Introduction

The European Union’s structural funds were developed to promote economic growth and social stability. From 1992–2006, with up to 15 Member States, regional development funds were allocated to territories with GDP per capita below the European average, particularly in Greece, Southern Italy, Spain, Portugal and Ireland. The 12 ‘new’ Member States have widened the gap between the richest and poorest EU regions, and the structural funds for 2007–13 have been increased (with spending on the Common Agricultural Policy reduced) and refocused towards the new Member States. The European Union receives about 1.2% of the total per capita GDP of the EU countries together. For the 7 years 2007–13, the structural funds total €348 billion, and they form about one-third of the total EU budget. The structural funds are defined in two ways. As Cohesion Policy, they are divided as €55 billion for Convergence, €283 billion for Regional Competitiveness and Employment, and €9 billion for Territorial co-operation. As Development Funds, they are also allocated in three parts: the European Social Fund (ESF, 22%), the European Regional Development Fund (ERDF, 58%) and (primarily for the new Member States) from the Cohesion Fund (20%). In simple terms, the ERDF assists public and private capital investment, the ESF assists people (especially workers), and the Cohesion Funds support a mix of actions.

Importantly, the funds are available to Member States on application only from their ministries of finance, not directly by lower tier organizations, and must be matched with national funding. Negotiation for structural funds for national sectors, such as ‘health’, is between the European Commission’s Directorate for Regions and the national ministry of finance. The Commission has allocations for each country, but also by sector: in the current period, up to €5 billion of the total is available for health, €1 billion for ageing and €5 billion for IT (all purposes). Within the 12 new Member States, the proportion of national funds allocated to health differ substantially, with Hungary and Latvia the highest at 5.4%, down to Cyprus at zero (table 1). The focus on poorer regions of Europe assists addressing regional inequalities, while other structural funds investment can assist ‘health in all policies’: expenditures within the ERDF and CF are 19% for environmental protection and risk prevention, 24% for research and innovation and 28% for transport.

Implementation

Since the structural funds are accessed nationally, Members of the Commission’s Directorate for Health have been working with national ministries of health in the new Member States to support their strategies for accessing the funds. National ministries of health need to:

1. Ensure a specific operational programme for health within the funds.
2. Determine priorities with a balance of objectives between health promotion and healthcare.
3. Agree health priorities within other sector policies and investments.
4. Determine health investments which take into account public health trends, and national and regional contexts and plans.
5. Increase administrative capacity and expertise.

Table 1 European Union structural funds: direct health sector allocations 2007–13 to new Member States

<table>
<thead>
<tr>
<th>Country</th>
<th>Total allocations directly to health field (€m)</th>
<th>National structural funds (%)</th>
<th>New Member States’ structural funds (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulgaria</td>
<td>70</td>
<td>1.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Cyprus</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>418</td>
<td>1.6</td>
<td>10.8</td>
</tr>
<tr>
<td>Estonia</td>
<td>145</td>
<td>4.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Hungary</td>
<td>1336</td>
<td>5.4</td>
<td>34.7</td>
</tr>
<tr>
<td>Latvia</td>
<td>247</td>
<td>5.4</td>
<td>6.4</td>
</tr>
<tr>
<td>Lithuania</td>
<td>240</td>
<td>3.5</td>
<td>6.2</td>
</tr>
<tr>
<td>Malta</td>
<td>29</td>
<td>3.4</td>
<td>0.7</td>
</tr>
<tr>
<td>Poland</td>
<td>947</td>
<td>1.4</td>
<td>24.6</td>
</tr>
<tr>
<td>Romania</td>
<td>147</td>
<td>0.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Slovakia</td>
<td>250</td>
<td>2.2</td>
<td>6.5</td>
</tr>
<tr>
<td>Slovenia</td>
<td>15</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Total</td>
<td>3835</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For information on the European Union’s structural funds, see http://ec.europa.eu/health/health_structural_funds/used_for_health/info_sheets/index_en.htm.
(6) Develop impact measures and demonstrate that programmes are following the proposed paths.

Equally, health policy for the structural funds should develop the role of the regions, which are strategic bodies in planning and may also coordinate health systems. Support for regions is being provided through two networks: HealthClusterNet, a network of regional authorities concerned with procurement practice, employment of vulnerable social groups, capital investments and promoting innovation, and EUREGIO III, which focuses on capacity-building of experts, regional policy makers potential funds applicants through international workshops and training events. There are also industry networks. For example, COCIR, the European coordination committee of the radiological, electromedical and health-care IT industry sees future ‘sustainable’ healthcare ‘through wide scale adoption of healthcare IT systems and related telemedicine technologies throughout the Member States’.

Strong evaluation is needed to show that healthcare investments through the structural funds are both effective and sustainable. Programmes often use administrative rather than health priorities because ministries of finance are risk averse: they want no flaws in the process, yet also full and legitimate use of the funds. The contributions of ministries of health, regional partners and end-users (municipalities, health authorities, health professionals) to the outputs and health outcomes of the programmes should be assessed. The challenge is greatest where health is a subsector within broader programmes, or where people need to work together across sectors, for example with environment, transport, social security and employment.

Opportunities
The structural funds can support country health systems through attracting and retaining workers, support for IT, the link to pensions and social security, and through research and innovation for economic development. The health sector also needs to make the ‘health = wealth’ argument, demonstrating that health is a beneficial investment rather than a cost. There need to be new models for prevention and care through technology diffusion, dispersed systems and parallel disinvestment in old systems. And the health sector should encourage beneficial indirect investments—e.g. through business sector attention to health and safety, and in ‘health in all policies’ through other European programmes.

Two further fields can be considered in the development of health within the structural funds. An important issue is planning for social and health-care services for the increasing proportions of elderly people. In many of the new Member States, upgrading acute hospitals has been the priority. Healthcare for elderly people depends on good hospital assessment and treatment, but this is only one part of the picture. More can be done at home with suitable community support, and long-term care provision is needed for people where family carers are no longer available. A second important field is health research. The structural funds already have separate operating programmes for research, and several of the new Member States are planning to spend >10% of their total funds on research in general. However, the emphasis for health research has mostly been on biomedical research, for example biotechnology and science parks. Ministries of health should engage with ministries for science to make the case for more research in public health.

Conclusion
Cohesion policy and priorities for the structural funds for the period 2014–20 are already being discussed. National ministries and regional tiers must develop expertise to identify need, launch calls and manage projects. The health sector should be able to present successful economic and social arguments, including business cases, within complex bureaucratic settings. Significant skills need to be identified, encouraged and developed. Academics, public health practitioners and non-profit organizations, as well as private consultants, have important contributions to make.

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Key points
- The structural and cohesion funds help poorer regions and social programmes, and are now one-third of all European Union funding; the 12 EU new Member States have become the main beneficiaries.
- Funds are allocated by Member States, usually through the ministry of finance and with variable involvement of lower tier organizations.
- In the 2007–13 programme, 1.5% is allocated to health, while further benefits can come through ‘wider determinants’.
- Work is needed to evaluate the health outcomes and impacts of the funds.
- Unmet needs for funding in future include social and health services for elderly people and support for public health research.

References