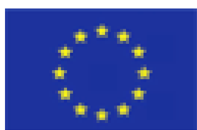

Report 1 for Executive Agency for Health & Consumer

Health and Structural Funds, Stakeholders, expertise and resources: Progress made in 2009

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[1] Health ClusterNET is an interregional European Network of regions for support, advise and exchange of expertise in using health sector investment to improve regional economic and social development

Contents

Acknowledgements	2
Abbreviations used in report	6
1. Background to the report	7
2. Conducting the stakeholder questionnaire and the use of Capacity Building Framework	10
Introduction	10
Using a capacity building framework	11
Diagram 1: The capacity building framework and EUREGIO III	*13*
Links between CB and EUREGIOIII	*14*
Table 1: Links between EUREGIO III health gain functions and the CB framework	*15*
3. Methodology of the Stakeholder survey	16
4. Main findings and some additional comments	16
The briefing paper about the understanding the stakeholders, expertise and resources in the SF system and operating context of EUIII	17
The Template for stakeholders and expertise in SF Health Investment	19
The Template for resources in SF Health Investments	21
5. Defining terms in Work Package 6	21
Stakeholders	21
Expertise	22

Resources	22
Screening & Scoping	23
Stakeholder analysis	24
Capacity Building Audit	26
6. Defining stakeholders information and training needs at the 1st Regional Master Class on Innovative Utilization of Structural Funds in Europe	28
Leadership (Table 2)	28
Organisational development (Table 3)	29
Resource allocation (Table 4)	29
Workforce development (Table 5)	30
Partnership working (Table 6)	31
7. Example(s) of Managing Authorities Organizational Model	33
Greece	33
Diagram 2: Organizational Chart of the new Managing Authority Model in Greece	34
8. Review of the First Inventory of Stakeholders and expertise	35
Table 7: Feedbacks from EUREGIOIII Reference and Core Group members about the up dated contact details of the stakeholders and expertise	36
9. References	37

10. Annexes

Each Annexe is attached to this Report available and can already be downloaded. Please look for www.euregio3.eu to view the Report and All Annexes:

10.1 ANNEX A: Action Plan for 2009

10.2 ANNEX B: Briefing paper about the understanding the stakeholders, expertise and resources in the SF system and operating context of EUIII

10.3 ANNEX C: Stakeholder Questionnaire

10.4 ANNEX D: Template for stakeholders and expertise in SF Health Investment

10.5 ANNEX E: Template for resources in SF Health Investments

10.6 ANNEX F: First Stakeholder and expertise Inventory in EU12

10.7 ANNEX G: First Stakeholder and expertise Inventory in EU15

Abbreviations used in this report

EIII	EUREGIO III
SF	Structural Fund
EU	European Union
MS	Member States
EU12	European Union 12 (New Member States)
EU15	European Union 15 (Old Member States)
CB	Capacity Building
CBF	Capacity Building Framework
CBA	Capacity Building Audit
NSRF	National Strategic Reference Framework
OP	Operational Programme
ROP	Regional Operational Programme
AP	Action Plan
HI	Health Investment
MH	Ministry of Health

Capacity Building Framework abbreviations

L	Leadership
OD	Organisational Development
P	Partnerships
RA	Resources Allocation
WD	Workforce Development

1. BACKGROUND TO THE REPORT

1.1 Funded by the European Commission's Executive Agency for Health & Consumer under the 2008 health work programme and started in January 2009, EUREGIO III supports the innovative approach of using Structural Funds for health.

1.2 The general objective of the project is to identify & share good practice and lessons learned for the effective use of SF for health and help reduce health inequalities among EU regions. It is a key resource to help Member States; regional authorities; local authorities and actors to develop, apply & implement SF project for health gain. EIII builds access to the practical know-how knowledge that regions have identified as a priority development for 2007-2013 periods.

1.3 The Inventory of stakeholders, expertise and resources (Work Package 6 – WP6) has the following objective for 2009: conduct a *Scoping and Screening Exercise* of existing information and expertise in the field of health gain related to SF and produce the *First Inventory*. The WP6 leader conducted a stakeholder survey in the first semester of EIII project. The purpose of the survey was to identify (i) the stakeholders and expertise involvement in EIII from the point of view of each Work Packages and (ii) suggest resources to include in the Template for resources in SF Health Investments.

1.4 The project started with a need to clarify the function of OP Managing Authorities and Programme Secretariats as well as other bodies executing the Programme in order to share the same understanding of the very diverse stakeholders involvement in SF Health Investment (see Annex B).

1.5 At the very beginning of the project it was very difficult to make decisions on a number of issues, including who are the key stakeholders/target groups of the project from the standpoint of differing views of the core group and reference group members?

1.6 The involvement of very diverse stakeholders and expertise in the EUREGIO III project would depend on the stakeholder's own information and training needs. Stakeholders will define their own supports needs and the WP6 Leader will have more results about this after the stakeholder analyses in 2010.

1.7 While the background papers for building up the first inventory of the stakeholders, expertise and resources were in progress it was realised that the management of SF is a very complex system it is very difficult to separate the different bodies tasks and responsibilities, because there are complementary and interdependent to each other.

1.8 At the 3rd European Conference of Health ClusterNET (Bilbao, 2008) we have learnt that one of the very significant problem of managing and implementing SF programme/project suffers, because the relevant bodies are often not in good communication with each other.

1.9 So, we needed to be very careful about making a decision on the focus of the key target audiences without having more information and knowledge of their real needs in the first year of the project.

1.10 We were also aware that the engagement of regional authorities in preparing and implementing (Regional) Operational Programmes as OP Managing Authorities and/or Monitoring Committees does not exist in all MS. There has also been no clear attention to holistic capacity building in most of the newer EU12 e.g. some mentions of workforce development (e.g. Slovakia); with only some holistic capacity building mentioned as planned in Latvia.

1.11 There are examples of new developments which are mainly partnership focused: Regional Growth Forums (Denmark); Regional Sub-committees (Hungary); economic & social partners engaged in implementation (Netherlands); Regional coordination committee (Romania); bottom-up planning (Slovenia); regional development programmes (Sweden).

1.12 At the same time one of the main challenge is how the get information to the level that matters in relation SF funded health-related investments. This is an art of how to translate understanding of need into successfully getting

Structural Funds. We need to address the issue of whether or not the capital investment case studies should be taken into account addressing the management of the project pipeline.

1.13 What is striking is the degree of bureaucracy involved in the SF process and there will inevitably be a filtering process in getting information to the end users, in particular stimulating greater awareness and innovative thinking about capital investment project opportunity at front line level - there is no easy answer to this at present.

1.14 The core group agreed that the need for capacity-building efforts is inevitable by EUREGIO III especially in EU12 countries. For EUREGIO III we will use a holistic capacity building framework (see section 2 below) including leadership (management), partnership, organisational development, training and allocation of resources. To become sustainable and to realize an impact, the project should aim and support at least to a certain degree of capacity building for continuous learning. WP5, 6, 8 and 9 should contribute to this process.

1.15 WP6 was set up by EUREGIO III with the following remit for 2009:

- Online Database (First Inventory) & Thematic Report1 on the existing stakeholders, expertise and resources
- For each EU member states a detailed contact lists of stakeholders and expertise regarding Managing Authorities (MA) of Structural Fund Operational Programmes (OP), projects, Ministries of Health and other stakeholders (see Annex D) has been produced divided into two Excel files one for EU12 & another for EU15 countries.
- This part of the Inventory presents an overview on the detailed management of programmes, which receive support from the Structural Funds. For every programme, they designate a Managing Authority (at national, regional or another level), which will inform potential Beneficiaries select the projects and generally monitor implementation.
- In most cases, it is identified who are the MAs for those Operational Programmes that have health Infrastructures and/or other healthy priorities already included in their OPs. This given in the form of bold and highlighted in red.

- The results of the Scoping and Screening exercise provided a conditional basis for the work of WP2, WP5, WP7, WP8 and WP9 (Annex A of this report shows the detailed Action Plan for 2009).
- After 2009 WP6 has to consider to pick up on the available information regarding resources using the Stakeholder analysis and Capacity building audit to build up the online database regarding the resources as well

2. CONDUCTING THE STAKEHOLDER QUESTIONNAIRE AND THE USE OF CAPACITY BUILDING FRAMEWORK

INTRODUCTION

2.1 At the first semester a questionnaire about the expectations and the definitions of stakeholders, expertise and resources were conducted. The questionnaire was sent to the Core Group (CG) members after the first project meeting in April 2009. At present the list of stakeholders, expertise and resources in Europe aims to capture a range of target audiences, systems and organisational elements that are considered important in the delivery of health gain by the use of SF.

2.2 Following the 1st core group meeting in Luxembourg the WP6 leader produced i) a briefing paper about stakeholders understanding of, expertise and resources in the SF system and operating context of EIII, (ii) a Template for stakeholders and expertise in SF Health Investment and (iii) a Template for resources in SF Health Investments (Annex E).

2.3 The purpose of the briefing paper was to explain to the Core & Reference Groups the kinds of organisations we would seek to include into the first inventory and use in our Master classes and workshops. An additional purpose was to get some understanding for the need for capacity building among these stakeholders and put them into the operating context of our project.

2.4 The Stakeholders and expertise in Structural Funds health-related investments template split into 5 categories (EU, National, Regional, local level & thematic) manly focusing on direct health sector investments

especially in 2009 and an overview on the detailed management of Operational Programmes, which receive support from the Structural Funds.

2.5 Based on Managing Structural Funds: A Step-by-Step Practical Handbook (Smail R., Broos L.,and Kuijpers E. 2008) the WP6 leader has identified examples of concrete resources, presented in template 2. This was completed by the suggestions from the members of the core group, together with the other template above.

2.6 A reminder about returning the stakeholder questionnaire followed in May 2009. Before the second project meeting June 2009 every core group member (except one) returned and/or commented on the questionnaires. Some questions have been raised and different positions about the priorities of the key stakeholders and target audiences were given. Methodological issues presented in chapter 3 the main findings and some additional comments are given in chapter 4. Annex C shows the questionnaire format.

2.7 In preparing an analysis of stakeholders questionnaire returns, the Core Group were clear that they wanted the analysis to move on considerably about who should be involved as a focus target audience of EIII from the last core group meeting (Luxembourg) and to take into account that the aims and objectives of the project is itself in a development cycle.

Using a capacity building framework

2.8 The analysis will be new and so merits some further explanation at this point. The summary framework that is used in this report is a Capacity Building Framework (CBF). The framework was originally developed in New South Wales, Australia. The approach has been rigorously tested and validated over several years. Its adoption has led to considerable strengthening of health improvement delivery in New South Wales. More recently, it has been used in the United Kingdom and Europe (i) to audit public health workforce development (ii) as an assessment framework to guide and measure improvements in the performance of local health systems (iii) as a basis for orientating a strategic review of public health provision.

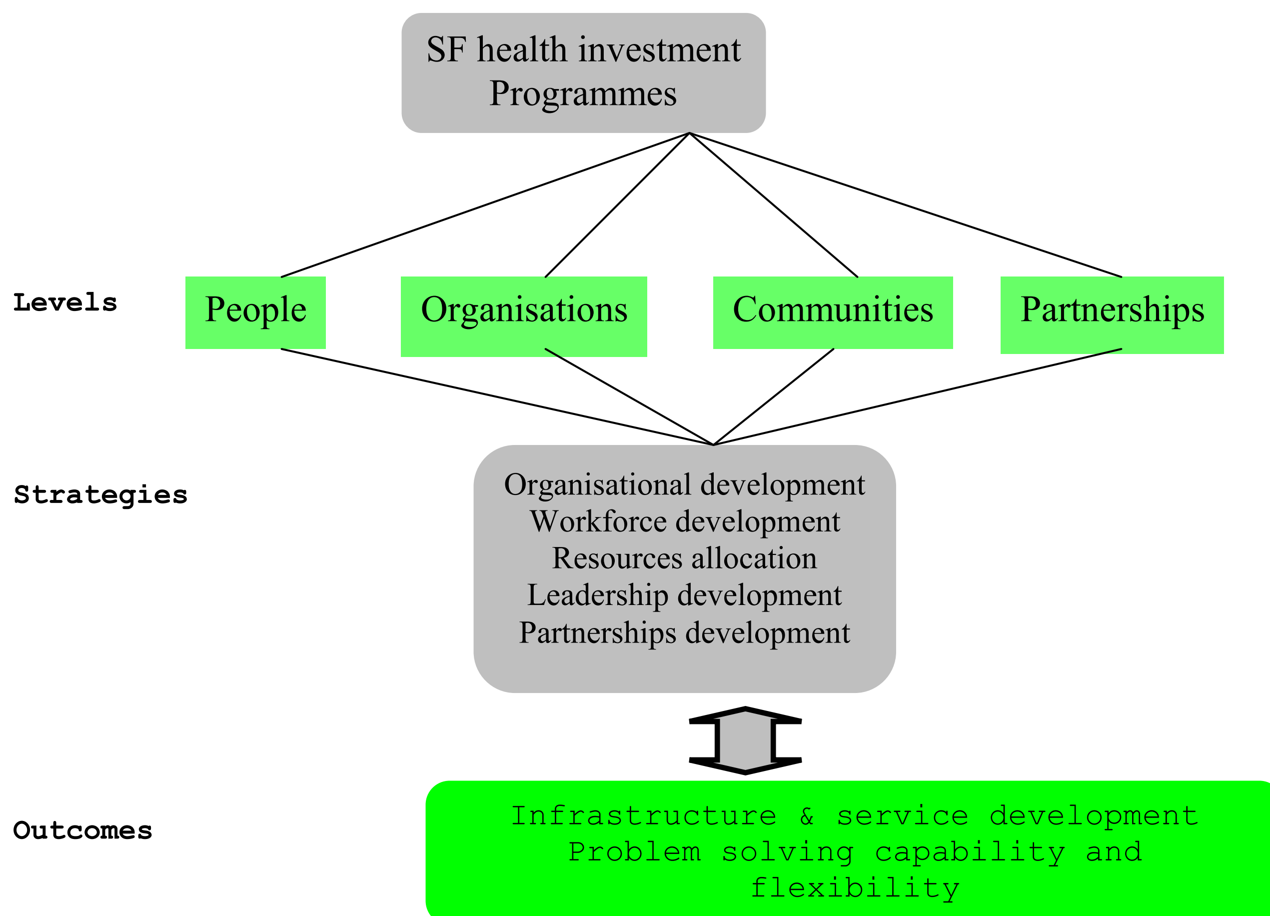
2.9 Capacity building in health development is conceptualised and organised in many ways. It has often been described as the invisible work that is essential in building health infrastructure, maintaining and sustaining programmes and creating flexible problem solving capability. This work is often visible as strategies for workforce and organisational development, leadership and partnership development, and resource allocation. Capacity building is the necessary "process" work of health improvement. In thinking about capacity building we can gain insight into what is working and why. Defining the capacity building effort enables day-to-day and strategic activity to be made operational and measurable.

2.10 For EUREGIOIII and their partners capacity building is essential in:

- building infrastructure to plan and deliver health investment at regional level (structures, organisational skills, resources),
- building partnerships and organisational environments so that regional HI programmes are sustained and programme health gains are sustained,
- building problem solving capability within the partnerships model.

2.11 Capacity building is an approach to development with the goal of producing effective implementation and achievement of outcomes in health investment. As important, is that using a capacity building approach creates a 'big picture' for EUREGIO III within which attention to the necessary detail of functions and priorities can be analysed and reported more coherently (see Diagram 1).

Diagram 1: A capacity building framework for health-related Structural Fund investments



Consequently, it was proposed to and accepted by the Core Group that the capacity building framework be used in the analysis.

2.12 In Australia, the development and systematic application of a capacity building approach has resulted in the development of a strong public health infrastructure over many years including: the development of Public Health organisations; delivery of sustainable and effective public health programmes, skills, organisational structures, resources; and commitment to improving community health and well-being.

Links between CB and EUREGIO III

2.13 Before using the CB framework in the Stakeholder Analysis and Capacity Building audit as a summary analytical framework, an assessment will be made of the extent to which the CB framework can take account of and integrate "evidence reported" by the key stakeholders regarding their information and training needs at the 1st Master Class in Budapest. This assessment involves (i) comparing *indicative action areas* identified by the Master Class participants, (ii) *'Health Improvement Functions'* of the EUREGIO III (direct & indirect health sector investments and non-health sector investment with potential health gain) with (iii) key action areas under the five domains of the *capacity building framework*. Table 1 below gives an example of the linkages.

2.14 Hopefully based on an assessment like this it will be concluded that, in general, the *CB framework can capture actions identified for the heath gain functions of EUREGIO III.*

Table 1: Example of the links between EUREGIO III health improvement functions and the CB framework

EUREGIOIII HI Function	Indicative action areas	Action areas under the Capacity building domain
Maximising the health impact of services (direct health sector investment)	• need for and access to services • providing health information • developing partnerships with stakeholders • extending the traditional role of health professionals	OD RA P Workforce development (WD)
Indirect health sector investments	EIII needs to pay attention to good practice examples of SF health-related activities	
Non-health sector investment with potential health gain		

2.15 It is important to note that a "tick in the box" for achievement is still no measure of quality, working processes, implementation or sustainability. Many capacity building measures are required to assess these factors further.

2.16 In summary, EUREGIO III are asked to recognise that

(i) the use of capacity building in analysis enables feedback to be framed in a way that is coherent and maps across to the key health gain functions and to regions strategic and organisational processes,

(ii) the use of this framework acts as a potential stepping-stone in the development of the CB process in EUREGIO III.

3. METHODOLOGY OF THE STAKEHOLDER SURVEY

3.1 This section provides the description of the methodology of the stakeholder survey as a tool for assessing the views of the core group members about the main target audiences of EUREGIO III. It documents the interest of project partners, their priorities regarding stakeholders, expertise and resources and the anticipated course at the start of the project. The aim is to document different perception of the stakeholders of the project and support the development of a common orientation.

3.2 The stakeholder questionnaire entailed only open questions concerning the stakeholders, expertise and resources of the project. It was sent to the Core Group (CG) members after the first project meeting in April 2009. A reminder followed in May and June 2009. All Core Group members except one commented and/or filled in the stakeholder questionnaire. The answers were summarized and descriptive (see chapter 4).

4. MAIN FINDINGS AND SOME ADDITIONAL COMMENTS

4.1 The list of suggested stakeholders, expertise, and target groups in the stakeholder template is very long. Actors are named from the European, national, regional and local level, from the political system and the European Structural Funds (EU SF) Managing Authorities, from the programme and the project level, as well as further beneficiaries.

4.2 It was thought to be useful to develop a long list at the start of the project and to prioritize the list over the course of the project – not at least for the organisation of Master Classes and Workshops. The stakeholder questionnaire was mentioned as a tool for both the development of the long list as well as *priority setting*.

4.3 Differences between older and newer EU MS should be taken into account because the countries and their health systems operate under very diverse conditions/in different contexts.

4.4 It was seen to be necessary to define the terms “stakeholder” and “target groups”. It should also be acknowledged that actors can belong to both groups, changing their status in line with the aim of interaction (e.g. DG SANCO is a stakeholder because it finances the project and has own interests in the project, while it can also be seen as a target group for the dissemination of project findings if they are beyond the scope of actual DG SANCO interests).

4.5 Some colleagues see difficulties in identifying the needs of stakeholders and target groups. There would be a long list with actors having complementary and interdependent responsibilities. The CG meeting would have been a good example how different backgrounds influence understanding. There could be a risk that the first Workshops and Master Classes would not meet the needs of the audiences because of missing knowledge.

4.6 For the project, a realistic perspective on what could be achieved is needed. It is assumed that the project will meet the needs of stakeholders/target groups in the fields of improving knowledge about process and good project management, while it would not be possible to deliver knowledge about outcome related returns.

4.7 It was recommended to follow Annex 1 of the Grant Agreement and to organise feedbacks by stakeholder and target groups (e.g. by the stakeholder questionnaire, Workshops and Master Classes) to check if something should be changed.

The briefing paper about the understanding the stakeholders, expertise and resources in the SF system and operating context of EUIII

4.8 An initial briefing paper by the HCN Executive Director proved to be very important, very informative document supporting the core group with what they need to consider in respect of information regarding stakeholders, expertise and resources in utilization of Structural Funds on Health Investments.

4.9 The descriptions of functions of the various actors are useful and informative. It is the case that there is quite a lot of overlap of roles and responsibilities.

This is a necessary feature of the way SF programmes/projects are implemented, even when this is done in an efficient way.

4.10 The identification of SF stakeholders and expertise has proved more difficult than anticipated because there is no central database & information is incorporated in a diverse range of locations embedded within the various EU Directorates and other resources.

4.11 A key challenge for EUREGIO III is how to get health people to make good cases to non-health people or how to translate understanding of need into successfully getting Structural Funds. For example, with the emphasis on infrastructure investment in the last and current SF periods: How to include a prevention scheme on back of a hospital capital investment project. That said, the Greek mental health programme is a different type of long-term investment. So, what happens when people invest for the longer-term? (J Watson, 2009)

4.12 The proposed workshops and master classes will work with these essential bodies in a complementary way or as the project proceeds decision needs to made how to group the different stakeholders according to their information and training needs.

4.13 Many public administrations in EU12 suffer from low wage levels, high rates of staff turnover, significant political change and influence, and rushed planning. The effects can be widespread, leading to a lack of ready legal instruments, capacity deficiencies, resource bottlenecks, and delays in initiating operations, weak engagement of potential partners, poor procedures and a failure to generate the best projects especially in the health sector.

4.14 It is to be hoped that *capacity building* measures are implemented to the full and that all MS move up their learning curve as quickly as possible. With the right exchange of experience activities, some may even be able to avoid the mistake made by others in the past.

4.15 Comments about some of these practical issues is an important ‘reality check’. As a study team, we believe we should spend some more time discussing the implications of this.

4.16 Generally, the paper needed some more discussion at the 2nd Core Group meeting in Budapest about (i) the approach needed to investment for health, in order to explain why the stakeholders WP6 leader has identified should be included. The list of stakeholders is comprehensive and appropriate, but we should accompany this by (ii) an adequate discourse to explain and justify this (Liverpool University, 2009).

4.17 It is clear that we will need to develop the list of stakeholders further during the time of the project. It is already mentioned that certain ministries often represent the nation state as a stakeholder. It might be possible to identify the stakeholders as "parts" of organisations/institutions (e.g. certain departments within certain ministries, certain units of the EU Commission etc.).

4.18 We will add more about the interests of the stakeholders in the 2nd year of the project. Maybe it is possible to identify groups of stakeholders or even existing networks of stakeholders especially in EU12. (K. Michelsen, 2009)

The Template for stakeholders and expertise in SF Health Investment

4.19 There were some uncertainties how we will go about identifying and selecting specific/named stakeholders in some of the groups. For entities such as the MA, this may/will be clear. However, for entities such as Universities, we will need to identify and select from a potentially large number (of institutions) in any given MS, and we need to find out which Universities - and Departments/individuals within the institutions – have relevant experience (Liverpool University, 2009).

4.20 It is important to separate our 'service function' from using WP6 to identify our target group for the project itself. So the lists have to cover everything. They have to show an 'ideal' picture, in which everyone is included, even if the practice looks different. Later on papers can be produced examining the 'reality', how to improve the process, how to build networks, strengthen cooperation.

4.21 The list of stakeholders is comprehensive and appropriate, but it would have been good to know how it works in the different countries. EUREGIO III

expected help in this from the RG. (E. Sebestyen, 2009). Unfortunately we received very little feedback on their view at the 2nd Reference Group meeting in June 30th, 2009, Budapest and after the meeting as well.

4.22 Reference Group members have been contacted with little success when asked to (i) provide country data to inform WP6 activities aimed at building the stakeholder/expertise/resources inventories in July and (ii) provide feedback to help the review of the First Inventory in November.

4.23 There was a need and very intense discussion and development the means of identifying the most relevant specific stakeholders within some of these groups (Liverpool University, 2009).

4.24 We discussed if all stakeholder are of the same importance, if some of them are of certain importance for certain stages of the EU SF process, and if they are of importance for the things we want to work or focus on for EUREGIO III. We should analyse their interests (K. Michelsen, 2009).

4.25 Potential Applicants/Managers and Beneficiaries of SF – have to be listed and categorised (the thematic list may already contain some of them). Who are these exactly in the different countries? We can also imagine that there are important differences between the older and newer MS also depending on the structure of the health system and the way investments made. WP5, WP9 and the Reference Group can help to identify these organizations, and we have to choose whom we are able to target.

4.26 The different DG-s at EU level can be further broken down into units that are important to us. E.g. Nick Fahy represented the Health Information Unit. He had a special perspective and interest in the SF process (see Purpose of the project.doc file from J. Watson, 2009). Other units probably represent other interests (E. Sebestyen, 2009).

4.27 Articles about EU SF policies stress that "partnerships", networking and cooperation have become very important. This includes also actors of the civil society like unions, employers' organisations, social movements, environmental organisations etc. We should clarify if and how they are

involved in Member States and regions and, if it makes sense, set them also on the stakeholder list (K. Michelsen, 2009).

4.28 We should involve WHO, in particular the European Office, and there may be other and related public health entities we should include to the list of stakeholders (Liverpool University, 2009).

The Template for resources in SF Health Investments

4.29 It is possible that we will add further resources if the project moves on and we decide that certain aspects are of high importance for us. For example, if we would decide to support sustainability, intersectoral learning, evaluative approaches for learning etc. we would have to add further resources (K. Michelsen, 2009).

5. DEFINING TERMS IN WORK PACKAGE 6

*5.1 Stakeholders: are persons, groups or institutions with interests in a project or policy or who may be directly or indirectly affected by the process or the outcome (*WHO, *Health Service Planning and Policy-Making, 2005, module 2).*

5.2 In the area of Health Policy and Health Care, stakeholders are any governmental entity, organization, company or individual that has a stake or may be impacted by a given health care system or health policy approach to provision, benefits or regulation of health care in a country.

5.3 Major stakeholders in health-care systems include providers, suppliers, beneficiaries, payers and decision makers. Providers of health care or medical devices are doctors, hospitals, and laboratories. Suppliers are pharmaceutical companies, and in some countries the governmental agencies as suppliers for health services. Beneficiaries of health care are the patients and their families. Payers of health care are health insurances, individuals, employers and in some countries the government. The government is the decision maker and sets the regulatory framework for providers, payers and beneficiaries of health care. In the context of national health policy and health care, each stakeholder plays a different role

according to the category he belongs to (Wilhelm Kirch, Encyclopedia of Public Health, 2008, p.1331).

5.4 However, increasingly, multiple sectors outside the health sector are being identified as stakeholders in health policy development and implementation. This includes not only the public sector but also agencies from the private sector. Law, finance, trade, and telecommunications are examples of sectors within governments with which the health sectors are required to collaborate on various aspects of public health.

5.5 Numerous legislations and regulations impact health of populations, likewise public health interventions call for economic and legal interventions for successful implementation. Thus, the public health professionals of tomorrow will be expected to have a wider understanding of determinants of public health beyond the health sector. Another challenge will be to work in close collaboration with multiple sectors, something that the traditional medical infrastructure, and even the health system to some extent, has not focused on, yet (Heggenhougen et al., International Encyclopaedia of Public Health, 2008, p: 3396).

5.6 Expertise consists of those characteristics, skills and knowledge of a person (that is, expert) or a system, which distinguish experts from novices and less experienced people. Experts recognize situations based on experience of many prior situations. They are in consequence able to make rapid decisions in complex and dynamic situations relying on recognition-primed decision making.

5.7 In line with the socially constructed view of expertise, expertise can also be understood a form of power; that is, experts have the ability to influence others as a result of their defined social status. Expert dominance refers to a tendency for the expertise of the specialist to influence unduly the outcome of decision-making and policy development.

5.8 A resource is any physical or virtual entity of limited availability. In economics, factors of production (or productive inputs) are the resources employed to produce goods and services. They facilitate production but do not become

part of the product (as with raw materials) or are significantly transformed by the production process (as with fuel used to power machinery).

5.9 To 19th century economists, the factors of production were land (natural resources, gifts from nature), labour (the ability to work), and capital goods (human-made tools and equipment). Recent textbooks have added entrepreneurship and “human capital” (labour’s education and skills).

5.10 In project management terminology, resources are required to carry out the project tasks. They can be people, equipment, facilities, funding or anything else capable of definition (usually other than labour) required for the completion of a project activity.

5.11 The lack of a resource will therefore be a constraint on the completion of the project activity. Resources may be storable or non storable. Storable resources remain available unless depleted by usage, and may be replenished by project tasks, which produce them. Non-storable resources must be renewed for each time period, even if not utilised in previous time periods.

5.12 Resource scheduling, availability and optimisation are considered key to successful project management. Allocation of limited resources is based on the priority given to each of the project activities. Their priority is calculated using the critical path method and heuristic analysis. For a case with a constraint on the number of resources, the objective is to create the most efficient schedule possible – minimising project duration and maximising the use of the resources available (from Wikipedia).

5.13 Screening *is the process of deciding whether a plan or programme requires Strategic Environmental Assessment (SEA). Integral to this will be establishing the objectives of the SEA: how does it intend to improve the planning process; what is its role? (A Practical Guide to the Strategic Environmental Assessment Directive, 2005, p.43).*

5.14 SEA is designed to explore and evaluate suitable alternatives. The sooner an SEA is introduced to policy formulation and plan making, the greater the chances are to identify opportunities and influence outcomes. The explicit

focus throughout the subsequent process should be on integrating environmental considerations (alongside economic and social ones) into key decision-making points when options and proposed activities are being developed and evaluated (DAC Guidelines and Reference Series, Applying Strategic Environmental Assessment: Good Practice Guidance for Development Co-operation, 2006, p.54).

5.15 Scoping is the process of deciding the scope and level of detail of an SEA, including the environmental effects and alternatives which need to be considered, the assessment methods to be used, and the structure and contents of the Environmental Report (A Practical Guide to the Strategic Environmental Assessment Directive, 2005, p.43).

5.16 A scoping process should establish the content of the SEA, the relevant criteria for assessment (e.g. goals set out in the National Sustainability Development Strategy). These should be set out in a scoping report. A pragmatic view needs to be taken on how much can be achieved given the time-scale, available resources, and existing knowledge about key issues. An open and systematic process should be followed. The SEA should actively engage key stakeholders to identify significant issues associated with the proposal and the main alternatives. Based on these issues, and the objectives of the SEA, decision criteria and suitable indicators' of desired outcomes should be identified. Scoping may also recommend alternatives to be considered, suitable methods for analyses of key issues and sources of relevant data.

5.17 Scoping procedures and methods, such as matrices, overlays, and case comparisons, can be used to establish cause-effect links between different specific plans or programmes or to identify the environmental implications of more general policies or strategies. A detailed options review may be undertaken as part of the scoping process to clarify the environmental advantages and disadvantages of different potential courses of action. Scoping meetings with stakeholders should result in a revision of the scope or focus of the SEA and improvements (as needed) to the draft engagement plan developed during screening (DAC Guidelines and Reference Series, Applying Strategic Environmental Assessment: Good Practice Guidance for Development Co-operation, 2006, p.56).

5.18 *Stakeholder analysis is a technique used to identify & assess the importance of key people, groups of people, or institutions that may significantly influence the success of the project and any possible cooperation mechanism (EUREGIO III, 2009).*

5.19 This information is a necessary step to develop strategies for managing these stakeholders to facilitate the implementation of specific decisions or organizational objectives within the context of existing policy. The stakeholder approach may result in higher public health care performance if the stakeholders of a health care organization appraise the value of health care collectively and all stakeholders have the best available evidence on which to make decisions about health care and services. However, it cannot be ignored that stakeholders in the area of health policy have cooperative and competitive interests and that policy development is a complex process-taking place in a continuously changing context. Therefore, the utility of stakeholder analysis for predicting future policy developments is limited.

<u>*Interaction and Conflicts*</u>

5.20 Analyzing the different stakeholder interests in quality of care may serve as an example to demonstrate that the interaction between stakeholders in a health system leads inevitably to conflicts. Providers tend to view quality in a technical sense meaning accuracy of diagnosis, appropriateness of therapy and the resulting health outcome. Payers focus on cost-effectiveness and patients, as the beneficiaries demand compassion, skill and clear communication.

5.21 This leads to the following two types of conflicts:

- Conflict of interest between providers and payers of health care:
  - In order to provide the best service, providers tend to use the most accurate and newest tests and treatments, which are also likely the most expensive.
  - Payers prefer a clear, evidence based, diagnostic plan, which will provide accurate diagnosis and treatment with the fewest visits and least number of tests.
- Conflict of interest between patients and payers of health care:

- Patients expect the payers (insurance companies, employers and the government) to offer a wide variety of options for health coverage that can be customized to their specific needs. They look to the employer to fund the majority of the cost of health insurance with the least out-of-pocket cost to them.
- Payers want to maintain or lower their cost contribution. They want the patient to seek only needed care, follow providers' instructions, and recover quickly. Patients should also seek to reduce their health risk behaviours through, for example, diet, exercise and smoking cessation (Wilhelm Kirch, Encyclopaedia of Public Health, 2008 p.1332-1333).

5.22 Capacity Building is the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organizations, and; the development of cohesiveness and partnerships for health in communities.

5.23 The competency of individual health promoters is a necessary but not sufficient condition for achieving effective health promotion. The support from the organizations they work within and work with is equally crucial to the effective implementation of health promotion strategies. At the organizational level this may include training of staff, providing resources, designing policies and procedures to institutionalize health promotion and developing structures for health promotion planning and evaluation.

5.24 The scope of organizational capacity building encompasses the range of policies and partnerships for health promotion that may be necessary to implement specific programs or to identify and respond to new health needs as they arise. At the community level, capacity building may include raising awareness about health risks, strategies to foster community identity and cohesion, education to increase health literacy, facilitating access to external resources, and developing structures for community decision-making.

5.25 Community capacity building concerns the ability of community members to take action to address their needs as well as the social and political support

that is required for successful implementation of programs (Ben J. Smith, WHO Health Promotion Glossary: new terms, 2006, p.2).

6. DEFINING STAKEHOLDERS INFORMATION AND TRAINING NEEDS AT THE 1ST REGIONAL MASTER CLASS ON INNOVATIVE UTILIZATION OF STRUCTURAL FUNDS IN EUROPE

6.1 In Budapest at the Regional Master Class on Health Investments in Structural Funds 2000-2006: learning lessons to inform regions in the 2007-2013 period participants defined their information and training needs regarding using Structural Funds for Health Investments.

6.2 This section provides the description of the information and training needs of very diverse stakeholders according to which capacity building domain these items belongs to. At the Master Class it was a very valuable first opportunity for the participants to present their needs and expectations from a project like EUREGIO III.

Leadership

6.3 In Hungary using Structural Funds for health investments is a priority at strategic level and it is recognised and presented by a participants from a Regional Development Committee. At the same time there is a recognition to the need how to harmonise the different development policies in order to use SF effectively and sustainable by informing direct health spending and exploring how to maximise wider health gains as well.

6.4 There is understanding of the complex policy challenges facing government. However policy design and critically, implementation is still pursued through sectors and sectoral interest groups rather than developing more flexible, intersectoral means of identifying, designing and delivering action. In parts this reflects a lack of investment in modernising public administration, especially in the health sector.

Table 2 Links between information and training needs of the stakeholders and capacity building domain (leadership)

	EUREGIOIII information and training needs	Stakeholders
(i)	Need for long term planning for development	Regional Development Committee
(ii)	How to harmonise development policies?	Health Institute/county level

Organisational development

6.5 Capacity building in organisational development context has been mentioned in issues like (i) barriers of implementation of a SF funded Capital investment project, (ii) changing legal frameworks that support projects implementation, (iii) how to plan and run a SF project on Health Electronic Registering between health institutions and (iv) how to advocate the added value of quality insurance regarding infrastructure development projects.

6.6 Representatives from Hungary, Slovakia and Romania mentioned that in many public administrations in EU12 suffer from low wage levels, high rates of staff turnover especially in Managing Authorities of Structural Funds programmes. The effects can be widespread, leading to a lack of ready legal instruments, capacity deficiencies in organizational development and delays in initiating operations, poor procedures and a failure to generate the best projects especially in the health sector. This reflects well on the main findings of the Stakeholder survey conducted at the 1st semester (see above).

Table 3 Links between information and training needs of the stakeholders and capacity building domain (organisational development)

	EUREGIOIII information and training needs	Stakeholders
(i)	What are the barriers (at strategic and bureaucracy level) of implementation regarding Capital investment in an inpatient clinic in a micro region in Hungary?	Mayer in a small town/Member of the Parliament/Member of a Regional Development Committee
(ii)	Legal frameworks in Hungary that support projects implementation changing. Implementation hindered. Can we/how to change the project?	Health Department/Budapest Municipality
(iii)	Planning and running a SF project on Electronic Registering between health institutions	National Health Insurance Fund
(iv)	Sell the added value of quality insurance. Infrastructure development helps to improve quality	Institute for Quality Insurance

Resource Allocation

6.7 At the European Master Class in Budapest participants presented ***resources allocation*** as the most important domain where capacity building should have

to focus in the EU12 countries. In this context 10 very diverse issues has been mentioned (see in Table 4).

6.8 The resources allocation domain includes knowledge, skills, information and financial resources as well. Integrated aspects of a capacity building approach helps with building the evidence for the link between this critical approach and the successful development of SF funded programme, projects and services (See Figure 1 above) and get the most effective use of the SF available in 2007-2013 period in EU12.

Table 4 Links between information and training needs of the stakeholders and capacity building domain (resources allocation)

	EUREGIOIII information and training needs	Stakeholders
(i)	Further funding opportunities for ROP regarding health investments. International examples for learning	EU affairs/Budapest Municipality
(ii)	How to assert professional knowledge in Structural Funds project?	EU affairs/Budapest Municipality
(iii)	Financial management of Capital investment	Hospital director
(iv)	Knowledge allocation regarding project management. What factors help or hinder the project implementation?	Master student in sustainable regional health systems
(v)	Project Management Mechanism of EU project	Hospital director
(vi)	Administrative questions of implementation	National Health Insurance Fund
(vii)	How to develop a proposal? Problems with bureaucracy.	Hospital director
(viii)	Efficiency in bureaucratic environment	National Health Insurance Fund
(ix)	Appropriate budget management. Project was planned in 2007 – ho to implement in 2009? Because of very slow processes budget became not realistic.	Project manager of a capital investment project regarding an outpatient clinic in a micro region
(x)	General interest. To get experience how to apply for SF money?	Hospital director, Berettyoujfalu

<u>*Workforce development*</u>

6.9 Training needs were mentioned in some cases as a priority in relation to (i) how to carry out and make easier a planed capital investment project, (ii) how a hospital can apply for SF, (iii) how to collect ideas, experiences, good examples and (iv) how to get the most out from SF projects.

6.10 The EC promotes the cost effective use of Structural Funds in the area of Health Investment planned under national or regional Operational Programmes. DG SANCO and DG REGIO recognise the value of training opportunities such as what EUREGIO III offers, and their eligibility in principle under ***Technical assistance***/capacity building priorities or measures.

Table 5 Links between information and training needs of the stakeholders and capacity building domain (workforce development)

	EUREGIOIII information and training needs	Stakeholders
(i)	Training opportunity for how to carry out and make easier a planed capital investment project	Capital investment for health sector/Budapest Municipality
(ii)	Training need on how a hospital can apply for SF? How to collect ideas?	Bethesda Hospital, Hungary
(iii)	Training need on (a) how to make a good business plan and (b) how to get the most out from SF projects?	Health Institute/county level

<u>*Partnership working*</u>

6.11 Partnership working was mentioned in some cases as a priority for (i) motivate and support partnership working at regional level, (ii) networking between administrative and health sector in convergence region and (iii) partnership working for delivering balanced services.

6.12 The European Union Structural Funds policies also stress that “partnerships”, networking and cooperation have become very important. This includes also actors of the civil society like unions, employers’ organisations, social movements, environmental organisations etc.

6.13 During the Stakeholder Analysis we should clarify if and how partnerships are involved in Member States and regions.

Table 6 Links between information and training needs of the stakeholders and capacity building domain (partnership working)

	EUREGIOIII information and training needs	Stakeholders
(i)	How to motivate regional partnership working? How to support regional cooperation?	Entrepreneur
(ii)	Networking between administrative and health sector at regional level in convergence regions	Regional representative, Romania
(iii)	How the very diverse stakeholders work together in the region for building balanced services?	Hospital director/Vas county, Hungary

7. EXAMPLE(S) OF MANAGING AUTHORITIES ORGANIZATIONAL MODEL

Greece

7.1 The Special Service Health & Social Solidarity is the only governmental service in Greece, dealing with the planning, management, coordination and evaluation of EU co-financed investments in the health sector. The Low 3614/2000 of the Hellenic Republic as well as a special Trans- ministerial decision regulates the service role and structure.

7.2 The Service is in charge of monitoring and implementing the Strategic Planning and 4 Operational Development Plans of the Health & Social Solidarity Sector, managing or coordinating investments co-financed by the Structural Funds of the European Union.

7.3 The Service is responsible also for the organizational and technical support of the Intra-ministerial Body for the national coordination of the health and social solidarity co-financed investments in Greece.

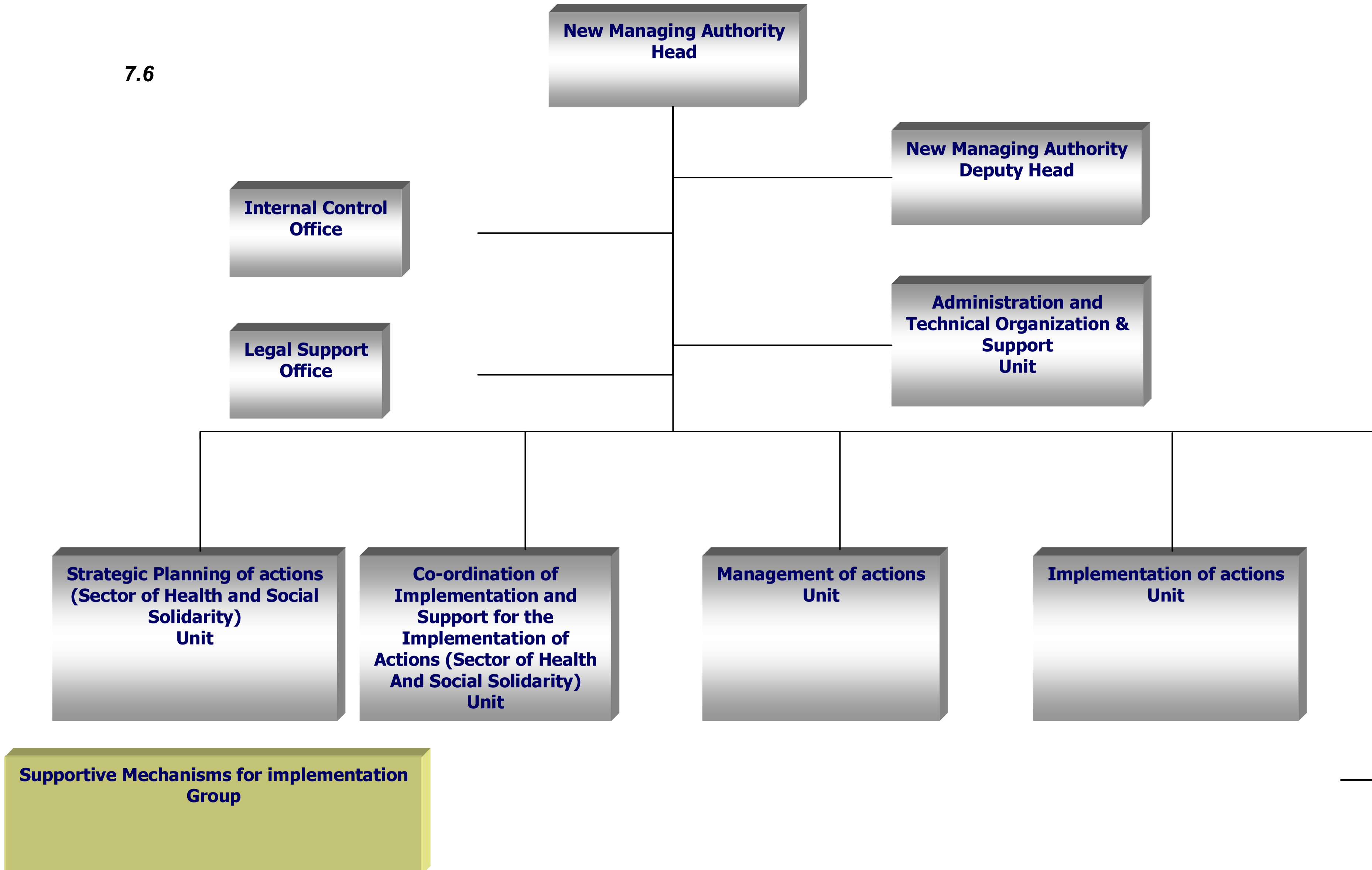
7.4 For the 3rd planning period, the Service operates as Managing Authority for the 0,5 billion Euro Operational Programmes "Health & Welfare", planned to close officially in 2009.

7.5 For the running period 2007-2013, the Service is operating as Intermediate Body for 400 M Euro Priority Axis under the OP Development of Human Resources (ESF funded) and Coordinator for a total of 1,2 billion Euro investments, planned under Sectoral and Regional Development Programmes in Greece (funded by the ERDF & Cohesion Fund).

Diagram 2: Organizational Chart of the new Managing Authority Model in Greece

NEW MANAGING AUTHORITY MODEL

7.6



8. REVIEW OF THE FIRST INVENTORY OF STAKEHOLDERS AND EXPERTISE

8.1 Phase 1 of WP6 of the EUREGIO III conducts a scoping and screening exercise of existing stakeholders and expertise in the field of health gain related to Structural Funds. The lists of all stakeholders have been put together (Structural Funds Programme organization and management, regional health services, regional governments, economic development agencies, universities, SME associations, public health networks, experts, regional policy makers, potential SF applicants, decision makers in national, regional, local institutions etc.) by middle of November 2009.

8.2 The inventory comprises a list of existing contacts information of stakeholders and expertise regarding Managing Authorities (MA) of Structural Fund Operative Programmes (OP), projects, Ministries of Health and other stakeholders in the EU12 & EU15 European countries. This part of the Inventory presents an overview on the detailed management of programmes, which receive support from the Structural Funds. For every programme, they designate a Managing authority (at national, regional or another level), which will inform potential Beneficiaries select the projects and generally monitor implementation.

8.3 The inventory is available on the EIII website (www.euregio3.eu) and provide a conditional basis for the work of Work Packages 2, 5 and 7-9. A first inventory available after 10,5 months of the project but will continuously be updated. WP2 builds on this WP by using it for the conduct of the Stakeholder event in Venice (month 14, 2010)

8.4 In some cases, it is identified who are the MAs for those Operational Programmes (OP) that have health Infrastructures and/or other healthy priorities already included in their OPs. It is bold and highlighted in red.

8.5 The WP6 leader has asked the members of the Reference Group to review the contact details regarding their own country/region and identify those contacts who are MAs of health-related SF OPs and/or projects as well as indicate contacts of unit(s)/department(s) of Ministries of Health dealing with SF.

8.6 The members of the Reference & Core Groups have been asked (i) to add contacts if necessary and/or (ii) highlights contacts that are key regarding investing in health from SF and send back the revised excel files to the WP6 Leader by November 27, 2009. The Inventory will be used for the master classes and workshops, organised by the project and provide a conditional bases for disseminating the outputs and results of EUREGIO III for potential target groups.

Table 7: Feedbacks from EUREGIO III Reference and Core Group members about the up dated contact details of the stakeholders and expertise

List of countries providing feedbacks	Name of the Contact Person	Institution/Position of the Contact Person	Contexts of the feedbacks
Estonia	Helen Ojamaa	Ministry of Finance of Estonia, Structural and Foreign Assistance Department	Deleted contacts from the list
Slovakia	Peter Pazitny, expert	Health Policy Institute, Expert to undertake a Health & Structural Funds assignment that EIII can inform and that can also contribute to EIII (Recruited by DG SANCO)	Asked to move him into a different categories of stakeholders
Italy	Silva Mitro	Region Veneto, Local Health Authority n. 10 Eastern Veneto	She forwarded it to the Italian Ministry of Economic Development for their review
Greece	Anna Kanakaki	Programming & Evaluations Unit, Managing Authority, Operational Programme "Health & Welfare, Greece	She is working on the review of the Greece database

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