process aimed at improving the efficiency of the national healthcare system. In addition, the EC has viewed eZdravje as a typical example of a capacity building project that builds on previous interventions financed by EU pre-accession instruments in Slovenia. However, previous health IT projects were not co-financed by the EU.

The project features the delivery of three system modules, parts of the national electronic Health Information System. These are the national health information exchange telecoms network, the national eHealth portal, and the national Electronic Health Record. Additional deliverables include the Slovene National Centre for eHealth and an education and training programme for healthcare professionals on using eHealth services.

The objectives that the Slovene national project aims to meet are the following:

- Offer to all healthcare providers, specialists, GPs, pharmacists unified, secure and reliable access to all key patient information via a standardized Electronic Health Record and other data sets
- Facilitate better planning and management of the national healthcare system on the basis of good quality, accurate administrative, clinical, and economic data

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► Improve access to all necessary information and the ability of citizens to participate in the development of quality healthcare services
► Promote an active role and responsibility of citizens for their health and healthcare services
► Improve access to healthcare for persons excluded due to disability, age or other reasons

**Need for the implementation of the project**

To improve health information processing and the evidence base on a changing national epidemiological profile.

Namely, it is necessary to manage the following issues:
► An ageing population characterized by low birth rates, fertility ratios, and an increase of chronic diseases
► Regional variations in morbidity and mortality, with changes expected at a national population level
► Empowerment and involvement in care delivery on behalf of citizens and patients
► Enhancing the efficiency of the national healthcare system
► Modernization, connectivity, and wider utilization of existing health-related IT platforms to improve disease surveillance, health services planning and delivery

**Project modules:**
► eHealth Network zNET
► Central eHealth Portal zVEM
► National Electronic Health Record Dataset
► National Centre for eHealth
► Education, Training & Promotion

**Project outcomes**

The national eHealth project of Slovenia has been implemented during 2007-2015.

Tenders were prepared for the national eHealth telecoms network, national eHealth portal and pilot projects in the spring of 2010, a year after the feasibility study was completed. The time taken to publish these, and subsequent delays associated with some of them being recalled and legally challenged are understood as significant delays by stakeholders.

By mid-2011, one pilot project, Lab-Poštar, the zNET network implementation, and the Education and Training module had progressed. The National Waiting Lists and Teleradiology pilot projects, eHealth portal and EHR platform were lagging behind. Representatives of domestic stakeholders understand the project to be delayed due to the inactivity of the MoH in 2010 in the first instance. The EC sees the project to be delayed due to the consensual project management framework taking time to deliver key decisions; another reason identified the project’s relevance to the wider Slovene health care reform.

**Total project expenditures**

The Slovene national eHealth project spans the period of September 2008 to June 2015. Its expenditure, estimated at approx. €67 million, is funded by the Slovene Ministry of Health, the European Social Fund, and other Slovene public funds as follows:
► Slovene MoH ordinary budget: €26 million
► ESF: €27 million
► Other Slovene public funds: €15 million
A follow-up project is anticipated in 2015-2023, of approximately €67 million forecasted expenditure.

**Success factors identified**

Innovations anticipated by the expert informants during the operational phase of the eZdravje system modules include:

- Collaboration between ministries in operating the eHealth telecoms network
- Operation of the national Electronic Health Record, and the perceived right and responsibility of individual citizens to access and keep their records updated
- Use of the national electronic health insurance (HIC) user terminals for authentication

Suggestions on how the process could be enhanced include:

- The adoption of a more open approach to designing tenders for the project
- Expertise input to tender design on
  - Using several different technologies that may support a service
  - Possible design architectures
  - Full project lifecycle costing

**Challenges / problems during the implementation**

- The procurement process – preparation of tender documentation, publication and the associated complaints procedure – has proved to be cumbersome, taking much more time than originally planned.
- Key project management decisions adopted through the special project management framework have taken considerable time to be reached and implemented.
- There has been a lack of a fuller engagement with the IT industry as a stakeholder.
- There has been a need for a larger team and setting of project management priorities at the MoH.
- ESF monitoring and reporting have been reported as a complicated process, generating additional workload for those stakeholders concerned (MoH, MA).

A central problem associated with the relative lack of progress of eZdravje is identified in the process of designing, issuing public tenders and awarding project contracts.

Informants interviewed have identified the following areas where uncertainty is currently felt with regard to the short and medium term future of eZdravje:

- Shortage of qualified staff to manage the project at the MoH and other organizations, acknowledged by nearly all stakeholders
- Shortage of experts with the appropriate qualifications and experience required to staff the aforementioned committees and collaborate to advance the project, acknowledged by nearly all stakeholders
- Legal action by IT companies on future tenders of the project
- Pressures on the MoH ordinary budget due to ongoing financial crisis
- EU funds not spent on time and risking withdrawal, due to lack of progress
- Changes in government and policy
Lessons learned / best practice

As already mentioned the main problem put forward in the case study is that stakeholder consultation has not delivered clear, inclusive and well understood contractual arrangements among them as a basis for implementation.

The related lessons learned include:

► Consensual decision making might be too rigid
► Lack of a fuller engagement with the IT industry as a stakeholder can cause major problems in eHealth projects

Other lessons learned:

► Shortage of qualified staff to manage the project at the Ministry of Health and at other organizations and shortage of domestic experts with appropriate qualification and experience hamper project realization
► Procurement problems in the process of designing, issuing public tenders and awarding project contracts, caused major lack of progress. The problems were specifically related to:
  ► Tenders of too large scope, which limited the number of potential tenderers
  ► Lack of clear tender and technical specifications
  ► Focus on one specific technology only
  ► As a consequence, the tenders were legally contested.
  ► EU funds were not spent on time which put Slovenia into the risk of withdrawal due to lack of progress.

8. Estonian eHealth Information System (HIS) statistical module

Source of funding

ERDF

Project description

The goal of the project was to create a database for the Estonian e-Health Information System to enable data analysis and statistics collection. The statistical module would enable a transition from using aggregated data from healthcare providers to personalized data from the e-Health Information System. Initially, the system would enable users to compare aggregated data from service providers with personalized data from the statistical module. Health care providers would be able to provide feedback on the data they sent to the system. Also, surveillance in health care would be improved.

Need for the implementation of the project

The e-Health Information System lacked functionality for analysing and reporting on the large amount of data available. Health care providers lacked the ability to provide sufficient feedback on the amount and quality of data they provide to the e-Health Information System. Health care policy makers needed better input for the decision-making process in the form of personalised national health data.

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10 Data provided by the Ministry of Social Affairs of Estonia, Health Care Department.
Project outcomes

The project main outcome is the creation of a regularly updated database that enables e-Health Information System data to be analysed and reported on – as this functionality was previously lacking. Personalized health statistics are available and interlinked with data from the population register and the Health Insurance Fund. Different user groups can use the data according to their specific needs.

Project progress

► Created database
► Working interface with two other information systems
► Regularly updated data (every night)
► Nine reports created from the database and used by both government agencies and health care providers

Total expenditures

€501,274

Success factors identified

Procurement was conducted according to procedures and in a timely manner that allows time for potential disputes and repeals.

Challenges / problems during the implementation

The project was not finished on time and thus the deadline had to be extended.

Lessons learned / best practice

The main lesson learned from the project is that the duration of larger and more complex projects should be at least 3 years.

9. Validation module for monitoring (Estonia)11

Source of funding

ESF

Project description

Validation module is a module for monitoring the confidentiality of e-Health Information System data use by automatically collecting and pre-analysing e-Health Information System date use logs. Two modules were developed during the project - the validation module and the analysis module. The modules allow authorized users to detect and analyse deviations in e-Health Information System's usage patterns. A procedure for action in case of the misuse of data was also developed; it involves an authorized user notifying proper authorities on suspicion on data misuse.

Need for the implementation of the project

The project aimed to address potential security risks.

11 Data provided by the Ministry of Social Affairs of Estonia, Health Care Department.
**Project outcomes**

The outcome of the project is a working solution that allows minimizing misuse or unauthorized access to e-Health Information System data. Cost effectiveness is achieved by savings on having to deal with security breaches.

**Total expenditures**

€402 430

**Challenges / problems during the implementation**

- One of the biggest challenges was to ensure that procurement is conducted according to procedure.
- The project was implemented at higher costs than originally planned.

10. e-Emergency (Estonia)\(^{12}\)

**Source of funding**

ESF, Estonian national budget, Estonian-Swiss Cooperation Programme

**Project description**

The project involved the development of the e-Ambulance Central System and portal that is part of the complete e- ambulance solution. The central system enables ambulance card data to be used in the eHealth Information System. The portal allows ambulance service providers to manage their employees, brigades, vehicles, departments and branches as well as all users of the portal and their authorization. Additionally, the portal allows ambulance service providers to compile, copy and print work schedules, monitor working hours, compile reports on work load, check the procedure for filling out ambulance cards, compile statistical reports, consult clinical guidelines, input transport orders for patients and compile bills for transport services.

**Need for the implementation of the project**

The project was conceived with the aim of sharing ambulance card data with other health care service providers and creating a database, allowing ambulance service data to be analysed and its delivery to be better planned.

**Project solution**

The e-ambulance solution includes a standardized electronic ambulance card that can be completed at the scene. It includes real time information from the emergency call center and patient medical records from the eHealth Information System. Information from the electronic ambulance card is transmitted to the emergency department in the hospital receiving the patient.

**Project outcomes**

The e-Ambulance Central System and portal were developed during this project. The two are part of the complete e-ambulance solution that enables the use, transmission and collection of e-ambulance cards. The complete e-ambulance solution is still under development.

**Total expenditures**

€493 585

\(^{12}\) Data provided by the Ministry of Social Affairs of Estonia, Health Care Department.
Challenges / problems during the implementation

Several challenges were faced during the implementation:

► Procurement failure
► Problems with interoperability of systems
► Problematic decisions on what should be included on the e-ambulance card
► Change of project manager mid-project

Lessons learned / best practice

The key success factor is compatibility of different systems and creation of a standardized database.

11. Integrated IT system for the Health Electronic File (Romania)

Source of funding

ERDF (81.62%), the national budget

Investment description and objectives

The development of an integrated IT system for the Health Electronic file is a national level project that concerns eHealth centralized solutions. The purpose of this project was to convert patient health files into electronic form, through which Romanian citizens would benefit from a higher quality of health care services. The project objectives were to:

► Improve the efficiency of the Romanian health care system through the implementation of the Patient EHR-Electronic Health File
► Increase the assimilation and degree of development of IT in the Romanian health care system and the development of relevant applications
► Increase interoperability among different health care service providers and also between them and the central institutions, as stakeholders within the Romanian health care system
► Increase the efficiency and the quality of health care services. The information system that is to be implemented through the project will mainly contribute to decreasing the time allocated to a patient consultation, as a result of decreasing the time necessary for administration.

Approach to the investment

The Electronic Health Records (EHR) system is comprised of an electronic records collection, gathered from various sources and locations. Stored data includes medical history, allergies, immunizations, prescriptions and documentation of medical procedures. The content of the relevant medical data from EHR and access to it were discussed and agreed by a commission comprised of representatives of family doctors, hospitals, patients, the Ministry of Health and the National Health Insurance Authority.

The EHR system:

► Stores and locates any diagnosis or therapeutic measure in a standardized manner

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13 Data provided by the Ministry of Health of Romania.
Facilitates optimal presentation of medical concepts, without ambiguities and maintaining the original context

Reflects the chronology of medical events and allows different data views depending on the user

Assures on-line data exchange between health care providers and builds a central inventory where relevant medical data is found

Data exchange is created with the help of modern technologies and web services and has integrated mechanisms to assure a high degree of data security and availability of all subsystems. The patients can check their own health files online and doctors can see a patient file only with the patient’s approval. Any change or access to any section is accompanied by the date, hour and signature of the doctor who operated the changes or who accessed the file. A doctor who has no access to the patient file can only see the abstract for emergency situations.

**Beneficiaries**

- National Health Insurance Authority which has the role of buyer and system administrator and assures the coordination of the project implementation and its integration with the m-electronic card system and electronic prescription system
- The district health insurance authorities whose role is to represent the National Health Insurance House in the territory and assure the coordination of the project implementation in the local areas administered by them
- All Romanian citizens, insured or not, who benefit from health care services according to the current legal framework
- All existing health care units and public health care service providers who contribute to the supply of health care.

**Investment outcomes**

The proposed system centralizes relevant medical data at national level in order to build medical support and health policies. The citizens’ benefits are a strengthened patient statute and the turning of citizens into active agents of the protection and promotion of their own health. Citizens are also provided with health care services without operational, administrative or geographical borders. The institutional benefits lie in the creation of better working instruments for health care personnel. The system aims at making management more effective, and increasing the economical effectiveness of health care services. The implementation of the proposed information system will contribute to the increased efficiency of the public services provided to citizens.

**Indicators**

- Number of medical files introduced in EHR
- Number of health institutions connected to EHR which sent medical documents and which provided:
  - Family medical services
  - Out-patient hospital services
- Number of doctors who submitted information to the medical documents transmitted in EHR

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14 The EHR portal is accessible at the www.des-cnas.ro web address and has a section consecrated to the more frequent asked questions about using the system, by the doctors and by the patients. (http://www.des-cnas.ro/wps/portal/cnas/FAQ).
Length of the reform implementation

The project runs for 39 months: from February 2011 to May 2014. The actual period of implementation for the IT project was 13 months: from March 2013 to April 2014. The project was successfully finalized with the possibility of further developments to complete the activities in this area.

Success factors identified

► Interoperability with existing systems
► Legislative basis
► Promotion of the project at the level of health care providers and patients

Challenges / problems during the implementation

► Very short implementation period caused by litigations concerning the data set (Relevant Medical Data)

Lessons learned / best practice

There are many external agents that can influence or prolong the implementation of the projects, including health care service providers and patients’ associations. At the same time, the collaboration between the IT industry and the representatives of the medical professionals and patients is essential. The elements of medical data security and physicians’ access to it raised the largest number of questions and discussions. There has to be a balance between the embraced technical solution, the legislation for EHR, the expectations and the fears of citizens, the motivation of medical professionals and the dynamic evolution of the whole EHR system.

12. Electronic prescription (Romania)\textsuperscript{15}

Source of funding

ERDF

Project description

This project aims to replace the traditional paper medical prescription with an IT procedure in which data that forms the prescription, issued by the doctor, is electronically submitted and then transferred to pharmacies for dispensing medication to the patient. The announced goals of the system are:

► Real-time monitoring of demand and consumption of medication in Romania
►Elimination of medication and reimbursement errors and any possible fraud in the current prescription system
► Implementation of supervision of medical prescriptions

A set of rules was projected into the specific legislation. It clearly states that use of an electronic prescription is mandatory and that the only method for prescribing and dispensing medication is through the social health care system. Penalties are imposed on those practitioners who do not report their off-line prescriptions in the system.\textsuperscript{16}

\textsuperscript{15} Data provided by the Ministry of Health of Romania.

\textsuperscript{16} Off-line prescriptions are allowed in defined situations.
**Need for the implementation of the project**

Medication is the most commonly-used part of medical care, which makes prescriptions a core medical process with an extremely high volume of transactions. Most prescription processes today are paper-based and managed primarily by health care providers, which usually happens without adequate IT support. As a result, serious prescription errors are widespread (although avoidable), caused by illegible handwriting, overlooked drug interactions, ignored allergies, wrong dosages or frequency of usage.

**Project outcomes**

Over 3 500 000 prescriptions per month are issued and the process of validating dispensed medication to pharmacies is improved.

**Indicators**

- Number of people trained to use the system
- Estimated number of users of the project (practitioners, pharmacists)
- Estimated number of individual beneficiaries

**Beneficiary**

- National Health Insurance Authority of Romania

**Total project expenditures**

- €8 783 000

**Success factors identified**

- Cooperation between all legislative agencies
- Already functional electronic signature system at the practitioner and pharmacist level
- All practitioners and pharmacists were already using computers, no major investment was necessary for electronic prescription purposes.
- The Internet coverage in Romania is very good.

**Challenges / problems during the implementation**

The procurement process was difficult.Procurement appeals were brought by companies that did not participate in those procurement procedures and induced delays.

**Lessons learned / best practice**

- It is important to prepare a coherent legislative framework which has to be operational from the beginning. This legal framework should provide a transition period in which both systems can be used. After this transition period only an electronic prescription can be used.
- There is a need for a functional electronic signature system for practitioners and pharmacists.
- It is very important to communicate with all agencies involved. The system should be very well explained to them, and to the medical software providers, who can be partners in this kind of project, but can also be enemies of the implementation.
13. Sjunet – radiology consultations between Sweden and Spain (telehealth)\textsuperscript{17}

**Source of funding**
Other [non EU SF]

**Identification of the project**
The project aims to address a shortage of radiologists in Sweden. The hospitals involved had implemented the analyzed eHealth application, allowing regular teleconsultations between Swedish patients and specialists in Spain.

**Project description**
Radiology nurses at the Sollefteå and Borås hospitals conduct magnetic resonance imaging (MRI) examinations, and for less urgent cases the images are sent to the Telemedicine Clinic in Barcelona for analysis via the Swedish secure ICT network for healthcare, Sjunet. Borås also regularly sends a number of computed tomography images. This lowers the pressure on the radiologists in Sollefteå and Borås, and shortens the patient waiting lists. The hospitals can not only better cope with the shortage of specialists in Sweden, but are also more flexible in coping with short term peaks in demand.

**Need for the implementation of the project**
There was a shortage of radiologists in Sweden.

**Project solution**
- Allowing regular teleconsultations between Swedish patients and specialists in Spain.

**Project outcomes**
With over 85% of the total economic benefits, estimated at over € 800 000 per year from 2006 onwards, citizens gain significantly from reduced waiting times. The cost per scan analysis for the two hospitals has decreased by about 35%. Net economic benefits were achieved in the second year of operation and are sustainable at over €700 000 per year beyond 2007.

**Core impact:**
- Reduction in waiting times for patients by up to 50%
- Improvement of a key bottleneck and more flexibility in coping with peak requirements
- Example for the development of a truly pan-European healthcare services market
- Improved service quality at a considerably lower cost

**Main beneficiaries:**
- Citizens gain due to reduction in waiting times for MRI and CT image analysis and consultation
- Swedish hospitals benefit from cost savings; no extra local resources are required
- The Spanish Telemedicine Clinic benefits from more sustained business.

\textsuperscript{17} Source: Cikowski, Zbigniew; Lindskold, Lars; Malmquist, Gustav; Billing, Hans et al.: Sollefteå and Boras hospitals; Sjunet, Sweden: radiology consultation between Sweden and Spain, Bonn: February 2006, available at www.ehealth-impact.org.
Success factors identified

Teleradiology is well developed and transferable across member states. It has an economic impact where there are insufficient radiologists or other capacity constraints. However, it is important to acknowledge that success is not just a matter of setting up the service. The TMC service is effective because of the people involved.

Challenges / problems during the implementation

- Time invested in training and quality control, so that the workflow process is very smooth.

Lessons learned / best practice

- Identifying use of ICT as a tool, not a goal in itself, was a key to realizing benefits in health.
- Application development was driven by citizens’ needs and greatly facilitated by existing infrastructures in Sweden and Spain.
- Teleradiology was an appropriate telemedicine application to start with as it is in general easier to integrate in clinical processes and was also a solution to a specific problem in the form of a shortage of radiologists.
- Additional gains proved to be more important in realizing a net benefit of the tool than cost reductions, even though being significant.

TRANSFORMATION OF HEALTH CARE SERVICE PROVISION

The following case studies introduce approaches leading to the improvement of cost-efficiency, support of a cost-effective path of care and the connection of health and social services.

14. Structural reorganisation of the health system (Hungary)\(^\text{18}\)

Source of funding

ERDF

Project description

The project was aimed at structural reorganisation of the health system, supporting a change of functions, making the necessary alignments with new needs, development of emergency care and modernisation of medical equipment. The investments were mainly infrastructural.

Need for the implementation of the project

The reform was needed in order to improve the efficiency of the health system and adapt it system to real needs.

Project outcomes

After the reorganization there is no inpatient healthcare institute in Hungary, where there were no investments at all.

\(^{18}\) Data provided by the National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI) in Hungary.
**Indicators**

- Number of developed health care institutes

**Length of the project**

Completion was very fast compared to previous construction. It took around a year and a half.

**Success factors identified**

- Efficient, centrally managed project coordination. The calls were prepared and approved centrally by the health administration and it proved to be a more effective method compared to previous investments.
- There was a closed circle of applicants – the institutes were not competing with each other and they made proposals working in close cooperation with each other.
- Investments were in line with real needs and the money which the institutes applied for fitted the professional content of the proposal.

15. **Continuity of health care reform, optimization of the health care infrastructure (Lithuania)**

**Source of funding**

ERDF (cross financing for laboratory renovation of public health care institution)

**Investment description**

The investment was aimed at improving health care service quality and accessibility by developing outpatient, nursing, maintenance treatment and palliative care services, and at optimizing inpatient services. The investments were targeted on:

- Development of out-patient services (ambulatory rehabilitation, maintenance treatment and nursing services)
- Optimization of in-patient services (palliative care, day surgery, emergency services)
- Investments into the development of ambulatory services, optimization of in-patient services and development of nursing and supporting treatment
- Laboratory renovation of public health care institutions

The main aims of the health care reform were to improve the quality and availability of health care services constantly as well as to optimize the scope and structure of provided services with regard to the residents’ health care needs. These aims are being implemented by curing widespread illnesses in health care institutions located nearer residents and by concentrating high technology in university hospitals and hospitals where the flows of patients are the highest.

**Need for the implementation of the reform**

In Lithuania, among the identified needs were not only improvement of health facilities provided to outpatient, nursing, maintenance treatment and palliative care services, and better day surgery service quality, but also the

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19 Data provided by the Ministry of Health of the Republic of Lithuania.
need for much faster disease detection, more accurate treatment, reduction of the flow of patients in hospitals, and the possibility of reducing service costs.

**Beneficiaries**

- Health care institutions

**Investment outcomes**

Investments helped to improve the quality and availability of health care services and reduce the differences among them. It was necessary to decentralize and develop primary health care further by bringing it closer to people and strengthen specialized ambulatory help and rehabilitation. Investments renewing the infrastructure of health care institutions providing ambulatory services by modernizing and supplying them with modern equipment and technologies were necessary. This will help to diagnose health disorders sooner, while cheaper and more efficient services, located nearer people, will improve their well-being and increase their working capacity. At the same time it will allow more rational use of the Compulsory Health Insurance Fund and state budget. In order to improve elderly people’s health care services as well as to ensure continuity of health services and proper treatment, it was necessary to integrate nursing and long-term supporting treatment services in general profile hospitals.

**Indicators**

- **Result:** Number of patients to whom the quality and availability of health care services improved
- **Output:** Number of health care institutions which received support
- For monitoring the implementation of OP’s measures, additional and secondary indicators are applied and used for evaluating the changes in quality and accessibility of health care services, modernised by 2007-2013 EU structural funds, as well as to analyse the implementation of investment objectives in separate investment fields and means:
  - Number of nursing and supportive care, palliative care services (days spent in hospital) provided (in order to calculate the indicator, data of information system SVEIDRA is used according to the codes of respective services)
  - Number of established palliative care beds (in order to calculate the indicator, data of personal health care institutions, which received EU structural support, is used)
  - Number of established additional nursing and supportive care beds
  - Number of secondary-level ambulatory and ambulatory rehabilitation services provided
  - Number of new ambulatory rehabilitation procedures, which appeared after implementing the project financed by EU structural support
  - Number of laparoscopy daily surgery services provided
  - Number of patients who underwent laparoscopy
  - Number of daily surgery services provided (separately according to the code of each day surgery service)
  - Number of patients who after daily surgery services did not need an extension of care over 48 hours

**Coordination of the projects contributing to the reform**

The coordination of the projects was sufficient. The Ministry of Health supervised project implementation, considered issues raised during the implementation of projects, and took actions to control the situation.
Length of the reform implementation

The implementation of the projects started in 2008. It will be completed in 2015.

Success factors identified

► The main success factor was the creation of the project planning system that helped to plan detailed projects at start-up stage (the number of projects, list of equipment beneficiaries may buy, maximum rates for contract work, etc.).
► Concentration of investments and complex project approach brings more benefits (one project could cover more than one area).

Challenges / problems during the implementation

► Large amount of legislation and relatively frequent changes
► Applicants’ lack of experience (preparing applications, performing public procurements etc.)
► Investments into additional infrastructure were limited due to limited resources (for example laboratories or sterilization divisions which are necessary for provision of good quality health care services)
► Health care investment effect does not occur quickly, so it is difficult to demonstrate the benefits of it at the end of the programming period.
► Rises in price: a common situation is that after performing public procurements it becomes apparent that it is impossible to acquire contract work / medical equipment / services for the amount of money allocated in the original project budget to these activities or equipment. The Ministry of Health was facing a difficult situation, when about 32 beneficiaries were short of the project budgets. In the end, additional funding for these projects was provided, since other funds were reallocated.

Lessons learned / best practice

► If there is a lack of resources or funds during implementation of the project, it is very important to monitor such a project, as there is a threat to its implementation. The beneficiary, when submitting their commitments, should identify the particular sources of funding yearly, which must be clearly defined, reliable, eligible, sufficient and realistic, together with the supporting documents. Financing of eligible and non-eligible expenses, which do not receive funding, must be assured.
► It is extremely important that during the planning process of the projects all risks are assessed and price rises concerning contract work or medical equipment are foreseen.
► During the evaluation of the project, there must assurance that project activities are planned effectively and expenses are necessary for the implementation of these activities and in line with the market prices or tariffs, which are established in the description of project funding condition.
16. Improvement of in-patient health care infrastructure in Kurzeme regional hospital (Latvia)\(^{20}\)

**Source of funding**

ERDF

**Project description**

The goal of the project is the optimization of the network of health care providers by creating a union of hospitals in order to provide rational and effective usage of available health care resources.

In order to achieve the goal the following activities were implemented:

- Delivery and setup of medical technologies in Ventspils and Talsi hospitals
- Infrastructure development, including:
  - Inner and outer renovation of buildings, including provision of accessibility for disabled patients
  - New building (a unit of hospital) in Talsi

**Need for the implementation of the project**

Placement of premises of the hospital infrastructure and technical condition did not comply with regulations concerning working environment and micro-climate conditions for treating patients in practice. The number of bathrooms was inadequate and did not comply with existing regulations. Hospital premises (including patients’ rooms and bathrooms) were not adapted for patients with disabilities. In addition, to provide high-quality and all necessary medical examinations, new medical technologies were needed.

**Project solution**

The essence of the solution was to merge two hospitals, located in two different cities in one region, to improve the quality of the services provided in these former hospitals (in Talsi and Ventspils). They are now united in one Ziemeļkurzeme regional hospital that allows provision better quality services and split duties between the branches.

**Project outcomes**

As a result of project, the implementing hospital has purchased medical technology, developed infrastructure for children, ophthalmology, otorhinolaryngology, intensive care, diagnostics and pathology, anatomy units and adapted the accessibility for patients with disability.

In the framework of this activity which is represented by the Ziemeļkurzeme regional hospital project, other projects were implemented. As a result, 14 different hospitals were merged, forming six new hospitals with their regional branches. This helped to reform the health care system and reduce the number of hospitals, which was too high, taking into account the number of inhabitants of Latvia and the size of territory. Hospitals which implemented a merger received additional financing in the form of a bonus - an average €609 802 per merged hospital.

\(^{20}\) Data provided by the Ministry of Health of the Republic of Latvia.
Beneficiary
► Ziemelkurzeme regional hospital

Total project expenditures
► €4 938 467
  ► Eligible costs: €4 322 310
  ► ERDF: €3 673 964
  ► Municipality: €51 993
  ► State budget: €570 977
  ► Hospital: €25 376

Success factors identified
► High competency of project implementation unit
► Management team capacity
► Existence of policy planning document at the state level that provided the framework for hospital reform

Challenges / problems during the implementation
► Negative attitude in society about merging of hospitals

Lessons learned / best practice
► Wider scope of information and publicity about the reform of health care was needed.

17. Health voucher (Greece) 21

Source of funding
ESF

Reform description
This reform centers on the provision of a voucher for the long-term uninsured population of the country, which will allow the members of this vulnerable social group to have primary health care medical examinations. Thus, the uninsured will be helped to maintain a good state of health in order to be competitive in the labor market.

Need for the implementation of the reform
The number of long-term uninsured has improved dramatically over the last four years in Greece. These people are usually unable to pay for their primary health care needs, usually ending up neglecting those needs and worsening their position in the labor market.

Reform outcomes
There is a divergence from the target value of 278 935 beneficiaries, with only 13.5% of this target having been achieved six months before the completion of the project. There is also a divergence between the health vouchers

21 Data provided by the Ministry of Health of Greece.
that have been issued and those that have been approved for use, with the latter amounting only to 13% of the
former.

**Coordination of actions contributing to the reform**

The coordination of the individual actions that had to be undertaken for the success of the reform proved not to be sufficient. Important issues, where the lack of coordination became most evident, were the delay of payments between EOPYY and the hospitals, the lack of information about the reform among both the population that could benefit from it and the staff of the hospitals and the incompatibility issues between IT systems.

**Indicators**

- Number of long-term uninsured individuals that have used Health vouchers (output)
- Percentage Health vouchers that have been approved for use among those that have been issued (output)
- Long-term uninsured individuals who have been active in the labor market and have used Health Vouchers (result)

**Length of the reform implementation**

The reform started in January 2014 and will be completed in December 2015. A similar intervention could probably take place in the new programming period as well, as a part of the "Health Safety Net" policy that will be implemented.

**Success factors identified**

The critical factors leading to the success of the reform would be:

- The ability of the local primary health care structures to carry out an increased number of examinations
- Building of a stronger cooperation between the Greek National Organization for Health Care Provision (EOPYY) and the health service providers while overcoming any technical obstacles that may exist
- Spread of information on the reform to both the population that can benefit from it and the health professionals in order to strengthen the faith of all parts in the reform

**Challenges / problems during the implementation**

- The lack of preparation concerning the adequacy of human resources and the complexity of the administrative procedures which led to notable delays in the covering of the expenses of the reform. These are issues which have been found in the Greek health sector for a long time and they should have been taken into account.
- The unwillingness of a significant number of health professionals and long-term uninsured individuals to participate in the reform. This can be attributed to the lack of proper publicity for the project which could be dealt with by taking up more actions to inform the participants of the existence of the project, its potential benefits and the procedures it requires.

**Lessons learned**

The implementation of this specific reform showed the potential administrative problems that have to be faced in such large scale interventions. A potential renewed effort to provide a Health Voucher to the uninsured or other such health benefits to vulnerable groups of the population could take advantage of this experience and base its targets on more data. It also showcased the importance of communicating properly about an intervention and the
The fact that the scale of its scope and the importance of the potential gain from it do not necessarily guarantee its success.

The idea behind the intervention itself, which is to provide health services to a large part of the population which would not be able to receive them otherwise, is something that could prove useful to other Member States that have had their percentage of long-term uninsured population rise rapidly during the current financial crisis.

Another good practice that could be shared is also the utilization of data from three different national information databases in order to accurately assess the number of long-term uninsured.

18. Development of family doctors network (Latvia)

**Source of funding**

ERDF

**Project description**

The project was aimed at improving GPs’ accessibility in territories and municipalities, renovating premises and modernizing equipment in the primary health care providers’ network. The support was provided to GP practices, with additional, local improvements, including patient waiting rooms, procedure rooms, registration, dressing rooms, bathrooms and accessibility for disabled people.

**Need for the implementation of the project**

There was insufficient equipment and inadequate premises in GP practices.

**Beneficiaries**

Final beneficiaries of this activity were GP practices and health care centres that provide premises for GPs.

**Project outcomes**

The project gave an opportunity for GPs to improve the condition of their practices, which was also reflected in the patients. The project allowed improvement of the services provided by GPs and improved accessibility.

**Total expenditures**

There were 528 GPs supported in this activity for a total of €3 842 477.

**Length of the implementation**

There were four open calls in this activity. One beneficiary could implement one project in one GP practice. Average implementation period of a project was two years. The deadline for implementation is June 30, 2015.

**Challenges / problems during the implementation**

- There were problems identified in project administrative capacity, since most of the beneficiaries were GPs with very little or no experience in project implementation and administrative work.

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22 Data provided by the Ministry of Health of the Republic of Latvia.
19. Health Development Offices (Hungary)

**Source of funding**

ERDF

**Project description**

The infrastructural project of regional development programmes related to outpatient care service unit developments or reconstruction has the following goals:

- Set up the national network of HDO
- Create the infrastructural and methodological background of the operation of the Offices
- Set up coordination forms and official functional relationship with existing health care institutions
- Create real functional roles of the offices within the health care institutional system

**Need for the implementation of the project**

The Health Development Offices (HDO) provides risk-based preventive health care service connected to outpatient institutions in an integrated manner, which is a missing area in the Hungarian health care system. The HDO also takes care of coordination and communication activities with the involvement of general practitioners, and other organizations carrying out health promotion programmes on a daily basis.

**Project outcomes**

Operational and working conditions for HDO were created.

**Indicators**

- Number of HDO put into operation

**Length of the project implementation**

It is still an ongoing project which started in 2011.

**Success factors identified**

- Involvement of national screening programmes in preparatory activity
- Participation in life style coaching programmes like physical activity promotion, dietary guidance, anti-smoking campaigns
- Individual case-based prevention services

**Lessons learned / best practice**

Lesson learned:

- Health promotion activity must have a permanent character and at least one year of support services in order to reach lasting lifestyle changes.

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23 Data provided by the National Institute for Quality- and Organizational Development in Healthcare and Medicines (GYEMSZI) in Hungary.
Best practice:

► The HDOs’ focus on the importance of raising awareness of prevention rather than on institutional health care services. In this way the HDOs’ main task is to fulfil the missing primary prevention functions of the health care system.
► Adequate training programmes for health involvement of GPs into prevention programmes
► Primary prevention activities:
  ► Basic primary prevention services such as provision of information, health awareness motivation services, etc.
  ► Coordination activity and network building with local existing civil organizations and local initiatives, utilization of local good practices
  ► Counselling and training activity on primary prevention topics for local social and health professionals (e.g., teacher, social worker, school psychologist, social worker, family support specialist, etc.).
  ► Based on individual health base-line survey provision of case management towards available health prevention programmes or special health care treatments.

20. Optimization of infrastructure of psychiatric health care services (Lithuania)²⁴

Source of funding
ERDF

Identification of the investment

The investment consists of four main parts:

► Establishment of mental day centres for complex help to children and families
► In-patient psychiatry modernisation (modernise acute psychiatric hospital chain in accordance with the modern requirements of the EU)
► Establishment of mental day centres
► Establishment of crisis intervention centres

Reform description

Objectives of the reform were to:

► Develop children’s and teenagers’ psychiatric health care services
► Establish five day centres of complex help to the child and his family by supplying them with necessary equipment and investing in transport for provision of mobile help
► Early rehabilitation services centre
► Psychiatry centre for pre-school and younger school-age children with an in-patient department and day in-patient department

²⁴ Data provided by the Ministry of Health of the Republic of Lithuania.
► Teenagers’ psychiatry centre with an in-patient department and day in-patient department
► Day centre for children with autism
► Psychosocial rehabilitation centre for children with behavioural and social disorders as well as those who are addicted to psychoactive substances
► Modernise the chain of acute psychiatric wards according to the contemporary EU requirements by investing in equipping premises of in-patient departments of acute psychiatry with modern measures designed for special care as well as by supplying them with necessary medical equipment
► Establishment of mental day centres (develop mental health services, enhancing access to mental health services)
► Establishment of crisis intervention centres to ensure early intervention in crisis situations, disturbing human mental health

Need for the implementation of the reform

The aim was to:
► Create a complex psychiatric health care system allowing stronger psychiatric health of society efficiently and rationally
► Carry out prevention of illnesses
► Provide thorough help and social services to persons with physical and behavioral disorders
► Ensure effective and priority investment in a psychologically strong society characterized by a large social capital and low level of social pathology
► Reduce the number of cases of violence or other destructive behaviour directed towards oneself or others

Reform solution

Psychic health requires quantitatively and qualitatively new investments in order to ensure social and economic development of the country and the quality of people’s lives. In order to increase the availability of psychiatric health care services as well as to avoid treating persons in in-patient departments it was necessary to decentralize psychiatric health care services. If a patient’s psychiatric condition allows, treatment should occur in a day centre. In-patient services should be provided only in especially severe cases of exacerbation of psychiatric illnesses.

Reform outcomes

A complex psychiatric health care system was created, which allowed stronger psychiatric health of the society efficiently and rationally. Investments were made in infrastructure of flexible psychiatric health care services by establishing day centres of psychiatric care in addition to already created infrastructure of psychiatric health center at a municipal level as well as by supplying them with adapted premises and necessary equipment.

Specialized and extremely necessary services to children and teenagers with psychiatric and behavioral disorders have been provided insufficiently until now. While treating frequent children’s psychiatric health disorders and preventing them becoming severe social failures (attempts to commit suicide and suicides, delinquency, addiction to alcohol and drugs), it was necessary to create regional centres providing a complex of modern psychosocial services. Crisis intervention centres in the biggest cities of Lithuania (Vilnius, Kaunas, Klaipėda, Šiauliai, Panevėžys) were established.

Indicators
► Result: Number of patients to whom the quality and availability of health care services improved
Output: Number of health care institutions which received support

For monitoring the implementation of OP’s measures, additional and secondary indicators are applied and used for evaluating the changes in quality and accessibility of health care services, modernized by 2007-2013 EU structural funds, as well as in order to analyse the implementation of investment objectives in separate investment fields and means:

- A variety of services provided in comprehensive mental health centers of integrated support for the child and family (in order to calculate the indicator, data of information system SVEIDRA is used according to the codes of respective services, a variety, number and dynamics of services provided is evaluated)
- Number of beds in the wards before and after modernization (in order to calculate the indicator, data of personal health care institutions, which have received EU structural support, is used. It is submitted in the final project implementation report)
- The ratio between the day ward and its number of services (in order to calculate the indicator, data of information system SVEIDRA is used according to the codes of respective services)
- Number of services provided in the crisis intervention centers (in order to calculate the indicator, data of information system SVEIDRA is used according to the codes of respective services)

Beneficiaries

- Health care institutions with a psychiatry department (establishment of mental day centres for complex help to the child and families)
- Health care institutions with acute psychiatry department (in-patient psychiatry modernization)
- Primary mental health care institutions (establishment of mental day centres)
- Health care institutions with psychiatry department (establishment of crisis intervention centres)

Total project expenditures

Signed contracts value €19 690 000

Success factors identified

- Existence of a main strategic document with clear vision of requirements
- Strategic programme "Contribution to reduction of distress and mortality due to main non-infectious diseases: cardiovascular diseases, oncological diseases, traumas and other external causes of death, mental disorders" was implemented
- Created project planning system (detail projects at start-up stage)
- Concentration of investments

Challenges / problems during the implementation

- Legislation related to EU SF adopted later than planned and it had impact on the commencement of the programming period
- Lack of experience in setting performance and impact indicators

Lessons learned / best practice

- High-quality psychiatric health care services are impossible in the community without modern and efficient in-patient help in cases of acute conditions.
- Establishment of day centres brings services closer to their users
Availability of these services as well as secondary and tertiary prevention of illnesses improve, which causes the reduction of the need for in-patient services and economic benefit, allows users of services receive thorough services

Day centres promote development of communal services

In day centres, patients are treated more intensively and their ties to their families and ordinary environment are not broken.

21. Mental health reform (Greece)\textsuperscript{25}

Source of funding
ESF, ERDF

Reform description
The reform has targeted the following topics:

- Psychosocial rehabilitation
- Prevention of new patients becoming chronic
- Rehabilitation of persons with mental health problems living in the community
- Ensuring the continuity of care
- Further transformation of remaining psychiatric hospitals
- Achievement of full coverage of care needs in community structures

Need for the implementation of the reform
The reform aimed at addressing / improving the unacceptable conditions of patients in mental health facilities, and at ensuring the quality of life of these residents.

Individual projects under the reform

- Mental health dormitories
- Mental health hostels
- Protected apartments for mental health patients
- Mental health centres
- Mobile mental health units
- Psychiatric Department at General Hospital
- Hostels for short stay
- Social cooperatives

Reform outcomes
More than 3500 people were de-institutionalised and returned to the community, their homes and families and out of asylums.

\textsuperscript{25} Data provided by the Ministry of Health of Greece.
**Indicators**

- Number of asylums that have been closed
- Number of persons de-institutionalised
- Number of new mental health facilities
- Percentage of trained professionals in mental health

**Coordination of the projects contributing to the reform**

The mental health reform was coordinated by the Directory of Mental Health in the Ministry of Health supported by an ESF co-funded mechanism. The evaluation of Mental Health Reform showed that the coordination was sufficient.

**Length of the reform implementation**

From 1997 to 2016 (the estimated end of the reform).

**Total project expenditures**

The reform in its complexity was funded in following periods:

- 1994-1999: ESF and ERDF funds equivalent to €45 500 000
- 2007-2013: €228 000 000 [ESF]

**Success factors identified**

- Political commitment
- EU funding
- Effort of mental health professionals
- Change of public opinion and culture (promoting anti-stigma ideas)

**Challenges / problems during the implementation**

- The initial reactions of local communities
- Underfunding of national budget in some periods
- Quality management of care provided
- Low efficiency

**Lessons learned / best practice**

- Lessons learned from the implementation of the reform are that strong political commitment and support by the community are necessary for success.
- The mental health cooperatives proved to be the best practice which deserves to be shared.
22. Kymenlaakso Region, Finland

Source of funding
ERDF

Identification of the reform
The reform of existing structures, systems and scope of health care services, adapting to a rapidly-changing economic and service-oriented outlook.

Reform description
A new approach to capital (infrastructure) investment holds the key to effective change. The first principle of reform was a move towards an integrated model of care, moving on from separate sectorial resources to a shared resource structure. The model adopted was vertical integration focused on redesigning elderly care services and reshaping acute hospital services – within existing budgets – to achieve a targeted improvement in operational efficiency.

With the help of ERDF funding, an innovative and far reaching health reform model has been developed with the following objectives: save at least 10% in current operating costs of the acute hospital service and double the numbers at present of the delivery of a care for elderly service with no increase in operating (staff) costs.

The key components of reform are to:

► Integrate special/acute and primary care and some social services
► Reorganize service structures within hospitals to improve effectiveness and efficiency
► Rebuild age care residential accommodation to provide better support and promote healthy ageing
► Improve rehabilitation services
► Invest in illness prevention wherever possible

Need for the implementation of the reform
► Financially unsustainable health system
  ► Significant demographic change
  ► Outmoded and poor quality health infrastructure
  ► Operational service efficiency and effectiveness increasingly overwhelmed by the scale of these issues
  ► Increasing health costs set against reducing resource availability

Combination of changing service demand due to an ageing population and a shift of younger working citizens to major urban centres, both of which have significant economic impact, has necessitated a reappraisal of health strategy and a decision to reform the health care model. If no action is taken the cost of the current model of service delivery will increase by 35% whilst at the same time resource availability will decrease by 5%.

26 Source: Euregio III Case Study – Kymenlaakso Region, Finland. December 2011.
Individual projects under the reform

Kymenlaakso (Kotka) Central Hospital - transformation of the site and services moving from a conventional stand-alone hospital to a fully integrated health service centre (wellness park) incorporating a diverse, and complementary range of healthcare support.

In parallel, a similar concept is now being developed for the city (municipality) of Kuovola. It is at an earlier planning stage but in many respects will mirror the Kotka plan.

Reform outcomes

The conceptual planning is complete (December 2011 status):

► Regional plan for specialized and acute care
► Content and structure of the wellness park
► Local urban plan
► Reorganization of medical work and acute/primary care integration
► Outline infrastructure design

A more detailed design, construction and implementation plan is currently being commissioned.

Plus a similar concept developed for the city of Kuovola.

Coordination of the projects contributing to the reform

The project was financed through a combination of EU ERDF funding and match funding from the Finnish Government and the local Region.

Success factors identified

The Kymenlaakso project demonstrates the close alignment with overarching guidelines and targets, as follows:

► Europe 2020
  ► Healthy ageing
  ► eHealth as the connectivity component in integrated care
  ► Social inclusion as a horizontal priority
► Cohesion Policy guidelines
  ► Structural reform
  ► Economic growth and sustainability

Furthermore the concept is firmly in accordance with the EU Council Conclusions (6 June 2011).

Challenges / problems during the implementation

► Higher operational costs than expected in investment planning
  ► Too high treatment costs for using the new technologies and equipment
► Insufficient pool of patients requiring treatment with new more expensive equipment
► Medical personnel not properly trained to use new equipment
  ► eHealth and treatment and diagnostic methods
► Investments not reflecting the current mid- and long-term trends in health care
► Little attention given to health promotion and prevention programmes
Lessons learned / best practice

The following were identified as factors increasing the efficiency of the project:

► Measure and monitor sustainability of health investment before its implementation
► Assess future operating costs of investment actions
► Prioritize investment actions according to their sustainability - include “sustainability” into project selection criteria
► Assess sustainability in terms of availability of qualified and adequately trained human resources
► Promote projects aimed at: monitoring healthcare effectiveness
► Adopt healthcare guidelines and standards: reduction of unnecessary use of specialists; health prevention and promotion

EDUCATION IN HEALTH CARE

23. Effective use of ESF to support human resources in healthcare from Operational Programme Education in Slovakia

Source of funding

OP Education [ESF]

Identification of the project

Targeted support of specialized studies focused mainly on GPs and pediatrists.

Project description

The project was realized under the OP Education priority axis supporting specialized studies of professionals in areas which have been, in the long-term, undersized.

Ministry of Health in Slovakia used the sources to prevent risk of shortage of GPs and pediatrists in an approximately 10 year horizon that has been identified based on the analysis conducted. The support consisted in funding rewards for teachers, tutors and outpatient specialists who trained students as well as fees for health professional in the specialized study involved in this training programme.

Similar projects were realized at Slovak regions addressing specific geographical needs of each region.

Need for the implementation of the project

► Demographic structure of physicians in SK
  ► Average age of physicians - 47,7
  ► Average age of GPs and pediatrists - 54
► Brain drain

27 Source: Slovak Ministry of Health.
Out of 547 graduates 60% leaves SK and works abroad

The needs to strengthen the capacity of GPs and pediatricians and increase the attractiveness of these specializations among medicine students were identified mainly based on an analysis of the demographic structure of physicians in Slovakia.

Project outcomes

The project was well received by the public as well as the targeted beneficiaries (especially regions) as an effective way to support the replenishment of critically understaffed health professions and generally improve access to health care and quality of health care staff.

Slovak Ministry of Health will continue in similar support even in the future using mainly national sources.

Beneficiary

- Self-governing regions, Universities
- Partners involved: Teaching hospitals, Outpatient specialists

Success factors identified

- Easy-to-follow project set up
- The project was addressing the real needs of the system
- Real interest among beneficiaries and recipients

Lessons learned / best practice

The following was identified as factor increasing efficiency of this tool:

- Greater involvement of young university graduates
- Longer term (multi-annual) support
- Concentration on the most important specializations
- Involvement of self-governing regions in future placement of residents
- Greater financial support from national sources

24. Support for the training of medical personnel in the field of geriatric care (Poland)28

Source of funding

ESF

Project description

The aim of the project is to enhance care for older people in Poland by improving the competencies (by trainings) of health care professionals in the field of geriatric care.

28 Data provided by the Ministry of Health of Poland.
**Need for the implementation of the project**

Demographic trend resulting in population ageing caused a need to ensure appropriate care at primary health care (PHC) level for growing number of elders to make them able to function independently in their community. Health problems of older people result in greater demand for health care, nursing, recuperation and assistance.

Additionally, the project addresses following deficits:

- Insufficient knowledge of health professionals on geriatric care
- Lack of holistic approach in current trainings and courses on elderly care
- Inadequate system of geriatric care resulting from the disintegration and fragmentation of its stakeholders and insufficient number of specialists in this field
- Insufficient knowledge of healthcare system policymakers on the needs of elderly

**Project solution**

Apart from educational activities prepared mainly for target groups, information and promotion actions are also included in the project - media campaign and regional conferences aiming at dissemination of information on the project directed to health care professionals who take care of elders at PHC level, promotion of participation in trainings as well as spreading among society (including policymakers, representatives of authorities establishing health care entities, representatives of payers, health care entities’ managers) of knowledge on ageing and challenges for health care system resulting from it. Evaluation of geriatric care system is planned for years 2013 and 2014. It will be a basis for preparation of principles of comprehensive geriatric care at PHC level including improvement of continuous education system on geriatric care for health professionals.

**Project outcomes**

Project has not finished yet, but its coveted outcome is that trained health care professionals will gain better adaptation skills to ageing society phenomenon to ensure comprehensive and professional healthcare for older people in their communities.

**Indicators**

- Number of people who received the geriatric care training:
  - Primary health care physicians
  - Nurses during specialisation courses
  - Medical carers
  - Community therapists
  - Physiotherapists in the field of geriatric physiotherapy
- Prepared training curriculums for primary health care physicians, nurses, physiotherapists, medical carers, community therapists

**Beneficiary**

Ministry of Health – Department of Nurses and Midwives

**Total project expenditures**

€4 960 000
**Length of the implementation**
January 2012 – June 2015

**Challenges / problems during the implementation**
Lack of interest of primary health care physicians has been a problem encountered during project’s execution. Due to low participation rate among PHC physicians Department of Nurses and Midwives of MoH not only continued information and promotion campaign but also took other actions to make this professional group more interested in proposed trainings (e.g. request to Vice-Chair of the Polish Chamber of Doctors for co-operation in spreading information on trainings using websites of the Chamber and regional chambers).

**25. Development of qualifications and skills of nurses in the context of demographic changes being the consequence of an ageing society (Poland)**

**Source of funding**
ESF

**Project description**
The aim of this project is to enhance comprehensive nursing care for older people through the organisation of specialist courses on the care of patients with the most common age-related diseases.

**Need for the implementation of the project**
The current and forecasted demographic situation in Poland foresees a lack of nurses with qualifications needed for providing comprehensive care for older patients, which results in deficiencies and low quality services in this field. Currently post-graduate education system for nurses envisages geriatric care courses as a part of specialist training only. Existing barriers in access to this kind of education caused a growing deficit of geriatric nurses.

**Project solution**
The curriculum of specialist courses on comprehensive nursing care for patients with the most common age-related diseases developed in this project will be an innovative product used for post-graduate education of nurses. The training performed as part of this project is the first of its kind. It prepares nurses for care for geriatric patients in a comprehensive manner.

**Project outcomes**
As a result nurses will improve their qualifications in terms of comprehensive care over patients with the most common age-related diseases and the post-graduate training offer will be broadened and adjusted to the growing demand for nurse care over elderly people. The project is still ongoing.

**Indicators**
- Developed curriculum of specialist courses on comprehensive nurse care for patients with the most common age-related diseases

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29 Data provided by the Ministry of Health of Poland.
Number of trained nurses

Beneficiary
Center for Post-graduate Training of Nurses and Midwives

Total project expenditures
€3 749 000

Length of the implementation
January 2012 – June 2015

Lessons learned
Nursing personnel is a group which eagerly participates in various courses and trainings. The beneficiary did not encounter any difficulties in recruiting participants.

WORK RELATED AND OCCUPATIONAL DISEASES, HEALTH PREVENTION

In Poland, four prevention programmes were implemented in the 2007-2013 programming period under the OP Human Capital. We present the programmes as case studies below together with the outcomes of their evaluation. The evaluation had four specific objectives: (i) to evaluate the effectiveness of prevention programmes, (ii) to indicate best practices that can be used in the future on projects related to the prevention, (iii) to evaluate the cycle of trainings, conferences, workshops and sessions for medical personnel, and (iv) to develop a study for the needs of the 2014-2020 programming period of the model support for prevention activities.

In the 2007-2013 programming period, preventive programmes focused only on work-related diseases, which constitute merely 1,6% of all first-time incapacity for work statements – while there are a lot more health-related causes of being professionally inactive than only work-related. Therefore, the key lesson learned during previous programming perspective shows need to concentrate on interventions aimed at essential health and demographic deficiencies, foremost by broadening the scope of diseases addressed in preventive programmes to health areas other than work-related (such as cardiovascular diseases, oncology etc.). Another important aspect that seems to mitigate the results of realized preventive programmes is the lack of financing of diagnostics, which in 2014-2020 should be considered eligible in order to boost the impact of the actual support provided under the given programme.

26. Prevention programme in the field of hearing protection (Poland)

Source of funding
ESF

Identification of the project

The objective of the prevention programme for hearing protection was to develop interventions related to the implementation of measures aimed at reducing the exposure of workers to injury or loss of hearing in the workplace.

Project description

As part of this programme there were developed inter alia manuals for employers, health and safety services, staff of the State Labour Inspectorate and the State Sanitary Inspection, employees and physicians, as well as computer application, questionnaires and form specimen. In addition, there were conducted training courses / workshops for doctors, nurses, key trainers and employees of the health and safety services.

Criteria for inclusion of employees to the hearing protection programme were based on existing legislation, developed algorithms for the assessment of hearing loss and the risk of hearing damage, as well as further research questionnaires among employees.

Under the programme the following methods of preventive actions were proposed:

► Noise measurements and identification of jobs and workers requiring protection against noise,
► Systematic control of exposure to noise and other ototoxic harmful factors in the work environment,
► Selection and provision of employees with personal protective equipment,
► Implementation of medical prevention in terms of damage to workers' hearing.

According to the evaluation conducted, they include in a comprehensive manner the problem of prevention that is at service to hearing protection, due to the wide range of trained customers, as well as due to the proposed actions.

Success factors identified

► Clear description of interventions proposed
► Clear definition of the roles of different participants in the programme
► Development of other necessary documents such as manuals, questionnaires, research protocols, description of the computer application, multimedia presentations and educational video

Challenges / problems during the implementation

► Lack of information on costs and cost-effectiveness of the proposed solutions
► The timetable for implementing the programme in a specific workplace requiring fine-tuning and adaptation of activities provided in it, as well as the specificities of a company

Lessons learned / best practice

The following solutions can be considered as "best practice":

► Analysis of risk factors is based on a thorough analysis of the literature
► Conduct of training and awareness-raising activities among employees
► Greater cooperation between physicians-preventers and safety services in the field of prevention.
27. Prevention programme in the field of diseases of the musculoskeletal system and the peripheral nervous system (Poland)\textsuperscript{31}

**Source of funding**

ESF

**Identification of the project**

The objective of the prevention programme for diseases of the musculoskeletal system and the peripheral nervous system was the development of interventions related to the implementation of measures to improve the health of employees by reducing their exposure to risk factors associated with the musculoskeletal system and the peripheral nervous system.

**Project description**

The preventive programme for the diseases of the musculoskeletal system and peripheral nervous system included, among others:

- Development of a comprehensive prevention programme
- Monitoring the health of workers
- Development of educational materials for specific groups of recipients (physicians, PIP, PIS, BHP employees, and employers)
- Trainings and workshops for representatives of medical services and key trainers
- Informational and educational meeting for employees
- Development of multimedia teaching materials

The programme is mainly focused on the research that may be useful in the primary prevention (in healthy subjects) and secondary prevention (for patients diagnosed with diseases of the musculoskeletal system and peripheral nervous system). The proposed methods of operation under the programme are directed mainly to providing education and activities for raising awareness in certain occupational groups through systematic and comprehensive developing of educational materials.

There were also presented general recommendations as to the scope and manner of conducting early diagnosis by doctors or training of employees.

As part of the programme no criteria were provided for the selection of the risk group that will participate in the programme (in addition to the indication of professional groups) and no criteria for the selection of the recipients of the study conducted under the programme, either. Due to the framework project and research and educational character of the described prevention programme, no specific criteria (or groups of criteria) were provided to include recipients of programmes, nevertheless there were indicated general groups of recipients that should be covered with the programme (employees, employers, workers of health and safety services, doctors of Primary Health Care).

The communication methods specified in the programme included education of physicians and others involved in the care of the employees in the form of training. There were also conducted informational and educational meetings with staff in their workplaces. All information about the programme and educational materials are to be found on the Internet.

**Beneficiary**

Physicians and other subjects involved in the care of the employees.

**Success factors identified**

- Comprehensive study on professional identification of business and partly non-business factors
- Development of comprehensive prevention program consistent with current scientific evidence and in accordance with the inclusion of a broad audience
- Survey questionnaire, targeted to specific risk factors and identification of symptoms among workers
- Wide scope of professional groups covered with the training
- Development of guides for doctors and health and safety staff concerning risk factors, occupational diseases, responsibilities of the various professional groups together with a description of some interventions

**Challenges / problems during the implementation**

- Lack of an accurate determination of target groups of programmes, depending upon the intervention
- Failure to determine the measures of impact of the programmes
- Lack of materials separately developed for specific target groups
- No timetable for the programme, no monitoring of the programme progress and achieving the intended results
- Lack of information on costs and cost-effectiveness of the proposed solutions
- Lack of information on the effects of implementation of the prevention programme

**Lessons learned / best practice**

The following solutions can be considered as "best practice":

- Analysis of risk factors based on a thorough analysis of the literature
- Training and information activities conducted among employees about the dangers and risk factors related to the diseases of musculoskeletal system and peripheral nervous system
- Greater cooperation between physicians-preventers and health and safety staff as well as the State Labour Inspectorate services in the field of prevention.
28. Prevention programme in the field of cardiovascular diseases (Poland)\textsuperscript{32}

Source of funding
ESF

Identification of the project
The objective of the programme was to prepare and implement a prevention programme for cardiovascular diseases, taking into account environmental factors at work, and oriented on selected professional groups.

Project description
The prevention programme for cardiovascular diseases included the following activities:

► Identification of the factors present in the working environment, responsible for the development of occupational diseases
► Understanding of the needs, expectations, and the most appropriate form of implementation of the prevention programme for cardiovascular diseases
► Preparation of educational and informational materials on risk factors for cardiovascular diseases
► Development of the comprehensive prevention programme in the field of cardiovascular diseases
► Provision of electronic educational and informational materials on the website

The review of the literature identified the following risk factors for cardiovascular diseases: classical (e.g. smoking, physical activity, obesity, cholesterol, and diseases such as diabetes, hypertension and obstructive sleep apnea), and occupational and environmental ones (physical, chemical, and factors arising from the nature of work).

Due to the nature of the programme a general diagram of preventive measures is presented, including both professional and classic risk factors. However, the application of the proposed interventions is described in very general terms - all related to classical risk factors for cardiovascular diseases and prevention of stress as well as broadening the scope of preventive examinations.

The communication methods specified in the programme included education of physicians and others involved in the care over the employees (e.g. in the form of trainings), there were also developed guides and manuals to be downloaded from the project website. Moreover, within the framework of dissemination of guidelines of the comprehensive programme there were conducted conferences, and educational and informational meetings in the workplaces.

Other methods of communication applied were the surveys that collected information on the characteristics of workers and their exposure to risk factors as well as preferences in relation to methods of prevention.

Success factors identified
► Identification of occupational factors

Presenting a wide range framework of intervention concerning risk factors and studying preferences of workers in relation to preventive interventions

Comprehensive documents developed for physicians, employees, employers and supervising institutions

Wide range of target groups to whom the education is addressed

Challenges / problems during the implementation

- General definition of the roles of different participants in the programme
- No expected effects of the preventive actions
- No timetable for the programme, no monitoring of the progress of the programme and achieving the intended results
- Lack of information on costs and cost-effectiveness of the proposed solutions
- Lack of information on the effects of implementation of the prevention programme

Lessons learned / best practice

The comprehensive prevention programme for cardiovascular diseases presented includes several solutions worth to be duplicated that can be considered "best practices":

- Detailed presentation of information on the risk factors associated with work - supported by analysis of the literature and own research
- Development of complex documents for physicians, employees, employers and supervising institutions and providing trainings based on them
- Wide range of recipients of the education strategy
- Use of preventive examinations for early identification of risks of cardiovascular diseases
- Conducting surveys among employees, allowing identification of their preferences in relation to preventive measures.

29. Prevention programme in the field of psychosocial hazards (Poland)\(^{33}\)

Source of funding

ESF

Identification of the project

The objective of the prevention programme concerning psychosocial hazards was to develop a knowledge base for the implementation of preventive measures, involving the reduction of workers’ exposure to psychosocial factors in the work environment and diminishing of the negative effects of these factors on the health and functioning of the employees.

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**Project description**

Under this programme, manuals for psychologists, employers, employees, health and safety specialists, the State Sanitary and the State Labour Inspectorates’ specialists and doctors were developed. There were also conducted trainings / workshops for nurses, doctors, psychologists and key trainers.

Based on current law and available Polish and international literature, risk factors present in the work environment responsible for the development of work-related diseases and workers’ exposure to psychosocial risks have been identified. Due to the comprehensive character of the described prevention programme, there were no specific criteria provided for the inclusion of recipients of the programmes. You can, however, accept that the proposed comprehensive programme is open to all employees, regardless of risk group.

The methods adopted in the framework of this programme were the interventions in the development of materials and preparation of preventive measures, depending upon occupational groups and risk groups. It can be considered that on the basis of the proposed methods it was possible to establish a specific prevention programme tailored to the situation of each company (i.e. a model programme). However the programme was a comprehensive programme and due to that fact it has not provided for any specific tools to be implemented in certain workplaces. This means, nevertheless, that in the case of a decision on its application to a specific workplace it was necessary to develop specific materials for each programme addressed to that specific workplace depending on the target audience.

Within each of preventive risks in terms of psychosocial hazards a very large emphasis is made on educational activities that are part of primary prevention, including training for employees and management staff.

Communication methods in the developed programme for psychosocial hazards include education of physicians and other professionals involved in the care over employees. The main tools for education were books and articles. Moreover, within the framework of dissemination of the guidelines of the comprehensive programme, there were conducted conferences and trainings dedicated to medical service staff, psychologists and key trainers.

**Success factors identified**

- Very broad descriptions of the types of psychosocial occupational hazards and the likely consequences of these risks
- Tools for the identification of psychosocial hazards in the workplace, interventions that can be made in the situation of occurring of each hazard
- The risk management model presented

**Challenges / problems during the implementation**

- Descriptions of the proposed solutions and evidence of their effectiveness which requires a refinement
- Inability to assess the performance of the programme - that is, its costs and benefits
- Underdeveloped guidelines regarding the monitoring and evaluation of the programme
- Underdeveloped cost-effectiveness analysis

**Lessons learned / best practice**

The presented model prevention programme includes solutions that may be considered "best practices":

- Description of psychosocial hazards together with description of an intervention
- Manuals which can be used by companies
Comprehensive documents for physicians, employees, employers and supervising institutions and trainings based on them

Wide range of recipients of education strategy

Conducting surveys among employees which helps to identify the exposure of workers to psychosocial occupational hazards

Presentation of psychosocial risk management model developed by an international team of experts, under the PRIMA-EF project funded by the EU which may be implemented in each company.

ACCESS TO HEALTH CARE

30. French patient flows to hospitals and polyclinics in the Belgian Ardennes

Source of funding
ERDF

Identification of the project

An agreement over the project applies for an unlimited duration, authorizes reimbursement for care provided in one of the designated health care facilities across the border for all socially insured people residing in the ZOAST (organized cross-border areas for access to care) in both countries.

Project description

Inter-hospital agreements in the area has begun in the 1990s, but only with subsequent closing of small hospitals led innovative proposal in 2004 to regard Belgian hospital at Dinant as a branch of more distant French hospital at Charleville-Mezieres for the purposes of health care payments. The range of care included and area from which patients can cross the border has been enlarged with the ZOAST Ardennes (organized cross-border areas for access to care) agreement from 2008. All types of care are included, both inpatient and outpatient, except medically assisted reproduction.

Need for the implementation of the project

The Ardennes region is located in border region both in France and Belgium. On the French side, defined by low population density and impoverished socioeconomic situation, local hospitals often find it difficult to attract specialist and maintain accessible while sustainable health care. Thus, there was a need for ensuring access to local health care services for the population of the Ardennes region.

Specifically, objectives of the agreement are to:

► Ensure better access to high-quality health care for people living in the border area;
► Ensure continuity of care for these populations;

Optimize the organization of health care provision by facilitating the use or sharing of human and material resources;

Promote the exchange of knowledge and best practices.

Project solution

► Providing cross-border health care

Project outcomes

The agreement simplified the processes of verification of patients’ insurance status and issuing of the administrative E112 form, allowing patients to follow administrative access procedures similar to those in their own countries. When French patients arrive at a Belgian hospital covered by the agreement they show their national health insurance cards and reader devices in the hospital allow administrative staff to access all the required information. Through an electronic portal, and within 48 hours, the hospital receives the automatic administrative E112 form from the social health insurance fund to which the patient is affiliated.

Detailed project outcomes:

► Patients from France represent about 15% to 20% of CH de Dinant’s turnover (for both ambulatory care and inpatient care): a very high proportion.
► The departments of neurology and ophthalmology receive many French patients, apparently because the waiting times are shorter than for the equivalent departments in France.
► The polyclinics of the socialist sickness fund (which only provide ambulatory care) receive about 5000 French patients per year and the numbers are increasing.
► Flows of Belgian patients to France, on the other hand, are negligible.

Success factors identified

► All the actors directly involved had a stake in collaborating and making the cross border system work.
► Belgian CH de Dinant was very motivated to treat French patients from the beginning, and engaged in major efforts to facilitate the collaboration.
► Proximity, speed, efficiency and quality of services in Belgium were the main reasons put forward to explain the flows.
► French General practitioners have a separate phone number that connects directly to the hospital services they want to reach without having to pass through the telephone exchange.
► French General practitioners have also direct electronic access to their patients’ files at CH de Dinant and can consult examination results as soon as they are available.
► To avoid the issue of VHI funds (discussed further in challenges), in a pilot project two Belgian hospitals received a specific FINESS number, which gave them the status of official French hospitals. With this number, the Belgian hospitals opened bank accounts in France, into which French VHI funds pay invoices directly.

Challenges / problems during the implementation

► Several differences between the French and Belgian health care systems
► For technical reasons, French voluntary health insurance funds were not able to pay foreign hospitals
► Complexity
  ► Cooperation not only between hospitals but cooperation of health and social insurance is required
The creation of an additional agreement on emergency transport worsened the relationship between Belgian and French hospitals, since patients are increasingly transported to CH de Dinant for emergency care.

**Lessons learned / best practice**

- Financial issues had to be properly considered in order to prevent the emergence or facilitate the solution of the following obstacles:
  - Health care insurance funding and patients’ co-payments differ across European countries.
  - Technical obstacle such as complications with cross-border insurance payments.
  - To ease the administrative difficulties, cross-border hospital may obtain the status of official national hospital to ease the administrative difficulties.
- The system function was supported by the fact that all the actors directly involved had a stake in collaborating and making the cross-border system work.
- Relation of the public authorities’ legal frameworks and EU funding to local initiatives showed to be a problematic issue to solve:
  - Initiatives originally set up as pilot studies or experiments inclined to establish themselves in the system without going through proper assessment or political decision-making channels.
  - Field actors fell comfortable setting up agreements and finding practical and creative solutions even if these are not in accordance with legal frameworks.

### 31. Health investments using Structural Funds in Brandenburg

**Source of funding**

ERDF, ESF

**Identification of the reform**

Reshaping public health service delivery to reduce health inequality, to reach wider economic development, and to acquire new medical technology.

**Reform description**

Reform of regional healthcare through a shift of care from the current hospital centric model towards more local provision was in large part stimulated by empowering patients as co-producers of care and providing local eHealth-based support. The project was yet supported in the 2000-2006 programming period.

**Need for the implementation of the reform**

- Modernization and continual improvement of healthcare infrastructure
  - rundown rural infrastructure
  - need for modernization of the road networks
  - need for new medical equipment
- Development of primary care

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35 Source: Euregio III Case Study – Brandenburg, Germany and Sicily, Italy, December 2011.
new equipment
► built infrastructure
► organizational structure and processes
► better quality of care

The Brandenburg region in Germany has been in need of modernization of healthcare infrastructure and systems.

**Individual projects under the reform**

Coronary heart disease project - move care into locally accessible community settings and improve support to patients.

**Reform outcomes**

The project shows that steps need to be undertaken towards stimulating a transformational change in healthcare delivery. Health professionals have a clear “what to do” agenda and message:

► System shifted towards prevention and rehabilitation
► Putting the patient back in charge (an issue of trust)
► Increasing awareness of interactions between different system components, and stakeholder groups.

**Coordination of the projects contributing to the reform**

The main stakeholder organizations in the projects have been the German Ministry of Health, the European Commission (EC) Directorates General for Cohesion Policy (DG REGIO), Employment, and Social Affairs and Equal Opportunities (DG EMPL). Stakeholder organizations and groups include those of patients and their families, care frontline and management professionals, and residents of areas where new care structures are launched.

**Success factors identified**

Defining the Brandenburg region as a convergence region opened up opportunities for structural funds support. Regional health policy could deliver the required convergent benefits (reduction in health inequalities, stimulation of wider economic development, and development of new medical technologies).

**Challenges / problems during the implementation**

► Lack of guidance and expertise at the level of individual projects and the programme
► Time-consuming and overly complex SF process
► Prescriptive quality of the process as supported by relevant legislation and programming documents
► Perception of the role and expectations of the European Commission by domestic stakeholders, new structure managers, practitioners and patient organizations
► Weaknesses in project development, management and limited (missing) outcomes measures
► Number of competing political agendas which needed to be constantly managed
► Less readably available funding than in the 2000-2006 period

**Lessons learned / best practice**

► Overly normative procurement process made the implementation more complicated and less effective.
► Limited stakeholder alignment and their less frequent communication caused weaknesses in project development and management.
The project required the more frequent networking of all stakeholders, regular outcome assessments and specific project guidance.

Lack of clarity about involvement of DG SANCO led the actors to perceive insufficient guidance.

Systems and processes should be influenced by critical success factors such as innovation and adaptability to rapidly manage all possible changes.

32. Health investments using Structural Funds in Sicily³⁶

Source of funding
ERDF, ESF

Identification of the project
Ensuring uniform levels and quality of healthcare across the regions.

Project description
Previous two small-scale Structural Funds projects (2004-2005 and 2007-2008) helped to improve the collection and analysis of epidemiological data and a large-scale Structural Fund project with several objectives. Among the desired objectives were cost containment, trimestral performance monitoring and evaluation, filling of gaps in care (health access in rural areas), reshaping hospital network, territorial and social care, improvement of infrastructural facilities and technological innovations.

Need for the implementation of the project

- Improvement of evidence-based health services and infrastructure
- Modernization and continual improvement of healthcare infrastructure
- Development of primary care in terms of new equipment and built infrastructure
- Out-dated and insufficient technology
  - Priority: assistance to the elderly people at homes
- Organizational structure and processes, lack of trained health workforce
- Lack of resources and administrative inefficiency
- Unjustified high drug consumption, ageing population, high passive mobility, inequality

The Sicilian region in Italia has been in need of modernization of healthcare infrastructure and systems.

Project outcomes

Capacity, protocols and methods for the analysis of inequality was improved in the region which leads to improved registration (mortality system), quality of registration system (main diseases), methodological approach (pollution), capacity of system and the way health funds are used. Information services are centralized and some more services between the health facilities such as secondary transport or blood transport are now offered.

Moreover, the projects were successful as stakeholders realized that they needed to start working in partnership together.

³⁶ Source: Euregio III Case Study – Brandenburg, Germany and Sicily, Italy, December 2011.
**Coordination of the projects**

The main stakeholder organizations in these projects have been the Italian Ministry of Health, the European Commission (EC) Directorates General for Cohesion Policy (DG REGIO), Employment, Social Affairs and Equal Opportunities (DG EMPL), and the programme Managing Authority (MA) and government funded research institutions. Stakeholder organizations and groups include those of patients and their families, care frontline and management professionals, and residents of areas where new care structures are launched.

A lack of guidance in combination with missing strategic alignment between different health projects levels were identified as the main obstacles for SF projects. The Ministry of Health did not know enough about how the regions were utilizing and using the funding.

**Success factors identified**

Two small-scale SF projects (2004-2005 and 2007-2008) projects subsequently informed the current large-scale SF project in the 2007-2013 funding period.

- Clear and coherent processes and coordination mechanisms amongst organizations at a regional and national level
  - Close relationships with the regional health authority which was vital to make both projects a success
- Right timetable
- Innovation and adaptability

**Challenges / problems during the implementation**

- Lack of guidance and expertise at the level of individual projects and the programme
- Prescriptive quality of the process as supported by relevant legislation and programming documents
- Perception of the role and expectations of the European Commission by domestic stakeholders, new structure managers, practitioners and patient organizations
- Wide differences in health care and health expenditure between the regions
- Limited coordination between EU level and regional level
  - Little guidance on how to best manage SF projects
- Guidelines based on outmoded principles
  - Written nearly a decade before project realization
- Missing outcome measures

**Lessons learned / best practice**

- Procurement process of new health services through Structural Funds proved to be time consuming and very prescriptive.
- Strategic misalignment between various SF projects was mitigated by having individual project coordinators.
- Lack of guidance and inexperience in running complex Structural Funds projects had a negative impact on innovations in these projects.
- Frequent meetings and a high degree of information sharing led to clear alignment strategies between both small-scale SF projects with the current large scale SF project.
► Systems and processes should be influenced by critical success factors such as innovation and adaptability to rapidly manage all possible changes.

► Appropriate health project outcome measurements, going beyond financial measurements, would help to stimulate innovative project outcomes.

► There should be more emphasis on seeking to reach synergies between ERDF and ESF funds.

► Future health investment strategies could not be realized with the currently underdeveloped health data system.
C. Other projects

33. PMO at the Ministry of Health of the Czech Republic

Introduction of the implementation structure

In August 2012 the Ministry of Health of the Czech Republic launched the operations of the Strategic Project Management Office (SPMO) as its separate unit dealing exclusively with methodology and management of the MoH’s major projects. It represents the link between management of the Ministry and a controlled project.

Main competencies and responsibilities of the SPMO are to:

► Provide standardized methodology and set proper procedures
► Manage, control and evaluate processes
► Procure appropriate experts corresponding to a particular project

Need for the implementation of the project

The Czech Ministry of Health has decided to open its SPMO to combat its persisting difficulties:

► Insufficient information about its own project portfolio
► Lack of centralized management standards and best practices
► Unknown overlaps of various projects
► Ineffective use of resources
► Missing proper measure and evaluation of benefits

SPMO was established in order to discover the needs and opportunities and to ensure the continual improvements of project management at the Ministry of Health. Successful functioning of the SPMO would significantly enhance the strategic goals of organization, and therefore the transparency and efficiency of projects.

Challenges / problems during the implementation

Administration usually does not set explicitly measurable goals which represents one of the several barriers for the implementation of a project approach to management. Besides the lack of quantifiable strategic goals, there is also a problem with very rigid hierarchy of the management structure, the status quo preference and resistance to change at the key levels.

Individual project managed under the SPMO

Beside other projects, SPMO is responsible for methodology and management of the Psychiatric Care Reform. Its task is to ensure application of the approved methodology and the right process, project, system and communication settings. SPMO is also in charge of monitoring the goals’ fulfilment and data collection. Through this, the SPMO addresses the whole process through the evaluation.

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37 Source: Ministry of Health of the Czech Republic.
Main contributions of the model described

► Increased ability of the system to implement changes
► Increased capability of the individual shareholders to communicate, manage and control
► Establishment of the know-how depository
► Formalization and standardization of the activities

Lessons learned

SPMO has been established not a long time ago, which makes it difficult to properly evaluate which steps proved to be useful and which not. Nevertheless, one of the lessons learned already evident concerns the pre-implementation phase. Prior to the implementation of the SPMO within the Ministry four possible roles of a PMO were identified together with their pros and cons. Therefore, a PMO within a ministry can perform as:

► Support unit
  ► Incremental step forward in the project management organization
  ► Absence of the authority to an effective enforcement of tasks
► Control unit
  ► Control over the performance of individual shareholders and awareness about the current project phase
  ► Only a formal competence to control and audit
► Managing unit
  ► Ensuring transparency and efficiency in the performance of individual projects
  ► Personal and financial demands

34. Integrating result based management principles to the Managing Authorities – involvement of the Greek health agency

Introduction of the initiative

The Community of Practice on the Results Based Management - COP RBM is a community of professionals involved in the design, implementation and monitoring of programmes financed by the Structural Funds and whose members interact based on their professional and scientific field and background for the introduction of Results Based Management in the Structural Funds Management Authorities. Results Based Management is the way in which a service or an organization implements specific procedures and makes use of resources to achieve specific and delimited objectives / results.

This Community of Practice was launched in May 2009 (first funding period: May 2009 - February 2013) by the Flemish ESF Managing Authority, while the current COP RBM programme covers the period March 2013 - March 2015 and is being funded by the DG Employment, Social Affairs and Inclusion of the European Commission.

38 Data provided by the Ministry of Health of Greece.
Involvement of the Greek Special Agency of Health and Social Solidarity

The Special Agency of Health and Social Solidarity (EYTYKA) is via a binding statement an active and permanent member of the COP RBM since 2009, a network of 13 ESF Implementing Authorities across Europe, and along with the Managing Authority of the Ministry of Education are the only Greek participants in the programme.

Until today, EYTYKA has actively participated in the work of both the COP RBM workshop training sessions (two of which took place in Athens, with EYTYKA executives participating) and in the executive work of the Monitoring Committee (COP RBM steering committee).

One of EYTYKA obligations regarding the COP RBM for the foreseeable future is organizing a monitoring committee in Athens.

Main outputs / results of the initiative

The main output of the initiative in Greece is the establishment of the PMO in Health Sector (Programme Management Office). COP RBM is providing all the methodological and consultative help to establish and run effectively the PMO effectively as a body that will steer the effective implementation of Health Interventions in the 2014-2020 programming period.

Pros and cons of the approach described

- Long term support for Greek efforts by the core team of the COP RBM
- Complicated theoretical approach that the PMO members are not used to

Lessons learned

Effective adaptation to the new environment of the ESIF management requires significant level of willingness to change.

35. Developing the potential of project promoters: the role of regional branches of CzechInvest in the Czech regions

Source of funding

ERDF

Identification of the project

The idea was to facilitate face-to-face contacts with potential project promoters as well as to better understand the regional context of the proposed projects, CzechInvest established a network of regional branches in the self-governing regions (on NUTS III level).

Project description

The principal original objective of the network of regional branches of CzechInvest was for the latter to become easily accessible contact points for the whole spectrum of potential clients such as foreign investors, SMEs, municipalities, or potential applicants for the Structural Funds. The purpose was to establish a sort of “mini-
Czechiinvests” in the regions to help to promote project generation and to enhance absorption capacity for both the Structural Funds and national programmes and to decentralise part of the project cycle in order to facilitate the process of implementation for the final beneficiaries of the projects.

The regional offices provided consultation for a wide spectrum of potential project applicants, ensured the publicity of the programmes, conducted informative seminars and were in constant contact with entrepreneurs, representatives of municipalities and other actors to assist project generation. The staff of regional branches were supposed to be able to provide basic information about all support programmes managed by Czechiinvest to intermediate contacts. Representatives of the central office of Czechiinvest were in charge of specific programmes.

**Need for the implementation of the project**

In the Czech context, the setting up of regional branches of Czechiinvest represented a novel approach to support for business activities. The previous model in which the provision of some services was outsourced to regional development agencies, proved not to be ideal and a further goal was therefore to guarantee the provision of high quality services of the same standard in all regions in the country.

The given case study shows how the capacity building of administrators and the capacity building of applicants and beneficiaries are interlinked.

**Project outcomes**

“Mini-Czechiinvests” were set up in the regions to help promote project generation and to enhance the absorption capacity of both the Structural Funds and national programmes. In total, 13 regional branches were established in all of the self-governing regions of the Czech Republic (one joint office for the Prague and Central Bohemia regions).

A part of the project cycle was decentralized in order to facilitate the process of implementation for project beneficiaries.

The positive experience of Czechiinvest and its representatives abroad inspired the decision to set up a similar system of close support on a regional level with the help of the regional branches.

**Coordination of the project**

Intermediary Bodies in the Czech Republic in the first programme period acted mainly as enabling institutions supporting the activities of other agents (e.g. by administrating the project cycle) rather than acting as development actors themselves. Czechiinvest, a key IB for the Czech Operational Programme Industry and Enterprise, was an exception and developed and applied a much more pro-active client-oriented approach.

Regional branches dealt with the primary administration of project applications including the Check of Formal Acceptability of project proposals. In a similar vein, regional branches assisted project beneficiaries when regular monitoring reports and payment claims were submitted. As a result, regional offices were able to suggest via the central office of Czechiinvest (which proposed and discussed prospective changes with the Managing Authority) adjustments in the implementation system which nevertheless significantly helped to improve the implementation system.

Only two main types of final beneficiaries remained: municipalities (most frequently interested in projects related to preparation and management of industrial zones) and companies (mostly SMEs) seeking support from the Structural Funds for a range of business activities. Indirect beneficiaries were the offices of self-governing regions, various business associations and chambers of commerce etc.
Success factors identified

► A feeling of belonging by the employees of the regional branches
  ► Meetings, teambuilding
  ► Knowledge sharing, sharing of good practices and information exchange between regional branches
  ► Sufficient backing of the branches and cooperation from the center
  ► Idea of “getting closer to the clients”
  ► Well designed and professionally implemented system of central management methods. Several simple but efficient rules were applied.
  ► Strategy for the recruitment of staff for the new regional branches, which was to attract people from the business sphere.

As regards the capacity building of beneficiaries:

► Special helpline for project applicants was established. The help-line of CzechInvest was designed to provide not only the basic information (e.g. contacts) but also very detailed information on specific programme issues.
  ► The regional branches organized workshops for potential project applicants.

Challenges / problems during the implementation

► No comprehensive system of evaluation of regional branches was designed.
  ► Limit on the amount of new positions which could be created in the regional branches given the financial constraints within the public sector.
  ► Recruitment process itself (finding suitable candidates for job positions in the regional branches).
  ► Securing the technical and material equipment of the regional branches including adequate premises in cases where the branch office could not be situated at the premises of the respective self-governing region.
  ► The whole sphere of Cohesion policy was a brand new agenda and there was the obvious necessity for “learning by doing” but also for “learning by interacting”.
  ► Feeling of the staff of the regional branches that they were not sufficiently strongly backed by the central office of CzechInvest and / or by the Managing Authority.

Lessons learned / best practice

► Thanks to the operation of regional branches and a phone hotline among the Czech IBs, CzechInvest disposed of the most advanced tools for the successful support of project generation.
  ► For the regional branches, knowledge of the “terrain” was fundamental for strategic decisions on reallocations of financial allocations within the respective priorities of the OP.
  ► Due to the training programmes organized by the regional branches for potential project applicants, a further result was that the quality of projects elaborated in cooperation with the regional branches of CzechInvest was significantly higher than that of those project proposals that did not receive advice.
  ► Development of institutional embedding of regional branches within the CzechInvest structure showed that an independent section dealing with the Structural Funds should have been established at the same time as the regional branches. This would guarantee a clearer position and relationship of the regional branches to the centre and would eliminate the attempts of other sections of CzechInvest to charge
regional branches with tasks in other spheres for which the regional branches were not designed and their staff not trained.

► More detailed specification of the tasks of the regional branches would have been needed as the original definition of their role and competences was relatively broad and vague.