**Building Healthy Communities**

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# Building Healthy Communities

## III Thematic Report

# Building on the Use of Structural Funds by Regions for Developing Health Gains in Cities

**AMAROUSSION**
**BACĂU**
**BAIA MARE**
**BARNSLEY**
**BELFAST**
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**MADRID**
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March 2011

European Union

Connecting cities
Building successes

URBACT

"The Union's aim is to promote peace, its values
and the well-being of its people"

*(Article 3 in the Treaty on the Functioning of
the European Union – The Lisbon Treaty)*

"Being happy is even better if it lasts"

*(Fifth Cohesion Report of the European Union)*

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# 0. Forewords. Good Practices and Clear Difficulties

The Bacau Workshop organised by the BHC Thematic Network in September-October 2010 has been titled "Use of Structural Funds in developing health gains". The title of the workshop recalled the third theme of the network, after "Indicators and criteria for a healthy sustainable urban development" and "Healthy sustainable lifestyles". Since the first meetings it become clear that the relation between health and SF were going to become the more problematic issue: to involve representatives of the Managing Authorities was not an easy task, especially with the intention to have them concretely on board of their relevant local support group; cities in competitiveness objective areas found it very difficult to identify priorities in the Regional Operational Programmes related to health, even in indirect way; cities in convergence objective regions had a more favourable situation but also a more complicated general context in which health was mainly intended as infrastructures. In general, the relation between health and Structural Funds is linked to the definition of national and regional strategies and priorities so the possibility for cities to invest on health is strictly related to the possibility – if any – to cooperate with their relevant Managing Authority of the European funds. From the point of view of BHC this has raised two main problems: the role, again, of Managing Authorities in this process (i.e. their involvement in designing the local action plans) and the fact that national and regional programmes had already decided almost everything in terms of actions and initiatives.

After the first months, in late 2009 (Lodz meeting) and more clearly in early 2010 (by the second meeting in Torino) partner cities were broadening their idea of health to include the general wellbeing of their citizens and were designing local action plans that were focusing on linking holistically different interventions (often already planned or ongoing). From a certain point of view cities were practicing the "health in all policies" principles because it was too difficult to design or promote health policies! Not only cities were and are often not the competent body for health at the local level, also at the local level it is more evident the need to promote integrated interventions to improve the quality of life of citizens, to intervene to prevent certain phenomena to become problems, especially during the economic crisis that is still hitting hard local authorities spending and programming capacity. To this extent, cities have to use not only Structural Funds and among such funds not just one typology (European Regional Development Funds and European Social Funds). Furthermore, cities need to integrate health into existing programmes, so to "interpret", "adapt" and "imagine" differently. The situation is certainly complex and has produced different answers in the BHC partnership: from the complete absence of reference to Structural Funds to their indirect use via existing agreement between Managing Authorities and cities.

In Bacau we had the chance to listen to two precious presentations from Managing Authorities: Dorina Navruc, representing the Romanian national managing authority (operational pro-

grammes are centralized in Romania) and João Afonso, of the Region of Lisbon Managing Authority (from the URBACT II Mile project). In both cases there was a strong commitment of the MA to cities will to experiment and hopefully their example will be followed. The value of such presentations and of their participation is more in the proof that it is possible to work with cities than in showing what has been achieved. But this is exactly the weakest point in the Managing Authorities/cities interaction: to understand that cooperation will produce more than adaptation of one agenda to the other.
To foster the reflection among partners on these issues this report present the results of the Watson Report[1] on health and SF in the current programming period (a report commissioned by DG SANCO) and propose to deepen the debate taking into account some ideas on place-based interventions suggested by Fabrizio Barca in his report commissioned by DG REGIO[2].
This report offers a synthesis from the two above-mentioned contribution, but is intended to stimulate the curiosity to participate – as cities representatives – in the ongoing debate on the reform of the EU programming policy.

## Continuing the exchange experience as an added value of the network

After the Exchanges organised as multi-lateral meeting by partner cities in Belfast (on Health Impact Assessment), Barnsley (on social marketing) and in Madrid (on urban regeneration) a fourth and final exchange has been held in Lecce on urban planning and environmental sustainability (13-15 March 2011). Results from this highly participated exchange are presented in the Annex to this report.

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BHC Lead Expert

1 http://ec.europa.eu/health/health_structural_funds/used_for_health/index_en.htm

2 http://ec.europa.eu/regional_policy/policy/future/barca_en.htm

# 1. Structural Funds and Health

European Cohesion policy is applied through three regional cohesion objectives: convergence; competitiveness; and the territorial cooperation objective (fig. 1).
The cohesion policy has three main goals: to provide a more strategic approach to growth, socio-economic and territorial cohesion: ensuring a closer link with the EU2020 Strategy[3]; to simplify by reducing the number of objectives and regulations, through single-fund programmes, streamlined eligibility rules for expenses, more flexible financial management and through more proportionality and subsidiarity regarding control, evaluation and monitoring; to decentralize, through the stronger involvement of regions and local players in the preparation of the programmes.
Within the total of EUR 347.4 billion allocated for this period, 81.5 % has been allocated to the convergence objective (convergence and phasing-out regions), 16 % to the competitiveness and employment objective (including phasing-in regions) and 2.5 % to the European territorial cooperation objective.
European Union (EU) regional policy is financed by three main funds, which can be used under some or all of the regional policy objectives:

- European Regional Development Fund (ERDF);
- European Social Fund (ESF);
- Cohesion Fund (CF).

*Fig. 1 - Objectives, Structural Funds and instruments 2007-2013*

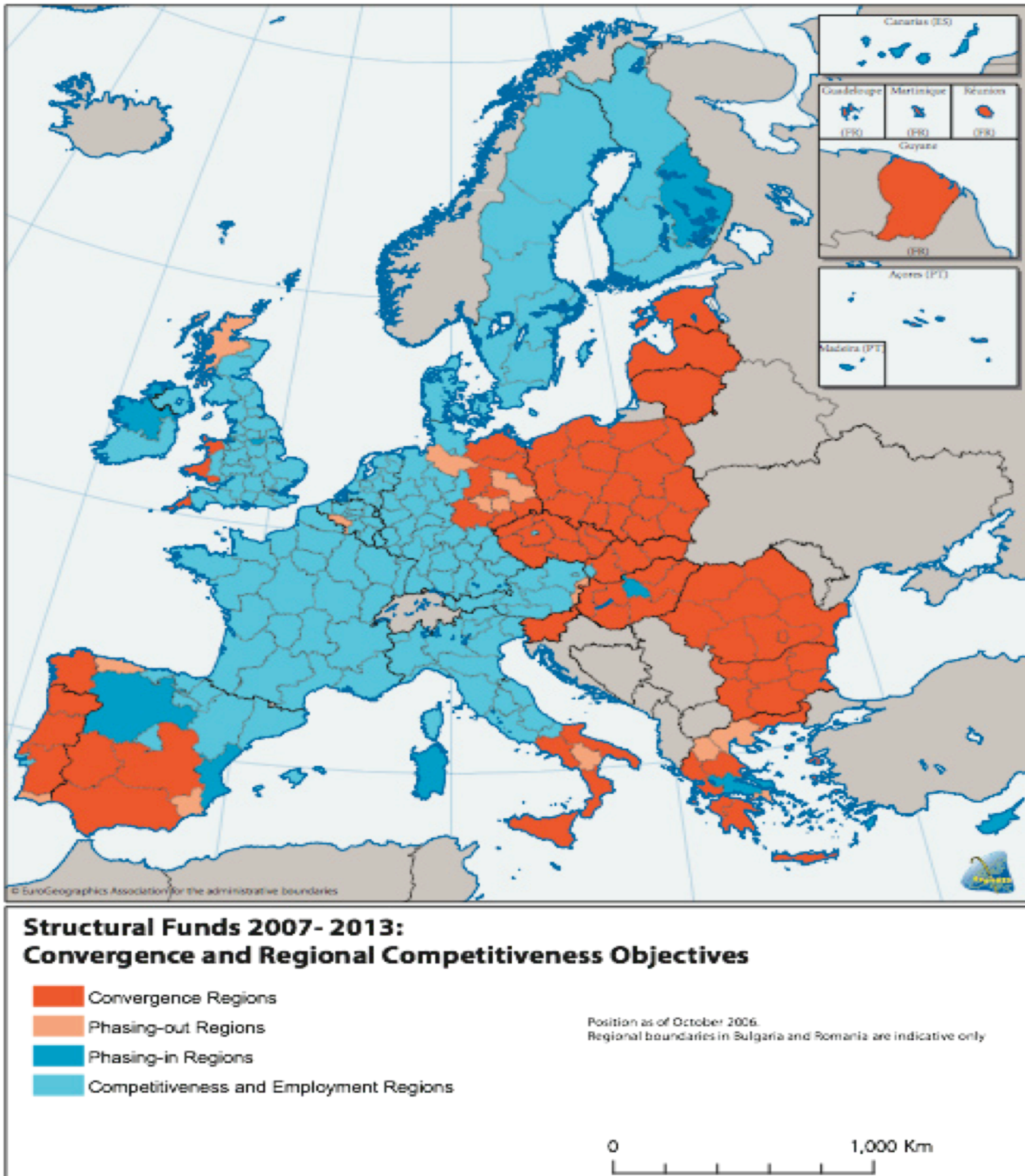
| Objectives | Structural Funds and instruments | | |
|---|---|---|---|
| Convergence | ERDF | ESF | Cohesion Fund |
| Regional Competitiveness and Employment | ERDF | ESF | |
| European Territorial Cooperation | ERDF | | |

*Source: DG REGIO*

In 2007, four new financial instruments were set up to provide technical assistance (Jaspers and Jasmine), improve access of SMEs to microfinance (Jeremie) and support urban development (Jessica).
*Structural Funds* (SF) are allocated in EU Member States according to criteria that differentiate regions within the States in competitiveness and convergence regions (plus some regions which are respectively in phasing-in or -out from convergence to competitiveness) (see fig. 2).
Each Member State has prepared a *National Strategic Reference Framework* (NSRF), agreed between the Member States and the European Commission in 2007 and applied through *thematic and regional operational programmes* (TOP and ROP, respectively) to identify the investment priorities, which also include health.

[3] http://ec.europa.eu/europe2020/index_en.htm

*Fig. 2 – Structural Funds 2007-2013: Convergence and Regional Competitiveness Objectives*




*Source: DG REGIO*

Under the *convergence objective* the aim is to promote growth-enhancing conditions and factors leading to real convergence for the least-developed Member States and regions. Outside the convergence regions, the regional *competitiveness and employment objective* aims at strengthening competitiveness and attractiveness, as well as employment, through a twofold approach: (i) development programmes to help regions to anticipate and promote economic change through innovation and the promotion of the knowledge society, entrepreneurship, the protection of the environment, and the improvement of their accessibility; (ii) more and better jobs by adapting the workforce and by investing in human resources.
The European *territorial cooperation objective* has been designed to strengthen cross-border cooperation through joint local and regional initiatives, transnational cooperation aiming at integrated territorial development, and interregional cooperation and exchange of experience.
Furthermore, the European Commission adopted in November 2006 a new initiative for the 2007–13 programming period under the territorial cooperation objective called "Regions for economic change"[4].

If we consider funding possibilities for health in the EU cohesion policy, we can focus on the categories of policy interventions and scope of the specific Funds for 2007-2013 (see tab. 1): in this case it is possible to see that there many categories that could be interesting to explore for funds (e.g. human capital or urban regeneration), but there is only one category which includes health (together with education, childcare and housing) and it is "Social Infrastructure". From table 2 it is possible to see that the vast majority of funds for social infrastructure is for lagging regions (i.e. convergence objective regions) and areas interested by the territorial cooperation objective. If we consider the allocation of cohesion policy budget by categories and subcategories for the same programming period (tab. 3), we can see that health is considered as "Health Infrastructure" and, thus, cohesion policy has been designed to finance mainly the renovation or upgrading of the existing health infrastructures or the improvement of health facilities in new Member States.
The role of a EU spending for health focused on such categories has been made clear by the Watson Report, one of the most interesting report commissioned by DG SANCO to evaluate the relationship between SF and health.

[4] http://ec.europa.eu/regional_policy/cooperation/interregional/ecochange/index_en.cfm. To this Initiative is linked the Fast Track label that has been assigned to Building Healthy Communities.

*Tab. 1 – Categories of policy interventions and scope of the specific Funds 2007-2013*

| Categories | Regional Fund (ERDF) | Social Fund (ESF) | Cohesion Fund |
|---|---|---|---|
| Research and technological development (R&TD) and innovation(1) | X | | |
| Support to firms' investments | X | | |
| Information Society | X | | |
| Transport | X | | X |
| Energy | X | | X |
| Environmental protection and risk prevention | X | | X |
| Tourism | X | | |
| Culture | X | | |
| Urban and rural regeneration | X | | |
| Adaptability of workers and firms, enterprises and entrepreneurs | | X | |
| Access to employment and active and preventive labour market measures | | X | |
| Social inclusion of less-favoured persons(2) | | X | |
| Human capital (education, life-long training, high-level studies in R&TD) | | X | |
| Social infrastructure(3) | X | | |
| Partnership and networking | | X | |
| Institutional capacity at national, regional and local level | | X | |
| Reduction of additional costs of outermost Regions | X | | |
| Technical assistance | X | X | X |

*Source: DG REGIO from the Barca Report*

*Tab. 2 – Allocation of cohesion policy budget by categories and territorial destination, 2007-2013 (% shares)*

| | Lagging Regions and countries | Non-lagging Regions | Territorial cooperation | Total |
|---|---|---|---|---|
| Research and technological development (R&TD) and innovation(1) | 13.0 | 21.9 | 16.3 | 14.5 |
| Support to firms' investments | 4.0 | 4.5 | 0.4 | 4.0 |
| Information Society | 4.4 | 4.2 | 7.1 | 4.4 |
| Transport | 25.7 | 4.5 | 13.2 | 22.0 |
| Energy | 3.1 | 3.3 | 4.3 | 3.1 |
| Environmental protection and risk prevention | 16.0 | 6.3 | 16.1 | 14.6 |
| Tourism | 1.8 | 1.5 | 7.4 | 1.8 |
| Culture | 1.7 | 1.5 | 6.0 | 1.7 |
| Urban and rural regeneration | 2.9 | 3.5 | 2.2 | 3.0 |
| Adaptability of workers and firms, enterprises and entrepreneurs | 3.0 | 10.4 | 1.8 | 4.2 |
| Access to employment and active and preventive labour market measures | 5.0 | 15.3 | 2.5 | 6.6 |
| Social inclusion of less-favoured persons(2) | 1.8 | 9.1 | 0.8 | 2.9 |
| Human capital (education, life-long training, high-level studies in R&TD) | 7.6 | 8.0 | 3.9 | 7.6 |
| Social infrastructure(3) | 5.5 | 1.5 | 5.7 | 4.9 |
| Partnership and networking | 0.2 | 0.7 | 2.8 | 0.4 |
| Institutional capacity at national, regional and local level | 1.1 | 0.2 | 3.5 | 1.0 |
| Reduction of additional costs of outermost Regions | 0.1 | 0.5 | 0.1 | 0.2 |
| Technical assistance | 3.1 | 3.1 | 5.9 | 3.1 |
| **Total** | 100.0 | 100.0 | 100.0 | 100.0 |

*Source: DG REGIO from the Barca Report*

*Tab. 3 – Allocation of cohesion policy budget by categories and sub-categories, 2007-2013 (million euros at current prices; % shares)*

| Code | Categories | Million euros | Overall share (%) | Share within category (%) |
|---|---|---|---|---|
| | **Research and technological development (R&TD) and innovation** | **50 046.5** | **14.5** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 01 | R&TD activities in research centres | 5 783.3 | 1.7 | 11.6 |
| 02 | R&TD infrastructure and centres of competence in a specific technology | 9 899.4 | 2.9 | 19.8 |
| 03 | Technology transfer and improvement of cooperation networks ... | 5 578.0 | 1.6 | 11.1 |
| 04 | Assistance to R&TD, particularly in SMEs (including access to R&TD services in research centres) | 5 574.0 | 1.6 | 11.1 |
| 05 | Advanced support services for firms and groups of firms | 5 150.9 | 1.5 | 10.3 |
| 06 | Assistance to SMEs for the promotion of environmentally-friendly products and production processes (...) | 2 504.6 | 0.7 | 5.0 |
| 07 | Investment in firms directly linked to research and innovation (...) | 9 029.6 | 2.6 | 18.0 |
| 08 | Other measures to stimulate research and innovation and entrepreneurship in SMEs | 6 526.7 | 1.9 | 13.0 |
| | **Support to firms' investment** | **13 605.4** | **3.9** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 09 | Support to firms' investment | 13 605.4 | 3.9 | 100.0 |
| | **Information society** | **15 284.7** | **4.4** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 10 | Telephone infrastructures (including broadband networks) | 2 256.5 | 0.7 | 14.8 |
| 11 | Information and communication technologies (...) | 3 597.8 | 1.0 | 23.5 |
| 12 | Information and communication technologies (TEN-ICT) | 523.8 | 0.2 | 3.4 |
| 13 | Services and applications for citizens (e-health, e-government, e-learning, e-inclusion, etc.) | 5 225.1 | 1.5 | 34.2 |
| 14 | Services and applications for SMEs (e-commerce, education and training, networking, etc.) | 2 144.4 | 0.6 | 14.0 |
| 15 | Other measures for improving access to and efficient use of ICT by SMEs | 1 537.2 | 0.4 | 10.1 |
| | **Transport** | **75 774.0** | **22.0** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 16 | Railways | 4 105.3 | 1.2 | 5.4 |
| 17 | Railways (TEN-T) | 18 518.6 | 5.4 | 24.4 |
| 18 | Mobile rail assets | 558.8 | 0.2 | 0.7 |
| 19 | Mobile rail assets (TEN-T) | 695.6 | 0.2 | 0.9 |
| 20 | Motorways | 5 133.1 | 1.5 | 6.8 |
| 21 | Motorways (TEN-T) | 17 482.2 | 5.1 | 23.1 |
| 22 | National roads | 7 659.3 | 2.2 | 10.1 |
| 23 | Regional/local roads | 9 775.8 | 2.8 | 12.9 |
| 24 | Cycle tracks | 634.4 | 0.2 | 0.8 |
| 25 | Urban transport | 1 793.9 | 0.5 | 2.4 |
| 26 | Multimodal transport | 1 635.4 | 0.5 | 2.2 |
| 27 | Multimodal transport (TEN-T) | 446.8 | 0.1 | 0.6 |
| 28 | Intelligent transport systems | 1 089.8 | 0.3 | 1.4 |
| 29 | Airports | 1 851.1 | 0.5 | 2.4 |
| 30 | Ports | 3 532.5 | 1.0 | 4.7 |
| 31 | Inland waterways (regional and local) | 265.8 | 0.1 | 0.4 |
| 32 | Inland waterways (TEN-T) | 595.6 | 0.2 | 0.8 |
| | **Energy** | **10 756.2** | **3.1** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 33 | Electricity | 272.8 | 0.1 | 2.5 |
| 34 | Electricity (TEN-E) | 313.2 | 0.1 | 2.9 |
| 35 | Natural gas | 658.6 | 0.2 | 6.1 |
| 36 | Natural gas (TEN-E) | 361.9 | 0.1 | 3.4 |
| 37 | Petroleum products | 171.6 | 0.0 | 1.6 |
| 38 | Petroleum products (TEN-E) | 0.0 | 0.0 | 0.0 |
| 39 | Renewable energy: wind | 787.6 | 0.2 | 7.3 |
| 40 | Renewable energy: solar | 1 071.6 | 0.3 | 10.0 |
| 41 | Renewable energy: biomass | 1 796.9 | 0.5 | 16.7 |
| 42 | Renewable energy: hydroelectric, geothermal and other | 1 129.8 | 0.3 | 10.5 |
| 43 | Energy efficiency, co-generation, energy management | 4 192.3 | 1.2 | 39.0 |

| | Categories | Million euros | Overall share (%) | Share within (%) |
|---|---|---|---|---|
| | **Environmental protection and risk prevention** | **50 120.2** | **14.5** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 44 | Management of household and industrial waste | 6 234.3 | 1.8 | 12.4 |
| 45 | Management and distribution of water (drink water) | 8 087.7 | 2.3 | 16.1 |
| 46 | Water treatment (waste water) | 13 906.6 | 4.0 | 27.7 |
| 47 | Air quality | 1 020.4 | 0.3 | 2.0 |
| 48 | Integrated prevention and pollution control | 738.9 | 0.2 | 1.5 |
| 49 | Mitigation and adaption to climate change | 304.7 | 0.1 | 0.6 |
| 50 | Rehabilitation of industrial sites and contaminated land | 3 450.6 | 1.0 | 6.9 |
| 51 | Promotion of biodiversity and nature protection (including Natura 2000) | 2 705.1 | 0.8 | 5.4 |
| 52 | Promotion of clean urban transport | 6 166.7 | 1.8 | 12.3 |
| 53 | Risk prevention (...) | 5 829.0 | 1.7 | 11.6 |
| 54 | Other measures to preserve the environment and prevent risks | 1 676.2 | 0.5 | 3.3 |

| | Categories | Million euros | Overall share (%) | Share within (%) |
|---|---|---|---|---|
| | **Tourism** | **6 355.3** | **1.8** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 55 | Promotion of natural assets | 1 142.4 | 0.3 | 18.0 |
| 56 | Protection and development of natural heritage | 1 427.6 | 0.4 | 22.5 |
| 57 | Other assistance to improve tourist services | 3 785.3 | 1.1 | 59.6 |

| | Categories | Million euros | Overall share (%) | Share within (%) |
|---|---|---|---|---|
| | **Culture** | **5 962.9** | **1.7** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 58 | Protection and preservation of the cultural heritage | 2 917.5 | 0.8 | 48.9 |
| 59 | Development of cultural infrastructure | 2 245.4 | 0.7 | 37.7 |
| 60 | Other assistance to improve cultural services | 800.0 | 0.2 | 13.4 |

| | Categories | Million euros | Overall share (%) | Share within (%) |
|---|---|---|---|---|
| | **Urban and rural regeneration** | **10 188.2** | **3.0** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 61 | Integrated projects for urban and rural regeneration | 10 188.2 | 3.0 | 100.0 |
| | **Adaptability of workers and firms, enterprises and entrepreneurs** | **14 427.9** | **4.2** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 62 | Development of life-long learning systems and strategies in firms; training and services for employees ... | 9 752.9 | 2.8 | 67.6 |
| 63 | Design and dissemination of innovative and more productive ways of organising work | 1 898.0 | 0.6 | 13.2 |
| 64 | Development of special services for employment, training and support in connection with restructuring of sectors ... | 2 777.0 | 0.8 | 19.2 |

| | Categories | Million euros | Overall share (%) | Share within (%) |
|---|---|---|---|---|
| | **Access to employment and active and preventive labour market measures** | **22 638.5** | **6.6** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 65 | Modernisation and strengthening labour market institutions | 2 375.5 | 0.7 | 10.5 |
| 66 | Implementing active and preventive measures on the labour market | 12 075.2 | 3.5 | 53.3 |
| 67 | Measures encouraging active ageing and prolonging working lives | 1 043.6 | 0.3 | 4.6 |
| 68 | Support for self-employment and business start-up | 3 247.2 | 0.9 | 14.3 |
| 69 | Measures to improve access to employment and increase sustainable participation and progress of women ... | 2 651.2 | 0.8 | 11.7 |
| 70 | Specific action to increase migrants' participation in employment ... | 1 245.9 | 0.4 | 5.5 |

| | Categories | Million euros | Overall share (%) | Share within (%) |
|---|---|---|---|---|
| | **Social inclusion of less-favoured persons** | **10 156.0** | **2.9** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 71 | Pathways to integration and re-entry into employment for disadvantaged people ... | 10 156.0 | 2.9 | 100.0 |

| | Categories | Million euros | Overall share (%) | Share within (%) |
|---|---|---|---|---|
| | **Human capital** | **26 030.8** | **7.6** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 72 | Design, introduction and implementing of reforms in education and training systems ... | 8 612.9 | 2.5 | 33.1 |
| 73 | Measures to increase participation in education and training throughut the life-cycle ... | 12 500.6 | 3.6 | 48.0 |
| 74 | Developing human potential in the field of research and innovation, in particular through post-graduate studies ... | 4 917.3 | 1.4 | 18.9 |

| | Categories | Million euros | Overall share (%) | Share within (%) |
|---|---|---|---|---|
| | **Social infrastructure** | **16 864.3** | **4.9** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 75 | Education infrastructure | 7 356.2 | 2.1 | 43.6 |
| 76 | Health infrastructure | 5 211.0 | 1.5 | 30.9 |
| 77 | Childcare infrastructure | 555.7 | 0.2 | 3.3 |
| 78 | Housing infrastructure | 802.9 | 0.2 | 4.8 |
| 79 | Other social infrastructure | 2 938.5 | 0.9 | 17.4 |

| Code | Categories | Million euros | Overall share (%) | Share within category (%) |
|---|---|---|---|---|
| | **Partnership and networking** | **1 274.5** | **0.4** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 80 | Promoting the partnerships, pacts and initiatives through the networking of relevant stakeholders | 1 274.5 | 0.4 | 100.0 |
| | **Institutional capacity at national, regional and local level** | **3 562.2** | **1.0** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 81 | Mechanisms for improving good policy and programme design, monitoring and evaluation ... | 3 562.2 | 1.0 | 100.0 |
| | **Reducing additional costs of outermost regions** | **647.5** | **0.2** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 82 | Compensation of any additional costs due to accessibility deficit and territorial fragmentation | 474.8 | 0.1 | 73.3 |
| 83 | Specific action addressed to compensate additional costs due to size market factors | 129.0 | 0.0 | 19.9 |
| 84 | Support to compensate additional costs due to climate conditions and relief difficulties | 43.7 | 0.0 | 6.7 |
| | **Technical assistance** | **10 838.6** | **3.1** | **100.0** |
| ***Code*** | ***Sub-categories*** | | | |
| 85 | Preparation, implementation, monitoring and inspection | 7 894.7 | 2.3 | 72.8 |
| 86 | Evaluation and studies; information and communication | 2 943.9 | 0.9 | 27.2 |
| | **Total** | **344 533.7** | **100.0** | **-** |

*Source: DG REGIO from the Barca Report*

## *1.1 The Watson Report: which funds for health*

The report "Health and Structural Funds in 2007-2013: Country and Regional Assessment" has been written by Jonathan Watson in 2009 to provide a clearer picture of the funding possibilities in the field of health. The report was commissioned by DG SANCO and focused on the different areas of investments that could be exploited. In the current ERDF regulation (article 4), investments in health and social infrastructure that contribute to regional and local development and increasing the quality of life are eligible in convergence regions. Article 6 refers instead to cross-border activities developing collaboration, capacity and joint use of infrastructures, in particular in sectors such as health, culture, tourism and education.

However, for all regions there is a new and substantially different operational context for the 2007– 13 ERDF operational programmes than what was previously available.

Health actions can be in fact supported under a range of ERDF priorities, although – as we have seen – the major investment in convergence regions will focus on health infrastructure including medical equipment. For example:

- *investment in health and social infrastructure*. Building and restructuring hospitals and primary health centres; developing multiple function infrastructure (e.g. healthcare, social care and education); restructuring inpatient specialist care (e.g. diagnostic centres); restructuring outpatient services; modernisation and revision of equipment (e.g. diagnostic, surgical, technological, informatics);
- *energy*. Low energy consuming buildings; development of systems to produce energy using mild energy sources (e.g. in the hospitals);
- *urban and rural regeneration*. Proving localised health service provision in marginalised and rural communities;
- *strengthening institutional capacity*. Integrated emergency medical services with effective communications networks;
- additionally, as from 2007, a major emphasis is being given to *health promotion and disease prevention*, e.g. through health awareness measures.

The above-mentioned areas for health investments are reflected in all National Strategic Reference Frameworks and Operational Programmes, but the actual implementation can vary.

Health-related actions can be also supported under all of the ESF priorities and are usually linked to relevant national strategies and programmes, for example in the actions listed in the Watson Report:

- *Enhancing access to employment*. Supporting inactive people due to health reasons and marginalised social groups (e.g. older people, female unemployed, people with disabilities) to access the labour market and strengthening cooperation between health and employment services through the provision of one-stop shops for jobseekers.
- *Reducing absence due to illness*. This goes beyond general occupational health and safety. Dealing with this factor is an accepted part of enterprises' overall plan-

ning to use human resources as part of the production process. It falls more naturally under the heading of ‘growth policy’.
- *Reinforcing social inclusion of people at a disadvantage*. Through counselling and guidance on health and lifestyle issues, to enable people from vulnerable social groups to (re)join the labour market.
- *Providing attractive workplaces*. Actions range from maintaining and improving the well-being of workers, through preventive programmes adapted to the needs of specific employee groups.
- *Fostering health promotion*. This includes enhancing local capacity to plan and implement public health activities on a regional level; increasing health awareness and the skills of people to make healthy choices in relation to physical activity, diet and nutrition, smoking, drinking and drug misuse.
- *Investing in human capital*. This is often undertaken through establishing lifelong learning opportunities for health professionals related to health issues in the working environment, promoting healthy lifestyles through revision of the education system, networking between universities, enterprises and the health.
- *Improving living conditions and urban environments*. This brings the social aspect alongside the economic and environmental aspects of urban regeneration and can include innovative personal services and a one-stop shop, especially for vulnerable social groups.
- *Developing administrative capacity*. Ensuring the design, monitoring and evaluation of health policies as part of health system reforms, capacity-building in delivery of revised health policies, improved effectiveness and costs, promoting innovative approaches to healthcare.

The Cohesion Fund (CF; see fig. 1) is an additional fund delivered through national operational programmes often linked to the convergence objective for the period 2007–13. Projects may include either indirect health investment or potential health gains from non-health sector investments. Transport, road and public transport projects can have benefits in terms of improving access to health and social care services for patients, carers and outreach services. Environmental projects might include water supply, renewable energy, wastewater treatment and solid waste projects.

Finally, the European Investment Bank (EIB) has promoted “the four Js” in addition to financial support: Jeremy (Joint European resources for micro to medium enterprises); Jessica (Joint European support for sustainable investments in city areas); Jaspers (Joint assistance in supporting projects in European regions); Jasmine (Joint action to support micro-finance institutions in Europe). None of the four Js prioritise health sector development. However, Jaspers is able to provide technical assistance also to health projects, and the Jeremie and Jasmine initiatives could be applied to projects that engage local SMEs better in regional health sector supply chains or health innovation clusters. The Jessica and Jaspers initiatives could be revised to promote added value health gains from projects that have the potential to impact on the

broader economic, environmental and social determinants of health.

## 1.2 Direct and Indirect Investments in Health (plus non-health sector investments)

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

*Direct health investments* in health infrastructure are mainly foreseen in Member States with convergence objective regions. In Bulgaria, the Czech Republic, Greece, Lithuania, Latvia, Hungary, Poland, Romania and Slovakia, health infrastructure is the core element of direct investment. This is essentially intended to underpin the modernisation of healthcare services. Improving access to services, especially in rural areas and for people in vulnerable social groups and ethnic minorities, is one of the drivers of modernisation in the 12 newer EU Member States. In general, using health infrastructure investment to ensure modernisation of healthcare services is the core element of direct health sector investment (see fig. 3). It also has the clearest budget allocation in NSRFs and ROPs.

*Indirect health sector investments* can be found in the NSRFs and ESF-funded (regional) operational programmes but there is rarely any indication if specific expenditure is anticipated. Indirect health investments can be observed where investment starts in another sector but will also include an element of investment in health services or resources. For example in the area of employment the major focus of indirect investment is the workplace and the workforce (a "healthy workforce") (see fig. 4). Supporting healthy workplaces combined with increasing inclusive employment activities requires regional health systems to work in partnership with other public, business and NGO sector employers at national, regional and local levels. It is considered crucial to modernise regional health systems and to maintain attractive and inclusive employment strategies. In addition, planned indirect health sector investment and non-health sector investments can be considered as interrelated.

In the area of *non-health sector investment* attention is paid to investments that have potential added value for health, and specifically potential impacts on the wider economic, social and environmental determinants of health (see fig. 5). In terms of SF allocations, this area is supported by almost all ERDF, CF and ESF investments. According to Watson, challenge for local and regional authorities would be to ensure the sustainability of such investments. With regard to regional health systems, this means assessing their potential to contribute to economic growth, social cohesion and environmental quality as well as service delivery. The business sector can contribute to health improvement, social cohesion and environmental quality in addition to its

core focus on economic competitiveness. Looking at the health innovations market and related knowledge hubs or innovation clusters, a key element would be a better involvement of the public health sector in developing, managing and anticipating health innovations at the local and regional level. The shift in health policy and health service design to prevention and the management of chronic conditions requires the development and application of health innovations within regions that support emerging integrated care models, in which hospitals are just one element.
To maximise health gain from the knowledge economy, Watson stresses, there is a clear need to ensure that regional health systems, their elements and the workforce are engaged in and contribute to knowledge hubs and innovation clusters.

## *1.3 Lessons learned on health and SF by Euregio III*

In 2010 partners of the Euregio III project met in Venice to debate on the relation between health and SF[5]. Interestingly, the report of the meeting provides some reflections on this relationship that can be useful for better understanding the EU framework.
The event was organised as part of a critical conversation between key stakeholders and EUREGIO III about to respond to the challenges effectively and sustainably. The event had the following main objectives:

- Building strategic relationships with 'key stakeholders' to enable a coherent approach to maximising health gains from Structural Funds;
- Informing the mid-term review about how health gains from SF mainstream OPs can be achieved in the current 2007-2013 period;
- Informing planning for the 2014-2020 period between key stakeholders in the SF process;
- Facilitating discussion and learning that helps inform planning and implementation of the Technical Platform of the new DG SANCO/Committee of the Regions Coordination Mechanism for health and regional development.

Main conclusions draw on the experiences of SF managing authorities and SF beneficiaries and evidence provided by Managing Authorities, SF beneficiaries and independent evaluators (see fig. 6). Among the most relevant points for BHC there are:

- knowledge – of the SF process, of funding priorities and existing financial resources – is a priority;
- assistance in developing programmes and projects is fundamental;

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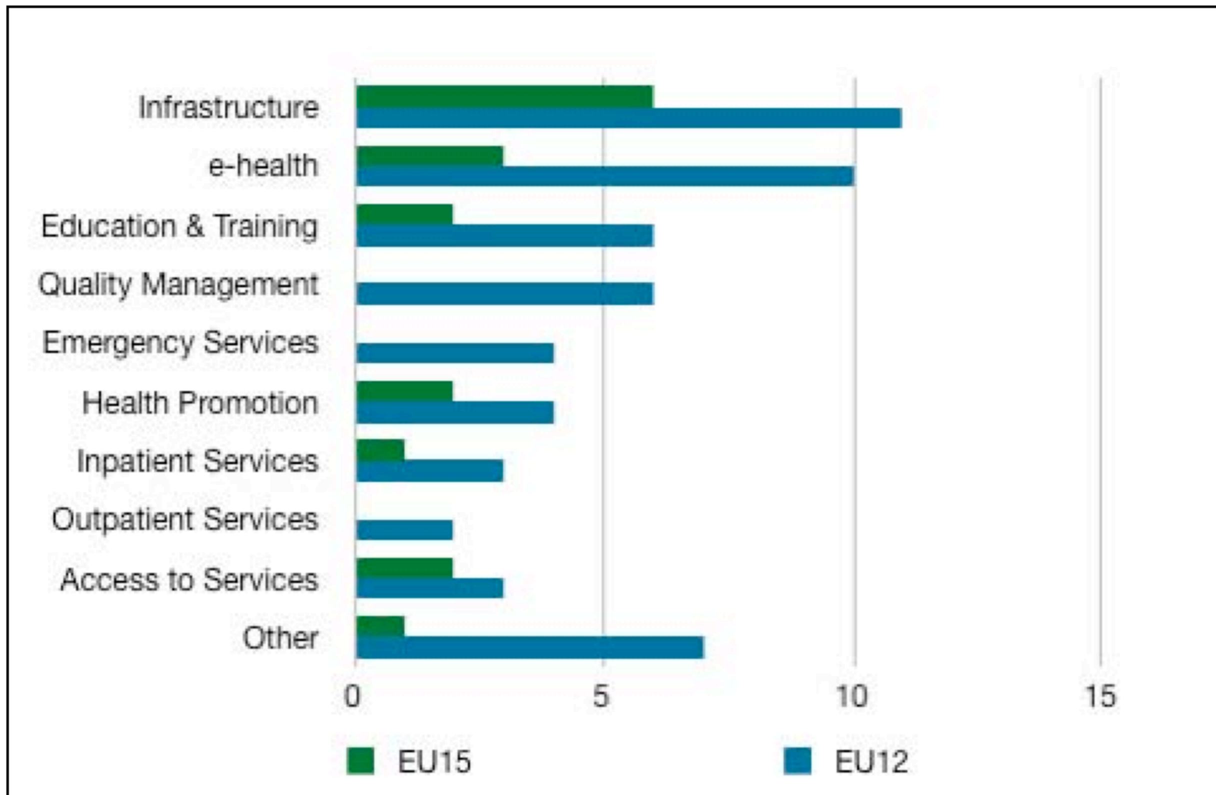
[5] EUREGIO III project is funded by the EU under the 2007-2013 Health Programme. The purpose of the project is to identify examples of good practice and lessons learnt from planning, seeking funding for, implementing, evaluating and managing health investments in the 2000-2006 Structural Fund period (& 2007-2013 period when available). With this practical knowledge EUREGIO III is designed to inform the use of SF in the 2007-2013 period and planning for the 2014-2020 period. The project has 10 work packages that contribute to identifying, assessing, creating and delivering practical "how-to" knowledge through active dissemination with EC stakeholders (DGs SANCO, REGIO, EMPLOY), national and regional Managing Authorities for mainstream Structural Fund Programmes, current SF pro- jects and potential SF applicants. The project is run by Health ClusterNET and several Associate Partners (EMK Semmelweis University, Maastricht University, University of Liverpool, Veneto Region and the European Centre for Health Assets and Architecture).

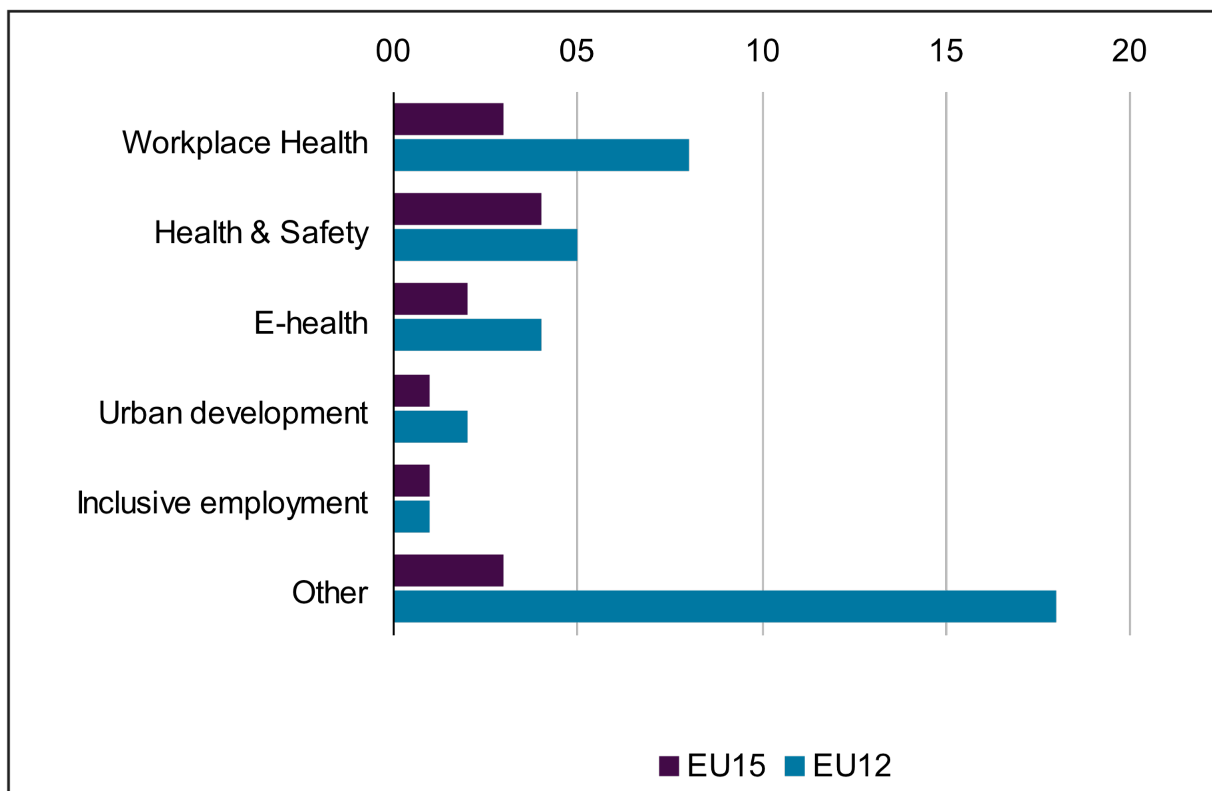
- coherence of national, regional and local policies has to be considered as an asset for future programming.

*Fig. 3 – Direct health sector investment in 2007–13 per country*



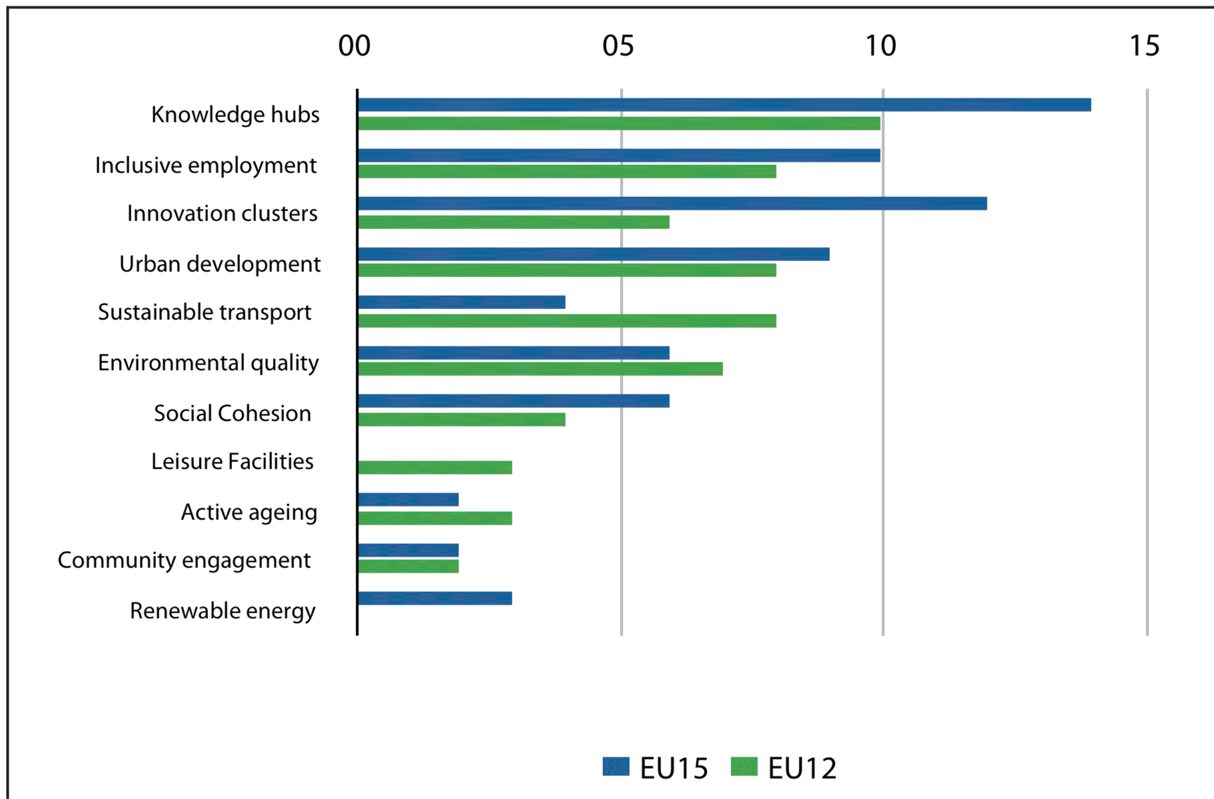

*Source: Watson Report*

*Fig. 4 – Indirect health sector investment in 2007–13 per country*




*Source: Watson Report*

*Fig. 5 – Non-health sector investment with potential health gain in 2007–13 per country*




*Source: Watson Report*

*Fig. 6 – Key messages on the relation between health and SF*

1. ***Many people in the health sector don't know the SF process*** –they do not know how to apply for SF money, what the money can be used for, where the money comes from or how it fits into national health budgets. And beneath all of this, who are the decision makers about health sector investment priorities and what gets funded at national, regional and local levels.
2. EC and national bureaucracy requirements – need ***a more collaborative and supportive approach with beneficiaries*** to assist the develop of programmes and projects
3. There is real need for a support programme to take people by the hand i.e. take regions through a ***peer review process with external/internal experts.*** This should be available as an ***ongoing call of support as and when needed*** in identifying funding priorities and existing financial resources; what Structural Funds are available and what can be done to access it and spend it in ways that are regionally relevant, cost effective, sustainable, flexible and delivers measurable benefit
4. Health-related investment in 2000-2006 and 2007-2013 is mostly based on ***out-of-date thinking and models e.g. continuation of the hospital centric model of care***
5. In generating good practice get behind the description of services to a ***more critical analysis of the process.*** Why does something work or not work? What is the tipping point? We needed a more global approach to the problems faced in the health system: what are the implications of a health-related investment with a view to regional development?
6. It's important to have better knowledge transfer between projects when they are happening e.g. through ***a moderated internet platform – a type of collegiate model of support using something similar to Facebook or Twitter***
7. Prior to the 2008/9 Economic Crisis, health systems across the EU tended towards a culture of cumulative asset growth – avoidance of controversial restructuring – the new emerging emphasis is on the principle of '***disinvest to reinvest'***
8. Managing Authorities should adopt ***conditionality towards evidence-based and integrated projects***. If you can't display this then go away. Needs to be done early enough
9. Within regions, ***SF must not be seen as an add-on investment*** but fully integrated within a regional master plan or strategy that is coherent with national policies. But how does ***regional master planning*** impact on accessing and use of SF? For example, see the best actions and lessons learned from Brandenburg from the 2000-2006 period.
10. Need for a stronger shift to return on investment principles and the contribution of ***health and integrated impact assessment principles*** to achieving this.
11. The strong option for ERDF/ESF beneficiaries is to 'leapfrog' previous (and now unsustainable?) convention – and ***target strategic and structural change*** in line with these principles. These principles can be supra-regional as well as regional.

*Source: Euregio III Report*

# 2. Regions vs. Cities

The framework that has been described thanks to the Watson and the Euregio III Reports shows some key points for a project that deals with health in cities:

1. Structural Funds are made to be managed by regions according to national priorities;
2. Regional prioritisation process should involve cities, but this is not always a guarantee for taking into account cities needs;
3. Health is considered mainly as infrastructures and services when directly addressed, up to 1.5% of the EU cohesion budget in 2007-2013;
4. Health has to be mostly indirectly addressed to fully exploit the SF potential.

It is not by chance that the 5th Cohesion Report, in its final version, relates health with wellbeing, highlights the potential of green policies for green cities and promote the adoption of an happiness index to measure the liveability of EU cities and regions (see for this the 2nd BHC Thematic Report). Health remains a "hot" political subject, which furthermore represents one of the biggest expenditure lines in national and regional budgets. Yet, while often without clear and direct competence on health, EU cities are called to face health related issues and to provide effective answers to their citizens. Being on the frontline means that local governments need to find space for health in their policies, to concretely introduce health in all policies (as EU is asking) by widening the spectrum of intervention possibilities: from facilitating access to health services to designing sustainable urban development strategies, from learning to monitor critical categories to promoting inclusion policies for the elderly or migrants.

The role of local governments, of cities and local bodies in general, in facing the issue of the wellbeing of their citizens has been clearly recognized in one of the most advanced policy document that the EU has commissioned in the last years: "An Agenda for a Reformed Cohesion Policy. A place-based approach to meeting European Union challenges and expectations". This independent report, prepared in 2009 by Fabrizio Barca for the former DG REGIO commissioner Danuta Hubner, design a Union in which a greater role is given to the local level in addressing and developing policies for a competitive and cohesive Europe. The Report suggests some core priorities for the EU action ("innovation" and "climate change", with a largely economic objective; "migration" and "children"[6], with a predominantly social objective and "skills" and "ageing", where the two objectives are of similar importance), where two of the criteria adopted for identifying those priorities are (i) their EU-wide relevance and (ii) their place-based nature.

## *2.1 Cities capacity to define priorities*

The Barca Report explains the rationale for place-based interventions and to do so it questions the "one size fits all" principle. Since institutions capable of supporting a healthy, sustain-

[6] The "children" priority is the one that is more directly linked to health, because healthy children will be healthy adults and then less-dependent citizens on social and health services. This is a rather economy-driven approach, but it is in line with the general EU approach to cohesion.

able market-based system are highly specific to local conditions, and since much of the knowledge they require cannot be transferred as a blueprint, local knowledge needs to be exploited. This means that the local level needs to be able to answer to national or EU stimuli not simply by answering to calls for proposals on the basis of already decided typologies of actions (as it is in the current programming period), but to propose to EU the kind of intervention that would suit better for its territory and the citizens. There is more, the local level is called to implement such intervention, to be able to monitor it and to learn from the process[7].

Apart from designing a possible form for the next programming period (2014-2020), it is possible to see that the relation between health and EU funds has also stimulated BHC cities to imagine creative ways of financing interventions in the field of quality of life and wellbeing of their citizens. In some cases the link with SF is clear, but in all the case this happened because at the city level local actors decided to "bring health into SF".

## 2.2 BHC Cities and SF

Among the 10 BHC cities there are some interesting examples of "indirect" use of SF for health and quality of life. The city of Amaroussion (GR), for instance, has promoted actions to upgrade urban green spaces by using priorities identified in the NSRF, while interventions on the renovation of building facades have been in part financed through the ROP, as some interventions in the field of road safety, public lighting and – with a more direct link to health – the funding for a mobile medical tests unit and for social inclusion initiatives.

Lecce (IT) local action plans builds on existing – and sometimes completed – interventions that have been funded by the EU (mainly URBAN II initiative), but is envisaging the involvement of the regional Managing Authority of the SF to continue to regenerate the historic centre and the peripheries.

Baia Mare (RO) has identified 48 different projects, part of which to be funded via the ROP (for 11 millions of euro). Among the foreseen actions: improve urban accessibility (road network), interventions on the public transport system, building a centre for disabled.

Also in Bacau (RO) and Torino (IT) there is a link with SF, direct funding in the case of the Romanian partner, indirect in the Italian case, but in the other cases (Madrid – ES, Lidingo – SE, Lodz – PL, Barnsley and Belfast – UK) there was since the beginning a great difficulty in linking the needs and ideas of cities with the ROPs. In the case of cities in competitiveness regions this was expected (as we have seen in part 1, health is not a priority for competitiveness regions), in convergence regions, instead, the main problem was to coordinate and harmonize regional and cities priorities.

In general, even when a good use of SF has been achieved (or foreseen), still the relation with the Managing Authority has been problematic – often because MAs have to take into account needs of many cities in their regions – making the scenario proposed by the Barca Report even

[7] It is not by chance that in this framework DG Regio is called to become a centre of competences, to provide highly qualified experts in the core priorities, with expertise on policy, measurement, institutions, and a capacity to tailor the analysis to specific contexts. For more info on such perspective see pp. 183-184 of the Barca Report.

more promising for the future programming period.

## 2.3 Key points for the future debate

- ⇒ Links between health and Structural Funds are possible as long as there is a concrete possibility of cooperation between Managing Authorities and cities (co-operation will produce more than adaptation of one agenda to the other)
- ⇒ Health and quality of life are very broad issues and their relevance is to be found in different budget lines, programmes, initiatives that can be interpreted, adapted and imagined differently
- ⇒ Greater attention should be paid to investments in non-health sector that have potential added value for health, and specifically potential impacts on the wider economic, social and environmental determinants of health
- ⇒ Knowledge of the Structural Funds process and of the funding possibilities is vital for cities
- ⇒ Assistance with EU and national bureaucracy requirements is needed
- ⇒ The local level should highlight its role in proposing, implementing, monitoring and learning about healthy policies

# Annex 1. The Lecce Exchange on urban planning and environmental sustainability

## A brief report on the Exchange by the Lecce LSG

In March 2011 nine out of ten partners of the BHC network met in Lecce for the fourth and last Exchange, on urban regeneration from the point of view of planning and environmental sustainability. The Exchange focused on the experience that Lecce has in urban regeneration having been an URBAN II city (with a project of renovation of its historic centre). Starting from this experience, the city has designed a local action plan that extend to the peripheries the regeneration process and adopt environmentally sustainable approaches to urban design.

The city, in fact, adopted an urban and suburban requalification plan to remove aerial electric cables, emphasising the city outlook improvement to reinforce citizen good perception of the city and their use of the public space.
The Local Action Plan (LAP), titled "Traditions projected towards the future", promoted the Lecce Municipality and designed the Local Support Group (LSG) for the Building Healthy Community (BHC) project originally started with the selection of specific actions to lay underground electricity cables in the historical centre of Lecce and in nearby degraded neighbourhoods (see fig. 1 and 2).

Fig. 1 – An example of electric transmission cable in the historical centre

Photo: courtesy of Lecce LSG

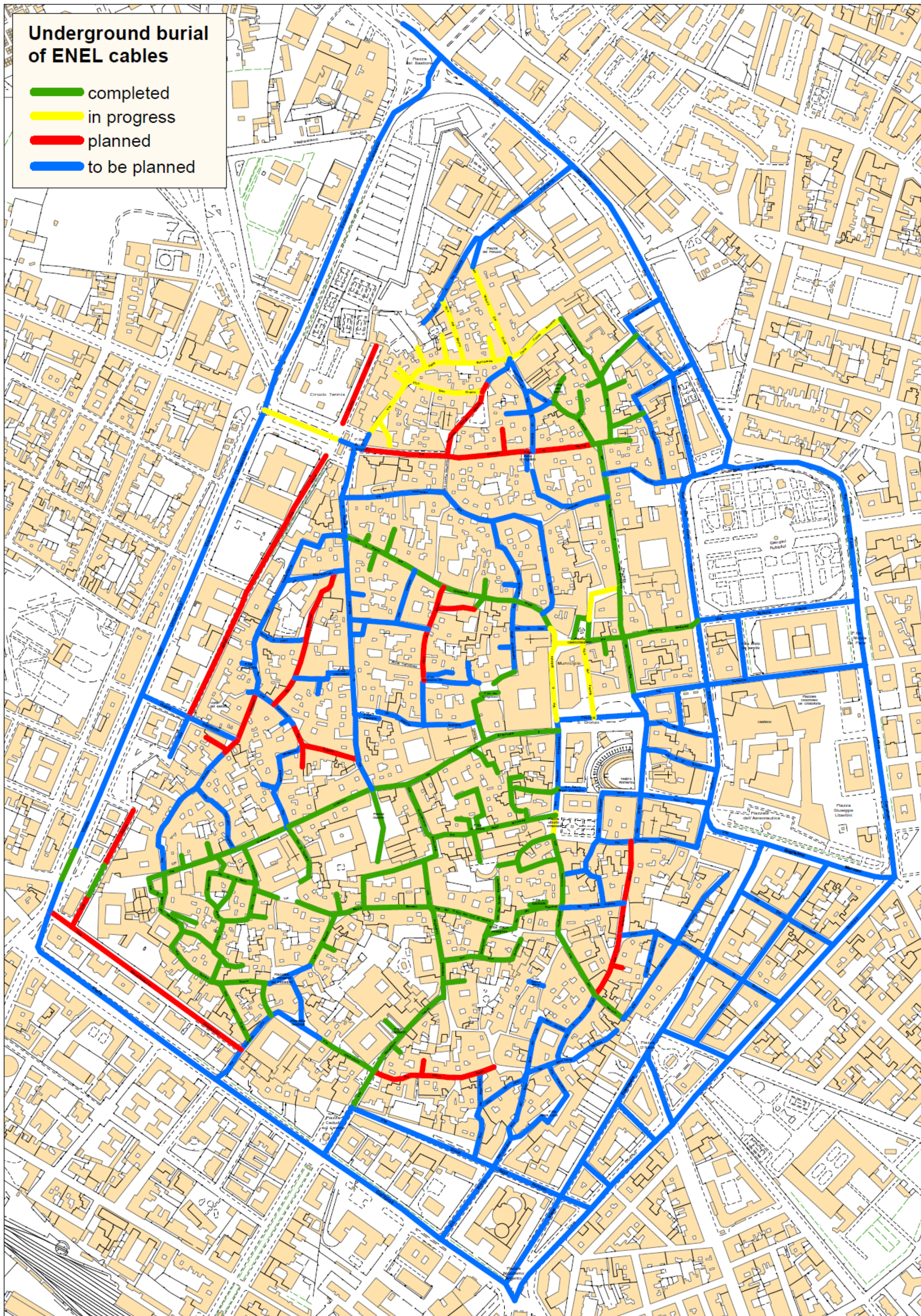
Fig. 2 – A view of the ENEL electric sub-station in the neighbourhood "zone 45"

Photo: courtesy of Lecce LSG

The rationale for such interventions being that a healthy urban community requires in addition to a series of indispensable infrastructures also a tidy and well kept environment, considered as elements of an attractive and lively city. These elements are somewhat linked to the city historical and cultural past and its projection towards the future. In our modern conception of city life, citizen more than ever have the right to enjoy the beauty of their historical building heritage, including the possibility of traffic-free streets to better benefit of public spaces of cultural/social interest. Lecce with its almost hundred thousand inhabitants has specific urban features being a pre-roman city, bounded by walls with three main accesses and mostly famous for its Baroque architecture.
Aerial cables' removal is among the latest actions which are part of a larger urban regeneration picture tailored to re-qualify the historical centre of the city. Specifically, Lecce's LAP builds on existing projects that have been already initiated and led to the removal of more than 3.5 km of aerial lines (see fig. 3). A total of more than 12 km of cables have been already planned to be removed allowing regenerating the latest buildings of historical and cultural importance. Speaking of health obviously aerial cable removal fulfils two purposes. In addition to the explained improvement of external city outlook, there are implications for the reduc-

tion of the impact of electromagnetic pollution, though not critical in Lecce city centre.

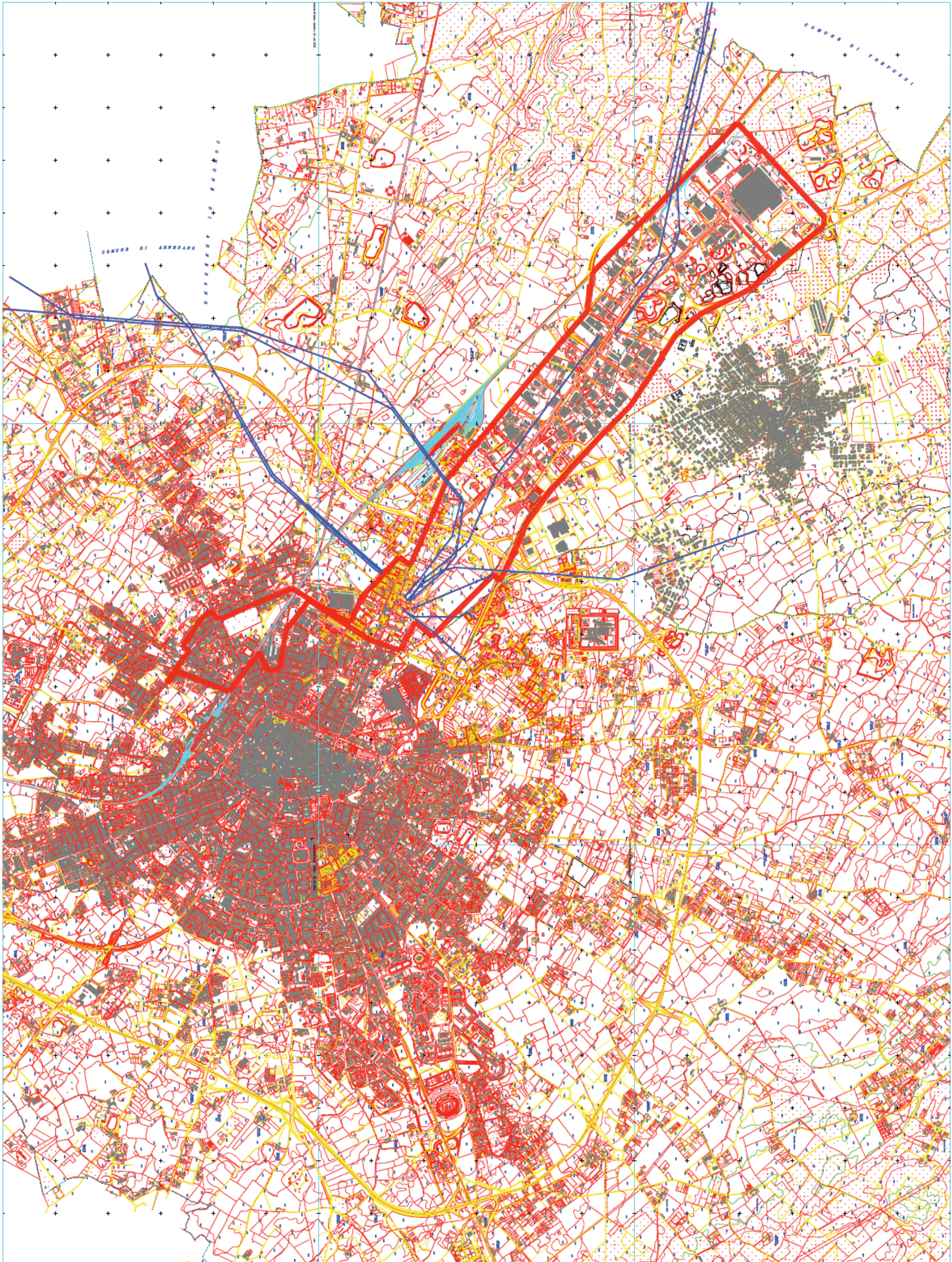
Fig. 3 – Map of the system of cables which have been laid underground in the historical centre




Map: courtesy of Lecce LSG

Lecce's LAP, though very specific, should be interpreted in a broader perspective. It is the result of two-year experience within BHC that allowed the local LSG to further expand its original aim. The LAP is one parcel of a larger mosaic of urban regeneration interventions initiated in the late '80 and actually concretized from the '90 onwards aimed to restore ancient buildings, archaeological sites including the roman theatre and the amphitheatre. Several interventions have been carried out benefiting of several EU projects such Urban II and others that allowed to regenerate the entire Lecce city centre. Starting from this the challenge the LSG intended to take is to extend the removal of electric cables to adjacent neighbourhoods. Following some initial steps we intend to put the basis for a possible relocation of a sub-urban electric station from ENEL located in the area called "zone 45". This is an interesting area currently not very attractive because it still suffers from being a former industrial area. Buildings in this neighbourhood are popular type of the mid '60. Although this area is a potential area of the city expansion, the closeness with an old style industrial area requires investments for its regeneration.
Again in this ambitious aim of the city development and regeneration, the role plaid by unattractive cables and electricity towers is problematic. BHC aims, goals and methodologies have been interpreted by the Lecce LSG in terms of identifying actions leading to new challenging "funded" projects to have a real impact on city life. The aim will be to restore and regenerate what represent a witness of the Lecce history by incorporating the new ideas and research findings in the context of urban sustainability. Without dismissing the city historical patrimony and heritage, we intend to promote those BHC ideas of healthy communities as a starting point for a better quality of life.
Specifically, starting from the historical center the LSG intend to build an ideal "healthy" path which connects the past with the future i.e. the historical centre with the industrial area located in the north-western side of the city. Given its specific geographic position this coincides with the main entrance/exit to/from the city. Building the "ideal healthy path" will translate in setting up new innovative and cutting-edge projects to regenerate all urban elements that we can find along the defined trajectory. It is worth mentioning that the work of our LSG has been that of identifying such a possible trajectory. The important features of the regenerations will take into account the presence of existing green areas and trees, the possibility of embellish existing roads with features for cycle and foot paths, facilities for less-able, elderly people and children.

Fig. 4 – Map of Lecce: The dark red line indicates the area where the ideal "healthy path" identified during the BHC project will be developed. It connects the historical centre of the city with its main industrial area




Map: courtesy of Lecce LSG