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Operations Evaluation

Evaluation of EIB
Financing of Health
Projects

Synthesis Report

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Executive Summary

Introduction

This report is the first ex-post evaluation of the EIB's investments in health since "health" became eligible for EIB funding under the Amsterdam Special Action Programme (ASAP). It consequently covers the period from 1997 to 2006. Over that period, the Bank financed 89 investment and framework loans in 22 countries for a total signed loan amount EUR 10.7 billion. In addition, financing to the health sector was also provided indirectly through lines of credit accounting for some EUR 2.9 billion distributed throughout 37 countries. This evaluation covers all countries, but concentrates mainly on projects in EU Member States.

The evaluation is based on 1) a general review of EU, Member States' and EIB policies regarding health, 2) a comprehensive portfolio review of all 89 projects financed, 3) a detailed desk review of 25 projects, which forms the basis of the final 13 projects selected for in-depth analysis. Since this is the first ex-post evaluation of EIB's operation in the health sector and due to the recent discussion on the health eligibility criteria, the section on relevance is the focus of more specific analysis.

It is worth noting that the health sector is politically sensitive and technically complex, with a heavy dependence on issues of country and cultural context. This complexity applies for all players – levels of government, health care workforce, patients, tax- or insurance-payers, hospital authorities, contractors and funders.

Policy Context/Relevance

EU policies and strategies govern the Bank's mission. While the Bank's strategy derives from EU decisions, the scope for EU action in the provision of health care services is limited. The subsidiarity principle implies that Member States are themselves responsible for the financing and administration of health care services. Consequently, the analysis of EIB's past and present sector strategy will have to reflect these specific characteristics of the health sector.

Direct EU responsibilities in health so far lie mainly in the areas of public health and prevention. The application of general EU rules and regulations on, for example, labour markets, the free flow of goods and services, or the free movement of persons (workers and patients) has had multiple, far-reaching impacts on national health and health care systems. Among others, the EU Work-time directive, judgements from the European Court of Justice regulating free access to health services, free movements of staff, general acceptability of degrees and diplomas and consumer protection have all changed important aspects of national health care delivery systems. In addition, the EU has developed general policy goals relating to efficiency and economic competitiveness and growth (most notably under the *Lisbon Agenda*). Recently, the EU Parliament has recognized the paramount role of health care services for a European model of Society and called for an increased commitment of the EU Commission to a) ensure all citizens receive equal right to access high quality of care in any EU country, b) to consider health care services as services of general interest. The EU Commission has established a programme for the years to come with the objectives to a) improve citizens' health security, b) to promote health for prosperity and solidarity and c) generate and disseminate health knowledge.

EU Member States have different health care systems, which can usually be categorised as either social insurance-type or tax financed systems. Beyond their differences, however, they all share the same problems and impasses that have led to similar health reform proposals all over the Union. All health care systems suffer from increasing costs, due to demographic, epidemiological and technological changes. Also, many national systems are somewhat inefficient by today's standards and are based on often-outdated management models, which rely, among other things, on too much in-patient (hospital) care and too little use of information and communication technologies. Most countries are therefore under pressure to introduce more quality control measures and develop an evidence base for all health interventions. Ultimately, this should improve the national health systems' efficiency, reduce overall cost increases and cope with budgetary problems.

EIB so far has implicitly taken the view that health is mostly equivalent to health care. Indeed, it has concentrated its financing mainly on the creation or improvement of hospital infrastructure. Two years after the Amsterdam summit, a Bank health sector strategy was drawn up, but it has not been applied consistently. In 2004, this strategy was watered down and became less focussed. With the Bank's new strategic orientation in 2005, health has been de facto categorised as a secondary priority, which was reflected in the 2007-2009 Corporate Operations Plan (COP). Education was kept as a top priority under i2i, leaving health as a secondary priority. Only with recent management decisions, which were taken during the course of this evaluation, health has been reinstated as a top-priority under the "environmental" eligibility – sustainable communities.

Although this latest approach is logical, it limits the visibility of the sector, inside and outside the Bank. Additionally, it contrasts the fact that in the future, health will most probably move to an even higher level of priority within the EU, in relation to the Member States agenda on an improved European Social Policy.

EIB's lack of a constant, longer-term health strategy to a certain extent mirrors the EU's situation, which has become more and more involved in questions relating to health, without a clear strategic plan. Legal decisions and the application of directives that had not been issued with health care in mind have been main drivers of this process - in the absence of a clear mandate from Member States.

The always-increasing priority within the EU could, within the years to come, lead the Bank to define Health as one of its core, stand-alone top priorities. In order to be prepared for this movement, the Bank's health strategy and objectives should be presented in a clear health policy paper, linking Member States and EU health objectives with Bank objectives and priorities. Ultimately, this paper should give guidance for more proactive project identification and appraisal.

This clearer strategy, combined with the use of new and innovative ways, might be able to broaden its health sector involvement to also cover public health, prevention and new, integrated models of care. It should continue to promote the use of information technology in particular for management and patient care, and promote measures aimed at improving energy-efficiency of new health care facilities.

Based on the sample of 13 projects, this evaluation found that EIB has supported generally good and sound initiatives. In addition to providing high quality of care in state of the art infrastructures, these projects have greatly contributed to local economies and to urban/rural revitalization. IT and e-health – two other priorities on the EU agenda – were substantial components of almost all projects. Hence, their Relevance is generally rated Satisfactory or better.

Project performance

All projects, except three, are rated Satisfactory or better against "Effectiveness". Most projects have been implemented without major difficulties, but delays and cost overruns are repeatedly observed, usually attributed to additions/modifications to the original project plans and sometimes linked to short-term political considerations. Conditions of local construction markets sometimes led to volatile prices and need to be taken into account during appraisal.

All but two projects have a positive rating for the "Efficiency" and "Sustainability" criteria, which is a good result. The projects show that the health sector is of great political importance locally and is thus of great local interest. A high level of political attention usually provides ample public funding for the sector, but also creates some instability; not all decisions are always rational and "evidence-based". ICT has been used in some projects in new innovative ways and is associated with increased importance for health networks across traditional "hospital" boundaries. The reduction of beds and the length of hospital stay are marked characteristics of almost all projects.

In some cases, promoters' inexperience should have required a higher degree of technical assistance. Beyond the traditional evaluation criteria for Project Performance (effectiveness, efficiency, sustainability), EV systematically highlights and now also specifically rates the Environmental Impact of the projects under evaluation. The projects are in line with national and EU environmental legislation and had in general a positive impact, in particular on social environment. Eight projects are rated Good for this criterion and five rated Satisfactory.

Criterion	Good	Satisfactory	Unsatisfactory	Not Rated
Relevance	11	2	0	0
Effectiveness	4	5	3	1
Efficiency	6	3	2	2
Sustainability	7	2	2	2
Environmental and Social Performance	8	5	0	0
Overall Rating	6	4	1	2

* Some of the projects could not be rated for all criteria or globally, due to mid-term evaluation – none of the projects rated Poor.

The evaluation confirms largely many of the ex-ante observations by the Bank's services at the time of this specific project approval.

EIB contribution and management of the project cycle

EIB financial value added is satisfactory, but several promoters reported that it decreased over the years. Promoters also underlined the EIB's major role in increasing competitiveness in the European banking sector. For the future, the Bank could increase its attractiveness for potential borrowers by underlining that it does not only offer financial advantages (particularly in the case of public borrowers, its financial value added is often limited), but also considerable non-financial ones (technical expertise, ability to network etc).

In most instances, projects were identified through ongoing contacts with Ministries of Finance or the equivalents at regional levels. The EIB has been mostly reactive in identifying new projects; the possibility of actively selecting projects (i.e., to be able to choose and reject) was very limited, because most projects were strongly supported by local public authorities and approved within national or regional health infrastructure plans. When reaching the EIB, project planning was usually already at an advanced stage. The case of PPP's is clearly an area where the Bank's expertise is significant, but also where the parameters for success are more difficult to establish.

Table of Recommendations

OBSERVATIONS & RECOMMENDATIONS

RESPONSE OF THE OPERATIONAL DIRECTORATES

<p>Observation: The project sample analysed was generally sound. However, the EIB has not always had and applied a clear, long-term strategy for the proactive identification and selection of health sector projects. The EIB's portfolio shows a concentration of large health care infrastructure projects (mostly hospitals), which do not reflect EIB and EU priorities in health (§ 2.3).</p> <p>1. Recommendation: ELABORATE COHERENT HEALTH SECTOR STRATEGY</p> <p>The Bank's health strategy and objectives should be presented in a clear health policy paper, linking Member States, EU health objectives with Bank objectives and priorities. Ultimately, this should give guidance for more proactive project identification and appraisal.</p> <p>This clearer strategy combined with the use of new and innovative ways would be able to broaden its health sector involvement to cover also public health, prevention and new, integrated models of care and tackle long-term care. It also ought to promote more intensive use of Information technology for management and patient care and promote measures aimed at improving energy-efficiency of new health care facilities.</p>	<p>Agreed.</p> <p>A Health Sector Lending Policy paper will be prepared on the basis of most recent EU communications and policy developments to provide the necessary guidance to operational staff.</p>
<p>Observation: The EIB has collectively developed considerable experience in health projects, but during the evaluation it became apparent that a number of key aspects could be improved in the health sector appraisal and financing (§ 3.2).</p> <p>2. Recommendation: IMPROVE EIB CONTRIBUTION IN THE HEALTH SECTOR</p> <p>a) <u>Knowledge management:</u> The EIB's technical knowledge should be further developed and applied, in particular beyond the EU, where the demand for such technical expertise is potentially greater. The establishment of an internal "knowledge management" function seems appropriate. In addition, there is potential to share its experience in the health sector.</p> <p>b) <u>Continue to promote more innovative products</u> in order to keep/retain the Bank's attractiveness particularly in mature financial markets.</p>	<p>Agreed via existing networks, such as the European Health Observatory or the EUHPN and by connecting promoters together.</p> <p>Agreed.</p>

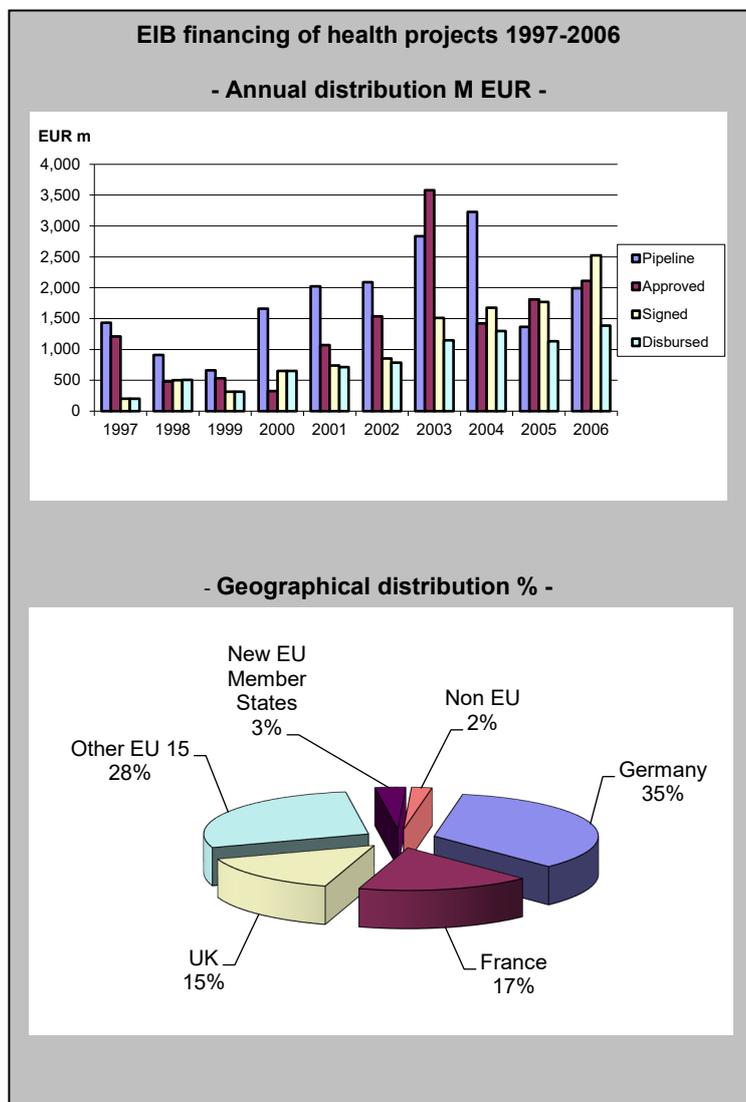
<p>3 Recommendation: IMPROVE EIB PROCESSES IN THE HEALTH SECTOR</p> <p>a) <u>i2i eligibility criterion for health (§ 2.3)</u>: Inconsistencies in the identification of the i2i eligibility criterion for health were noted. There seems to be no clear-cut definition on when to consider a project consonant with Education, Information Technology and Research and Development within i2i. Clear guidelines for i2i definition in the health sector are required, which need to be appropriately communicated within the Bank's departments.</p> <p>b) <u>Appraisal (§ 3.3)</u>: Quantifiable economic objectives and indicators have to be established at appraisal, which need to be monitored during implementation. It is crucial to precisely identify the impact on financial flows in terms of liquidity and, most importantly, on affordability. The Bank should formalise its appraisal procedures for health care projects in order to allow for a coherent approach (e.g. economic lifetime etc.).</p> <p>c) <u>ICT (§ 3.1.2)</u>: Opportunities to further develop the use of ICT and networking should be thoroughly discussed at appraisal, even if their applications will not be immediate. The economic case should include an estimation of the potential benefits (not necessarily valued in monetary terms) and cost of IT developments and the post-completion report should assess the realization of these objectives.</p>	<p>Agreed - In principle, only "teaching hospitals" and clear "medical technology" projects feature under i2i/Education and i2i/RDI, respectively/. The definition of "university hospitals" is not standardized across Member States.</p> <p>Agreed. Certain economic objectives can often only be confirmed after a minimum number of years of operational experience (particularly in this sector).</p> <p>Agreed.</p>
<p>Observation: During the course of this evaluation, health has re-entered the Bank's core priorities, through the recent decision of EIB Management to include future health care projects under the eligibility heading: environment - sustainable communities. Although this approach is logical and coherent, it limits the visibility of the sector. In the future, health will most probably move to a higher level of priority within the EU, in relation to Member States agenda on European Social Policy which will be more demanding: new EU constitution, increased concern from EU citizens (§ 2.5).</p> <p>4 Recommendation: IN LIGHT OF THE ABOVE CONSIDER HEALTH AS STAND-ALONE PRIORITY IN THE NEAR FUTURE</p> <p>The always increasing priority of social policy within the EU could, within the years to come, lead the Bank to define Health as a core, stand-alone priority.</p>	<p>Bank's services share with EV the importance of Health and confirm that health projects will be adequately covered under the eligibility heading: environment-sustainable communities. Bank priority lending objectives are set in the COP and adapted to reflect EU policy developments, as appropriate.</p>

1. Introduction

1.1. Objective and scope

This report is the first ex-post evaluation of the EIB's investments in health since the sector first became eligible for EIB funding under the Amsterdam Special Action Programme (ASAP). It consequently covers the period from 1997 to 2006. Over that period, the Bank financed 89 investment (42% of the total amount) and framework loans (58%) in 22 countries for a total signed value of some EUR 10.7 billion¹. In addition, financing to the health sector was also provided indirectly through lines of credit accounting for some EUR 2.9 billion distributed throughout 37 countries. This evaluation covers all countries, but concentrates mainly on projects in EU Member States and looks at all types of financing mechanisms used for health projects.

This ex-post evaluation assesses relevance and performance of these health projects using EV standard criteria (Relevance, Effectiveness, Efficiency, Sustainability, Environmental and Social Impact - see Annex 1), as well as EIB contribution and performance in these projects. The evaluation has two primary functions. Firstly, to increase transparency to the EIB's governing bodies and, secondly, to provide assistance to the Bank's operational departments, thereby increasing the Bank's value added in future operations. As the first ex-post evaluation of health projects, the *relevance* / policy part is of particular importance and has been developed in great detail, looking also at the most recent discussions and decisions.



Health financing became eligible for funding in its own right with the Amsterdam summit resolution (1997), which asked the EIB "to examine its scope of intervention in the areas of education, health, urban environment and environmental protection". In 1999, the Bank's position on Health (and Education) was reinforced when the Board of Governors endorsed the use of the term 'Human Capital' (to cover Education and Health) to be a key area of EIB activity. Further modifications to the different components of health eligibility were outlined in 2004. However, with the Bank's new strategic orientation in 2005, health has been de facto categorised as a secondary priority, which was reflected in the 2007-2009 Corporate Operations Plan (COP). In fact, Human Capital was retained, but only education was top priority under i2i, leaving health as a secondary priority. It is important to note that recent decisions taken by the Bank allow the inclusion of health under the revised 'Environment and Sustainable Communities eligibility' category (in the COP 2008-2010) and therefore health has re-entered EIB main lending priorities. The evaluation is intended to provide facts and evidence for the current debate on EIB's future positioning in health lending and might be able to further structure and guide the Bank's current policy debate.

¹ This includes components of framework loans classified under the health criteria.

Health vs. Healthcare services: International definitions of health and healthcare systems often highlight the complex social nature of health. It is therefore crucial to use precise definitions of terms. The World Health Organization (WHO) states that a) a health system “includes all actions whose primary purpose is to promote, restore or maintain health”; b) “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. In more recent years, this statement has been modified to include the ability to lead a “socially and economically productive life, which is in line with EU’s definition of good health as “a state of physical and mental well-being, necessary to live a meaningful, pleasant and productive life”. There are many factors that influence human health and most EIB projects could theoretically be included in this review, which would exceed the scope of this study. EIB’s narrower definition of health comprises health (and social) infrastructure projects. Hence, this evaluation examines health issues from a global perspective, but focuses on healthcare and the provision of healthcare services (including some social services), as the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and other health professions.

1.2. Methodology and structure of the report

The evaluation is based on 1) a general review of EU, Member States’ and EIB policies regarding health, 2) a comprehensive portfolio review of all 89 projects financed by the EIB in the health sector since the beginning of its lending operations in 1997, 3) a detailed desk review of all 25 projects from the initial project list that was carried out to form the basis for the selection of the final project sample and 4) an in-depth analysis of thirteen projects with site visits.

For a comprehensive and up to date evaluation of the health portfolio, a review of all key internal documents for the 89 signed loans was conducted. This allows a better understanding and a more dynamic and complete view of the EIB portfolio make-up and to incorporate the latest trends.

A detailed individual evaluation report is prepared for each in-depth analysis. The projects finally selected for in-depth individual evaluation are representative of the EIB health portfolio and, in general, operations concerned were to be completed before site visits in the case of investment loans; for framework or investment loans with large numbers of sub-projects, at least 50% of them were supposed to be implemented. In order to increase the relevance of the evaluation, some of the projects evaluated, which are important in terms of volume of lending or to increase representativeness, were not completed projects at the time of the site visit. The list of 13 projects analysed in depth is provided below.

Project	Sector	Operation/EIB Loan Size*	Type	Operation**	Counterpart
1	Hospital	Large/Large	Framework loan/investment programme	Mixed	Public
2	Social care	Small/Small	Framework loan/investment programme	Greenfield	Public
3	Hospital	Small/Small	Individual loan project	Greenfield	Public
4	Hospital	Medium/Small	Individual loan project	Greenfield	Private
5	Hospital and ambulatory care	Medium/Medium	Individual loan project	Mixed	PPP
6	Hospital	Medium/Medium	Individual loan project	Greenfield	PPP
7	Hospital	Small/Small	Individual loan project	Greenfield	Public
8	Hospital	Large/Medium	Framework loan/investment programme	Mixed	Public
9	Hospital	Medium/Medium	Framework loan/investment programme	Mixed	Public
10	Hospital	Medium/Medium	Individual loan project	Greenfield	PPP
11	Hospital	Small/Small	Framework loan/investment programme	Mixed	Private
12	Hospital	Medium/Small	Individual loan project	Greenfield	PPP
13	Hospital (& public health)	Large/Small	Individual loan project	Greenfield	Public

* Operation size/EIB Loan size – small < EUR 200/100 million, large > 500/250 million.

** Mixed: renovation/rehabilitation and new construction

In accordance with the Bank's evaluation procedures, individual projects were rated in four categories: "Good", "Satisfactory", "Unsatisfactory" and "Poor". The evaluation was supervised by an internal EIB team, but both the in-depth evaluation and the synthesis reporting were outsourced to specialised external consultants from AEDES (Belgium). The Bank's relevant operational departments were fully involved in the various stages of the evaluation.

The report is divided into two main, but closely interrelated, sections:

- i) Relevance – policies and strategies,
- ii) Analysis of the project performance and of the Role of the EIB for the 13 projects evaluated in-depth.

2. Relevance: Policies and Strategies

In order to fully understand this report, which addresses the Bank's health strategy in its Relevance section, one should underline that "*EIB is a policy-driven public bank with the mission to contribute to the attainment of EU's policy objectives*". Hence, the first part of the *Relevance Section* describes EU policies and strategies in the health sector. In its 2007 Corporate Operations Plan, EIB stated: [The] "*Bank's credibility and future as an EU institution (depends on) its responsiveness to EU policy changes and the effects of the progressive enlargement of the EU*". This ex-post evaluation therefore highlights the evolution of both the EU's competencies, priorities and interventions in the field of health, and EIB's health strategy and project portfolio, by asking the following three questions: 1) how do EU and EIB justify their involvement in the field of health (rationale and mandate)? 2) what are their stated priorities (at EU and Member State level) in this field? and 3) how do EIB operations contribute towards the realization of their goals?

While the Bank's strategy derives from EU policy, the scope for EU action in the provision of healthcare services is limited because Member States are themselves responsible for the financing and administration of healthcare services. Opportunities for capital investments in health infrastructure (hospitals, long-term and rehabilitation care, etc.) are identified at Member State or regional levels. Consequently, the EIB deals directly with the demands of Member States, regional or local authorities or private providers. Therefore, some of the major trends in national/regional health policies that focus on the provision of healthcare services are described. While healthcare systems are facing very similar pressures in all Member States, significant differences between Member States should be properly addressed by the EIB in order to propose the services that are best suited to each country's needs.

The third part of the relevance section describes the EIB's past and present strategies and operations in the field of health and the EIB's health investment portfolio. It includes all loans between 1997 and 2006 that have been considered eligible under the heading "health" (investment, framework and global loans), ranging from the small to the very large. In this section EIB policy and intended strategy, as well as the results for the relevance criterion of the evaluated projects are laid out.

Conclusions on relevance from the project sample are followed by a short outline on the future options for an EIB health strategy.

2.1. EU policies/actions and priorities

2.1.1. EU policies and actions

The EU's involvement in health policy is guided by the principle of subsidiarity. The Union is exclusively responsible for areas relating to public health and prevention, while health care delivery falls strictly within the sovereign power of Member States. Health issues were not *explicitly* included in the original treaties (Treaty of Rome)², but then gradually appeared in subsequent ones. Public health was included in the Treaty on the European Union (Maastricht 1992) to open the way for formal cooperation among Member States in this area and raised health protection to the rank of a Community objective. The Treaty of Amsterdam (1997) amended the wording of Article 152 of the EC Treaty³. Under the Treaty, EU actions must aim to **improve public health**,

² The next section discusses how the application of the principle of free movement of persons has a major impact on mobility of health care professionals and patients and subsequent consequences on national healthcare systems.

³ Article 129, renumbered article 152:

prevent human illness and diseases, and identify sources of danger to human health. The **Right to healthcare** is recognized in the Charter of Fundamental Rights (Nice 2000).

Though Member States are responsible for the organisation and delivery of health care, several *rulings of the European Court of Justice regarding the cross-border mobility* of patients, of the workforce (in a context of shortage of qualified health professionals in most former EU 15 countries) and of goods (with most countries imposing stringent national rules on any new investment) have had a fundamental impact on how, what, by whom, to whom and at what price health care services are being delivered. Such decisions have motivated very recent demands from the European Parliament for a directive on health services, in parallel with legislation on **social services of general interest to “re-establish and increase the confidence of European citizens in an area which is absolutely central to their lives”**. The Parliament justifies the need for such a directive with EU core priorities (see box below): With this call from the EU Parliament, health care services are recognized for their major economic and social role.

EU Parliament motivations and justification for demanding a directive positioning health services as services of general interest:

- Health services are one of the fundamental elements of the **European social model**; they contribute to the economic, social and territorial cohesion of the EU and can inspire citizens' confidence, or the reverse.
- The basic **values** of equality of access, universality, equal treatment and solidarity as well as affordability and financial sustainability must continue to be safeguarded.
- Health services are a substantial source for creating large numbers of skilled jobs, make an active contribution to the **Lisbon strategy objectives**, and their economic and social role is considerable.
- In view of the general **ageing of the European population** and pensioners' increased transnational mobility, it seems important to anticipate the creation of sufficient structures for appropriate care, in connection with the relevant social services.
- Member States do not sufficiently promote health care, as a result of which **patients' rights** are restricted;
- It is hard to draw a clear distinction between the provision of health-care services and the provision of other social services of general interest.

Source: European Parliament resolution of 23 May 2007 on the impact and consequences of the exclusion of health services from the Directive on services in the internal market

All these elements linking EU policies to the delivery of health care services provide a basis on which the EIB has and can continue to structure its interventions in the health care services sector.

“a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health”

“Community action shall encourage cooperation between the Member States in the area referred to in this Article and, if necessary, lend support to their action....”

“Community action in the field of public health shall fully respect the responsibility of Member States for the organisation and delivery of health services and medical care”

2.1.2. EU priorities

In spite of its limited jurisdiction in the field of health, and more specifically in the provision of healthcare services, the Union is strongly involved in health matters. The EU's approach to health has focused mainly on strengthening cooperation and coordination, supporting the exchange of evidence-based information and knowledge, and assisting with national decision-making. The "Programme for Community Action in the field of health 2008-2013" has set the conceptual framework for the Commission's funding of activities relating to health (see box). This framework reaches far beyond public health to include a number of crucial issues in the field of health care services. The priority areas defined within this frame should be reflected within a future EIB's health strategy.

improve citizens' health security

- health threats
- patients' safety, injuries and accidents
- legislation on blood, tissues and cells
- international health regulation

promote health for prosperity and solidarity

- foster active ageing,
- bridge inequalities with particular attention to the newer Member States,
- cooperation between health systems, cross-border issues, mobility of patients and health professionals,
- nutrition, alcohol, tobacco, drug consumption
- quality of social and physical environment

generate and disseminate health knowledge

- exchange knowledge and best practices
- gender health, children's health, mental health
- health information and education

To pursue its increasing involvement in health care services and base it on a strong foundation, the EU is currently drawing up a comprehensive health policy and accompanying health care strategy, based on far-reaching public consultation⁴.

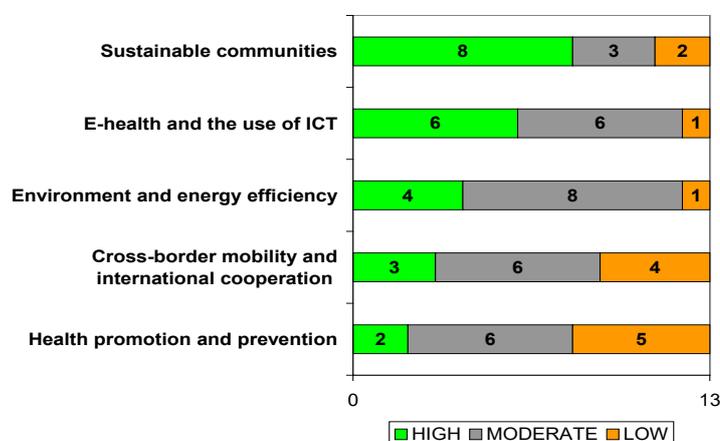
A very substantial proportion of community legislation directly or indirectly affects human health. Health – like the environment – is a transversal issue that cuts across all domains of economic and social activity. This was recognized in the EU's "**Health in all policies**" framework⁵ (2006).

2.1.3. A sample of 13 projects: their relevance in relation to EU priorities

Health – and more specifically health care services – is directly related to a number of key current EU policies on competitiveness (Lisbon strategy), the European model of society (health care and long-term care for the elderly population), urban renewal and sustainable cities (Leipzig Charter) and information society (through e-health). Thirteen projects were analysed to assess their relevance to EU priority areas in the fields of health (cross-border mobility and international cooperation, prevention and health promotion, e-health, ICT) and the environment (environmental impact and energy efficiency, urban renewal).

Ratings on 13 projects' contributions to EU policy goals

(number of projects in each category according to their contribution to EU objectives: direct and major, secondary or limited, marginal or none)



This graph suggests that the 13 EIB projects in the sample are contributing to different EU priority objectives, especially sustainable cities/urban renewal, e-health and the use of ICT. The projects played key economic and social roles in their surroundings, from big cities to small towns or rural areas. ICT components were present in all projects (except in schemes for long-term care), but in many projects no innovative applications were developed or there was scope for further IT development, especially with regard to networking with other care providers.

⁴ Consultation regarding Community action on health services. For further details, see http://ec.europa.eu/health/ph_overview/co_operation/mobility/community_framework_en.htm.

⁵ For further details, see http://ec.europa.eu/health/ph_overview/other_policies/health_other_policies_en.htm.

2.2. Member States: trends and pressures

2.2.1. Typology of healthcare systems

The mode of financing has traditionally been the main difference between European healthcare systems. In the EU15, there is an almost even split in number of states and populations between systems financed through general taxes and those funded by social taxes. Pure tax-financed *National Health Service* (NHS) countries have been Denmark, Finland, Ireland, Italy, Portugal, Sweden, Spain and the UK. Austria, Belgium, France, Germany and Luxembourg have had *Social Health Insurances*. However, these two distinctive systems are now slowly converging towards a new model that is financed by both social and general taxes⁶. Systems have also been defined by the percentage of the population covered (100% or fewer). Another criterion for differentiation has been the question of reimbursement, the so-called “basket of care and services”. This concept is complex and refers to what kind of care is reimbursed, as well as the level of reimbursement (or co-payment), and the clinical conditions which authorize certain types of care.

Another very important characteristic is the level of centralization in various aspects of health care. Public health, because of its legal and regulatory aspects, is often conceived at the national level⁷, the delivery of clinical care is increasingly managed at the regional level, even in countries that are rather centralized. Some Member States now allow their regions to collect health care related taxes (e.g. Spain and Sweden).

2.2.2. Commonalities of healthcare systems: similar pressures and responses

While legal frameworks for health care providers and payment or funding mechanisms are often based on different national traditions, similar problems and pressures have become important concerns in all EU Member States.

These are:

- the demographic problem: increase in demand for healthcare services related to aging of the population is to be attributed to the burden of age-related diseases combined with the increasingly changing family structures that could undermine family care;
- the epidemiological pressure: developing societies, at some point, undergo the so-called epidemiological transition from mainly infectious to chronic disease patterns. This happened in Europe decades ago, but now a second phase of chronic diseases is evident, in which these disorders not only increase morbidity and mortality for the population over 60, but much earlier in life. Obesity, diabetes and metabolic syndromes often begin during adolescence or even earlier. This trend has so far not reduced average life spans, but it has probably slowed the increase in life expectancy. For the health care systems this means that not only do the elderly need frequent care, but even younger people suffer from long-term and complex disabilities and ailments;
- the technology pressure: new technologies do not necessarily increase cost, but historical evidence shows that it is often a cost-driver. In addition, most European health care markets are highly regulated and politically influenced. As a consequence, the increasing (and often inefficient) use of technology also contributed to ever-rising costs;
- budgetary problems: on a global scale, most EU countries are rich, but international macroeconomic pressures have made it difficult for them to maintain high and growing levels of public spending. As a consequence, many previously generous social budget items have had to be reduced, or at least had to grow much slower than previously. This has meant that public funding for health care services has become scarce, given that costs have continued to grow at a rapid rate;
- quality issues: globalization and increased information flows has led to more transparency and competition in all sectors. Health care may be protected from direct competition, but greater international openness has led to the realisation that things are not necessarily good because they “have always been done in a

Project 2. Demographic trends and impact on the need for health and social infrastructures.

The new Spanish Law on Dependency marks a great social advance in Europe. This law creates a new universal right: the right of people who cannot fend for themselves to be cared for by the state and to be guaranteed a series of benefits based on the principles of equality, equity and universalism. In addition to demographic trends and the transition from a 'family-based' to a 'community-based' model of care, there are great pressures to complement and upgrade social and health services infrastructure such as nursing homes or day care centres. There is no doubt that investments in this area will grow rapidly in response to growing demand, not only in Spain, but throughout Europe.

⁶ In 1993, in France, 7% of public expenditures on health care were financed through taxes - it is now 40%.

⁷ There are of course many regional variations in health education and promotion.

certain way". Practically all EU15 countries now have reform strategies that aim to make health care more transparent and efficient, with faster access to care and to new treatment methods. Quality control and evidence-based medicine have become key objectives;

- hospital infrastructure aspects: hospitals, over previous decades, have changed their roles and functions completely. Formerly, they were mainly shelters for the old, the poor and the (infected) sick. At the end of the 1950s, hospitals turned into places in which efficient care was delivered, research carried out and innovations applied. Before the 1970's energy crisis, many hospitals in Europe had been built to respond to new quantitative (baby-boom, immigration) and qualitative demands (people did not accept staying in overcrowded rooms). These "new" hospitals were often built according to outdated designs and are now obsolete: their bed capacity is too high, based on average lengths of stay of 15 days and more⁸. They have limited outpatient facilities, no outpatient surgeries, insufficient hygiene concepts, high-energy consumption, and no climate control and inadequate provision for privacy. Some countries have already invested substantially in hospitals designed for the 21st century, but much remains to be done.

France – "Plan Hôpitaux 2007"

In 2003, the French Government launched an ambitious reform plan known as "Plan Hôpitaux 2007" with the objective of improving overall efficiency and management within the hospital sector and speeding up the modernisation of France's hospitals by helping them to undertake capital investment that budgetary constraints would otherwise have ruled out. Its three key elements are the modernisation of healthcare facilities and simplification of hospital sector planning, the renewal of hospital financing system and a new governance structure for public hospitals. Under the plan, the government intends to make extra resources available to the hospitals.

To react to these problem areas, EU Member States have attempted to reform their health care funding and delivery systems. These reform attempts have included:

a) Health care reorganisation:

- Measures to decrease operating costs by increasing health service efficiency, introducing quality control mechanisms and insisting on an evidence base for all interventions. It is in this context that Member States have begun to update and renew their hospital infrastructure (often the most expensive part of health care delivery) by replacing old, costly and frequently decentralised structures with new, state of the art facilities. In this way, information and communication technologies are being introduced to facilitate e-health, evidence based medicine, better communication and coordination, as well as research and development;
- The introduction of more transparency, accountability of individual players and competition into health services;
- The restructuring of health care financing systems, to make them less dependent on non-wage labour costs (e.g. by increasing direct funding through the tax system);
- A strong focus on prevention rather than curative medicine i.e. public health (help to stop smoking campaigns, environmental health protection, immunisations, nutrition awareness, etc.);
- The extension of outpatient care and better coordination of health and social care for the elderly and the handicapped. Conventional acute hospitals are expensive and inappropriate for anything other than acute-phase treatment. All countries have tried to promote outpatient care, or use of other less-intensive institutional settings, while improving coordination between different categories of health professionals. This has led to an increasingly crucial role for GPs (General Practitioners) and to the creation of "care networks". It has also resulted in a more decentralized organization structure.

b) ICT – developments:

All European countries recognize that they do not take full advantage of information technology in the health sector. This problem is older than it appears – its roots lie in the 1960s, but it has taken on a new dimension with the rise of personal computers, the internet and mobile telephones. The EU has tried to emphasise the potential benefits of ICT in health, but national expenditures on ICT for health remain relatively low (some 1.5% of hospital expenditures). The investments needed for new technologies are usually higher than predicted, because large sums must be spent on staff training and equipment maintenance. ICT systems will certainly form the backbone of medical care in the future, but they are complex, give rise to strong issues of data

⁸ 5 days for acute care in France in 2007.

confidentiality and take a long time to install and use. Health care institutions therefore need strong and financially powerful public and private partners.

c) Private solutions:

Most EU countries have private hospitals, either for-profit or non-profit. Outsourcing and subcontracting to private firms is a welcome opportunity for some, but is not usually favoured by trade unions and hospital managers. Public Private Partnerships (PPP) in health received some attention fifteen years ago, but a strong push towards them has only been seen more recently. "PPP" is a general term that has been applied to very different types of projects; from the integrated care models through construction and long-term maintenance (30-40 years, as it is the case in the UK) of a building to a more limited cooperation, such as the construction or the short-term management of some facilities. The criteria for evaluating, comparing and judging PPPs in health care must therefore be tailored to the needs of each situation, since no standardised, *one size fits all* PPP model for health care exists.

Not all problems are identical across the EU. Countries differ in some detail, even when they face similar situations overall. Health expenditures in Western Europe range between 7 and 11% of Gross National Product (GNP), but the rate of growth in the last thirty years has not been uniform. The percentage of primary care doctors within the medical profession, the number of hospitals, the number of nurses per doctor, the average length of stay in hospital, the amount of drugs prescribed per inhabitant per year, the type and the rate of surgeries for certain pathologies... many aspects vary between and even within countries. In addition, there is no direct relationship between a country's health care system and expenditure and its health performance indicators.

The situation is also different in some of the EU's new Member States. Although demographic and epidemiological pressures are similar all over the EU, most of the former communist countries originally had some kind of government controlled and managed unified health care system with universal access and coverage. After the fall of communism, these systems have been replaced generally by social insurance models with private components or by single payer state controlled (NHS-type) models. But in many cases the new systems have not yet fully settled down. In addition, health delivery infrastructures are often old and not state-of-the-art and cannot be easily transformed into modern high-tech centres. Therefore, investment in health care infrastructure is desirable, but often conflicts with other public infrastructure investment needs. Since health care is not the only priority area, new Member States have to make difficult choices regarding the type of infrastructure investments they want to carry out first.

The degree to which all these reforms have been implemented and whether the problems have been successfully addressed varies among Member States. In some cases, important steps have been taken, but nowhere have all problems been solved. Often, current reforms are only a first step in response to external changes. The full degree of reform measures will depend on the long-term development of demographic, epidemiological and migration trends. It must also be borne in mind that reforms are frequently difficult to implement because they threaten vested interests and social care systems that have existed for more than 100 years.

2.2.3. A sample of 13 projects: their relevance to national/regional priorities

All twelve hospital-infrastructure projects analysed in-depth were included in the national/regional hospital plans. More specifically, there was a strong focus on cost control and efficiency increases and, in most cases, new infrastructures have been implemented together with new processes, including a focus on quality control. However, evidence-based decision-making could have been further developed in some cases. New infrastructures were also responses to the introduction of more competition and transparency and to new financing schemes (mainly through Diagnosis Related Groups – DRG) that provided strong incentives for hospitals to be more efficient by decreasing length of stay. The reduction in number of beds, as part of most EIB operations and described below, is fully in line with this focus on efficiency and increase in ambulatory and outpatient services.

The one project of social infrastructure (care for elderly and disabled) is a response to strong demographic and sociological trends, shared throughout Europe. In addition, having a large number of small-scale schemes scattered throughout the region was very appropriate in a rural region with a high percentage of elderly population.

Promoters and final beneficiaries have highlighted the very sensitive nature of health services in the local political context. In fact, efficiency improvement and modernisations often lead to hospital closures and staff redundancies. It is a major issue and all projects have been the object of close attention from local governments.

2.3. EIB mandate, policies and health portfolio review

2.3.1. Initial mandate (1997-1999), confirmation and initial strategy (1999-2003)

The mandate:

Since 1997 (Amsterdam Summit), the EIB has been contributing to European policy on growth and development through its lending to support the formation of *human capital – health and education*. Following the Bank's announcement of the Amsterdam Special Action Programme (ASAP July 1997), several strategy papers were presented to the EIB Board. In 1999, **Human Capital** (to cover Education and Health) became a priority area of EIB development and activity. Following the Cologne Summit, human capital eligibility was extended to cover the candidate countries for EU Membership and later a further geographical eligibility extension was granted to countries having a partnership agreement with the EU.

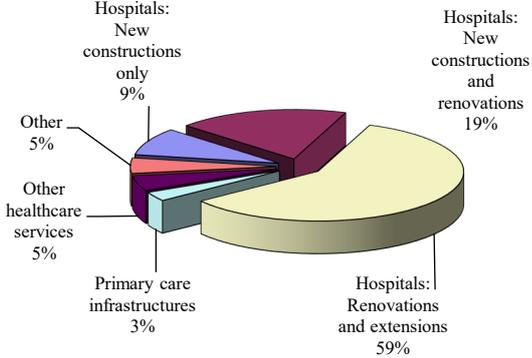
In 2000, education and training –the other component of Human Capital– was integrated into i2i, alongside *research and development* and *information and communication technology*, while *Health* remained eligible for funding with a stand-alone eligibility criterion *Human Capital*. This initially had no impact on the acceptance and selection of new projects for the EIB, since “human capital” was kept as a core priority.

The initial strategy and its implementation:

The 1999 health sector background paper that accompanied the COP identified five main recommendations for the health portfolio development (see table below) and presents eight main priority areas for EIB activity in the health sector. The paper also points out the main problems of EU Member States' health situations and health care systems, and recommended a focus on projects that increased system efficiency and quality and that responded to real epidemiological and social needs.

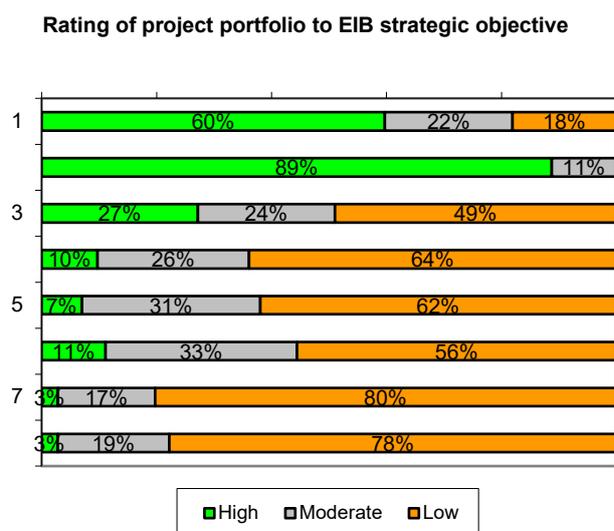
This document is well balanced and identifies key challenges that needed to be addressed. It tried to reconcile the EU's health mandate (public health, human capital) with pressures on Member States' health systems, their reform attempts (increased efficiency and quality, move towards outpatient care, long-term care and care for the elderly) and EIB's strategic priorities and operations (health care infrastructure, mostly acute-care hospital settings). It is to be noted that a number of key operational staff in the Bank's departments were not aware of this specific health strategy. This is an issue that needs to be addressed, in particular at times of high staff turnover.

However, the analysis of the different parameters of the strategy demonstrates that the Bank's portfolio diversification is limited and many of the initial recommendations have not been fully considered.

EIB strategy	EIB actions	Comments and recommendations														
Not limit to acute hospital sector	<p>Proportion of hospital infrastructure: in investment loans: : 88% volume signed, 73% projects in global loans: 56% volume allocated to hospitals</p>  <table border="1"> <caption>Hospital Infrastructure Investment Distribution</caption> <thead> <tr> <th>Category</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Hospitals: Renovations and extensions</td> <td>59%</td> </tr> <tr> <td>Hospitals: New constructions and renovations</td> <td>19%</td> </tr> <tr> <td>Hospitals: New constructions only</td> <td>9%</td> </tr> <tr> <td>Other healthcare services</td> <td>5%</td> </tr> <tr> <td>Other</td> <td>5%</td> </tr> <tr> <td>Primary care infrastructures</td> <td>3%</td> </tr> </tbody> </table>	Category	Percentage	Hospitals: Renovations and extensions	59%	Hospitals: New constructions and renovations	19%	Hospitals: New constructions only	9%	Other healthcare services	5%	Other	5%	Primary care infrastructures	3%	<p>There is a constant focus on hospital infrastructures, both for investment loans and global loans. Although there might be a certain restriction imposed by the minimum loan size, this argument does not hold true for global loan activities. It is to be noted that some 8% of all health allocations were not directed towards human health, but veterinary activities.</p>
Category	Percentage															
Hospitals: Renovations and extensions	59%															
Hospitals: New constructions and renovations	19%															
Hospitals: New constructions only	9%															
Other healthcare services	5%															
Other	5%															
Primary care infrastructures	3%															
Proactive selection of projects	<p>Throughout the years of EIB involvement in health, the Bank participated in numerous conferences and prepared several country specific sector papers. A major conference was organised and the Bank engaged with key international health bodies and institutions. However, the portfolio and discussions with EIB staff demonstrate a rather reactive project portfolio. This is mainly due to the often well-advanced status of the projects as presented to the Bank, supported by national public authorities. In addition, internal sensitivities to health projects differed widely, since a certain hesitance to actively look for more “subtle” health projects was apparent.</p>	<p>Define a strategy on health, including rationale for EIB involvement, priority areas and mechanisms for project identification. Have this strategy widely discussed and distributed within EIB.</p>														
Appraise health impact in any type of project	<p>Environmental due diligence is required for all EIB projects and includes one list item on “health impact” in the environmental annex.</p>	<p>The idea of health impact assessments also for projects in the EU could be considered in the future, especially in light of the recent EU “Health in All Policies” strategy.</p>														
Identify and communicate good practices	<p>There are no formal channels to identify and communicate good practices. EIB participates in the European Observatory on Health Systems and Policies and the European Union Health Property Network (in fact, the Bank is a founding member of both organizations). The overall stance of the Bank is, however, essentially based on financial support and participation in conferences. Those organizations are not sufficiently used to disseminate best practices observed in EIB projects and collective experience within EIB or develop benchmarking tools to be used during appraisals.</p>	<p>EIB has collectively developed considerable experience in hospital construction projects. This technical knowledge should be further developed and applied in particular beyond the EU, where the demand for such technical expertise is potentially greater. The establishment of an internal “knowledge management” seems required. The EIB should consider to work even more actively with relevant organizations (i.e. publish case studies) and to support a network of “EIB hospitals” with voluntary participation.</p>														
Develop impact assessment measures to compare ex-ante and ex-post indicators	<p>Very seldomly realized or with relatively partial vision (focused mainly on number of beds, volume of patients, length of stay). The objectives are usually not translated into clear quantitative measures and indicators and no baseline is available (see section 3.3.2). This was justified by EIB staff as being due to strong resistance from many promoters to provide figures; which has in some instances even resulted in the promoter interrupting its relationship with EIB.</p>	<p>EIB could be more demanding in its monitoring of implementation and impact of the investment (e.g. require 5 to 10 key indicators to be identified and monitored by the promoter). Having a new hospital built does not automatically mean that better care will be provided to the population. Implementation of the project is not per-se an indicator of effectiveness. Accountability and reporting of results have become routine in the recent past. The rationale of these requests should be clearly explained (EIB leaflet etc.).</p>														

The imbalance of the portfolio in relation to strategic objectives is highlighted in the figure above.

EIB Priority areas in health (annex to COP 1999)	
1	Rationalisation schemes aimed at reducing surplus capacity
2	Upgrading existing capacity where the quality of the property and/or equipment is poor
3	Focus on university and teaching hospitals with strong research role and catering for complex caseload
4	Support for medical and paramedical schools with innovative approaches
5	Facility, or non facility, community-based arrangements attempting to provide care in innovative or most cost-effective way
6	other innovative, R&D intensive projects to process, product or organisational aspect of health care
7	Special attention for mental illness and disability
8	Health care for the elderly, in particular prevention and postponement of disability



2.3.2. Revision of eligibility and priorities: 2004-2007

a. 2004 eligibility update

While during this period EIB's mandate to finance health projects was not revised, its policy framework changed. In 2004, an update of the eligibility guidelines for the Bank's financing, including those for *health*, was developed (which expanded the eligible categories for EIB financing to three main domains with 19 sub-criteria - see table in annex 2):

- Addressing inadequate supply of health funding;
- Repairing deficiencies in the legacy of healthcare infrastructure and, in the process, endeavouring to increase the future robustness of investment;
- Identifying the appropriate model of care and the capital facilities consistent with it.

The rationale for moving from the eight priorities set out in 1999, to three broad domains, and for adding separate categories of investment within those three wider areas, stemmed from EU Commission definitions, but their application remained largely unclear. The 19 sub-criteria do not appear to have added any technical value to the pre-existing 1999-list; in fact, they made things less clear and transparent. The new items are relevant to EU policy and Member States' policies but their addition had no impact on project selection, since the same projects would have been financed.

b. New EIB strategy (2005)

With the Bank's new strategic orientation in 2005, health has been de facto categorised as a secondary priority, which was reflected in the **2007-2009 Corporate Operations Plan (COP)**. In the COP 2007-2009 the Bank defined its core objectives and priorities as economic and social cohesion (convergence), TEN, i2i, the environment and SME (see box below). In fact, Human Capital was retained, but only education was top priority under i2i, leaving health as a secondary priority. This has led to an almost complete stop in the identification process of new health operations during the first half of 2007.

"In line with the renewed Cohesion policy for 2007-2013, the Bank will concentrate its regional development actions on convergence lending. (...) Outside convergence regions, the new regional EU policy promotes the objectives of competitiveness and employment (mainly concerning – at EIB level – i2i, TENs, SMEs and environment) and European territorial cooperation". (COP 2007-2009, p.12)

Health in convergence regions can be financed without problems. This particularly applies to new Member States, but demand for health care projects from these countries is currently rather low. These countries have infrastructure needs in various sectors and are first focusing on the needs they consider more pressing, such

as new roads (as illustrated by the relatively low investment cost allocated to health care in multisectorial framework loans in those countries). The COP 2007-2009 also highlighted joint operations undertaken together by the Bank and the European Investment Fund, which could lead to interesting avenues for shared health projects.

c. **Reentering of health – September 2007 – “sustainable communities” – eligibility:**

The environment in general, and the social and urban environment in particular, are categories under which EIB can classify general health projects, especially those pertaining to environmental health and to health care infrastructure. EIB health projects have so far not been classified under the heading *environment*, although many of them have contributed to the improvement and restructuring of European cities. Examples from the evaluation in Germany and Italy show that the complete renovation of a city’s or region’s health infrastructure has played an important role in the overall restructuring and renewal process of these places in Germany and also in the structural, social and economic development of an entire suburban zone of the city.

Recently, health has become a core priority again through its inclusion under “environment” - sustainable communities eligibility within COP 2008-2010. This decision of the EIB Management is logical, however, this approach limits the visibility of the sector by having it as a component of a sub-heading.

2.3.3. A sample of 13 projects: their relevance to EIB eligibility criteria

All projects analysed in-depth, except one, met at least one eligibility criterion in addition to Human capital/Health. Nine out of the 13 projects were in an Objective 1 or 2 area for regional development or in an accession country. Additional eligibility criteria were Education (within i2i and/or Human capital), i2i/Information Technology (3 projects) and i2i/Research and Development (3 projects)⁹.

Some inconsistencies in the identification of eligibility criteria were noted. In particular, there seems to be no clear-cut definition on when to consider a health project consonant with i2i (Education, Information Technology and Research and Development).

The definition of university and teaching hospitals varies widely across countries and naming cannot be used as the sole criterion for classification under i2i/Education. Questions were raised regarding whether it is enough to have doctors trained to be classified under Education or does the project need to have specific components attributed to Education (e.g. classrooms). More general questions were also raised on what innovation means for hospitals, how hospitals can contribute to enhancing the knowledge base and competitiveness of the healthcare industry, and if the current i2i definition (restricted to R&D, ICT, and education and training) is able to recognize projects such as Project 11 (i.e. process innovation) that act as motors for the competitiveness of the EU healthcare industry. No single project was classified within i2i under “diffusion of innovation”. Clear guidelines on the classification of i2i within health are needed.

Project 11.

The promoter has greatly contributed to the increased competitiveness of hospitals in the country by introducing innovative management techniques and, most of all, by being extremely transparent about it, e.g. with the publication of quality reports, for its competitors to adopt the same techniques.

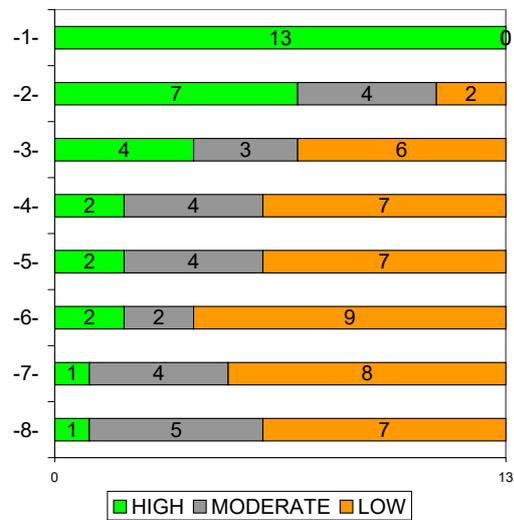
The promoter has probably been a major factor in securing positive changes, but this role is not recognized in the current i2i definition. The promoter doesn't regard the technological content as the major component of innovation. Instead of using the most advanced and extravagant technology, the promoter identifies a more important contribution by testing within their hospitals “scaled down” technologies useable in Eastern countries. In the promoter's dynamic view, transparency and transfer of techniques to competitors brings additional pressure on the group to perform and steadily improve.

⁹ This is also reflected in the overall signed loan portfolio – 69%/88%/64% of the projects had in addition to the health eligibility a regional development/i2i/education eligibility.

EIB Priority areas in health (annex to COP 1999)

- 1 Rationalisation schemes aimed at reducing surplus capacity
- 2 Upgrading existing capacity where the quality of the property and/or equipment is poor
- 3 Focus on university and teaching hospitals with strong research role and catering for complex caseload
- 4 Support for medical and paramedical schools with innovative approaches
- 5 Facility, or non facility, community-based arrangements attempting to provide care in innovative or most cost-effective way
- 6 Other innovative, R&D intensive projects to process, product or organisational aspect of health care
- 7 Special attention for mental illness and disability
- 8 Health care for the elderly, in particular prevention and postponement of disability

Rating of 13 projects to EIB strategic objective
(number see table)

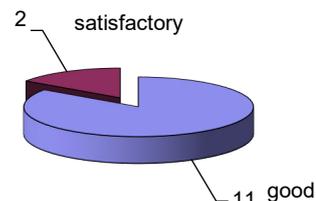


The findings above (section 2.3.1) are also confirmed by the specific analysis of the evaluated projects. Except for one project, all of the projects evaluated were appraised before 2004, but few contributed significantly to objectives 4 to 8. The main goal was to upgrade infrastructure to meet modern standards, particularly with regards to information technology. All but one included the implementation or improvement of *Picture Archiving and Communication Systems* (PACS). In most cases, improvement in quality was to be achieved together with improvements in efficiency (major decrease in bed capacity in 5 projects and reorganization of capacity on limited number of sites in 9 cases). Two projects were rated High on the objective “other innovative, R&D intensive projects to process, products or organisational aspects of health care” (Projects 4 and 11).

2.4. Summary and conclusion on relevance

The sampled projects present high ratings on the relevance criterion. As described above, they were all very relevant to the national /regional objectives, they were consonant with more than one EIB eligibility criteria (except for one) and contributed to attaining EU priority objectives. In addition to providing high quality of care in state of the art infrastructures, three projects have greatly contributed to local economies and urban/rural revitalization. IT and e-health – two other priorities on the EU agenda – were substantial components of almost all projects.

Relevance ratings for sampled projects



The EIB portfolio indicates that the Bank so far has implicitly taken the view that health is mostly equivalent to the creation or improvement of hospital infrastructure. These projects have been funded under some predefined relevance categories, at first without applying a transparent strategy that defined the Bank's goals and responsibilities regarding health. Then (in 1999), a strategy paper was drawn up, but it was not applied consistently. Later, the strategy was watered down and became less focused, until finally *health* lost its top-tier priority status altogether. Only recently, health is to be reinstated as a top-priority, under the environmental eligibility category. EIB's lack of a constant, longer-term health care strategy over the past 10 years somewhat mirrors the EU's situation, which has become more and more involved in questions relating to health care, without an explicit strategic plan. *European Court of Justice* decisions, and the application of directives that had not been issued with health care in mind, have been the main drivers of this process – often in the absence of a clear mandate from Member States. But more recently, the EU has taken important steps to extend its mandate to include health services as *services of general interest*. This reorientation could also be reflected in the EIB's strategic position regarding health.

2.5. Future option

Compiling all the analysis developed in the previous sections, the following chapter outlines some key arguments and avenues for EIB's future activities in the health sector.

Health and the European Union

Some of the most important reasons why health and health care are highly important to both the Union and Members States, can be summarised within the following architecture:

Human Rights		
Health is a human right and important basis for human capital development in Europe		
Motivation at EU level		
European Social Policy (ESP)	EU Citizens	Patient Mobility
<i>Health care is one of the core pillars of ESP.</i>	<i>Health care is a clear priority for EU citizens. Health outcomes may not be directly and necessarily linked to the quantity and quality of care facilities, but Europe's citizens expect universal and equal access to high quality health care. Health care services are to become "services of general interest" under the auspices of the Union.</i>	<i>Key component for the free movement of people and services within the common market.</i>
Sector characteristics		
Importance	Employment	Budget Constraints
<i>Health care is the economy's largest sector and has to be part of this trend for more competitive EU.</i>	<i>Productive and knowledge-based employment is found in health care and related sectors. Hospitals employ some 5% of the EU work force. The health sector should aim at attracting top-level researchers.</i>	<i>Health care is one of the most important items in government budgets; costs are going up and new ways to provide health services more efficiently and cheaply are needed.</i>

In the future, Health will most probably move to a higher level of priority within the EU, in relation to the Member States agenda on European Social Policy, which will be more demanding: new EU constitution, increased concern from EU citizens, ...

Health: the answer from the Bank.

Health is not a stand-alone core priority for the Bank’s lending activity, but health projects can be financed under four different headings in the COP objectives.

With the latest decisions proposed to the Board, the Bank’s reaction towards health projects can be summarised as follows:

EIB core priority	Comments
Convergence	<p>Health and health care are core issues for social cohesion among EU countries. While health care facilities and care provision are the responsibility of Member States, equal access and consumers’ rights to quality health services are EU prerogatives.</p> <p>Health care fosters social cohesion, but the way to assure equal quality and access will change: apart from new hospitals and infrastructure, information systems and exchange of best-practices knowledge will become increasingly important.</p> <p>Nevertheless, the new definition of convergence areas will limit the number of health projects eligible under this priority.</p>
i2i The Lisbon agenda	<p>Health care was funded by EIB under the <i>Lisbon Agenda</i>, as part of <i>human capital</i>, in the sense that better health care and better health contributed to people’s ability to be fit and productive.</p> <p>Today, i2i is the answer to the Lisbon agenda and to subsequent adaptations; some health projects are considered as being eligible under i2i (more precisely many of them have been).</p> <p>It will be important for the Bank to define more clearly what its i2i strategy should mean with regard to health. Under the heading i2i, and more often i2i/ICT, EIB should therefore include health projects with particular pertinence to technology and learning. New high-tech hospitals are ideal bases for national and even international networking and exchange of information. They can form the foundation for the future development of telemedicine and of cost-saving, innovative, community based care.</p>
SMEs	<p>Health projects promoted by SMEs will be treated as any other operations financed by the Bank in favour of SMEs. All financial instruments available to SMEs can be of application also within the Health sector. No specific action towards the health sector seems to be foreseen.</p>
Sustainable Communities	<p>The following selection criteria have been added under the Heading “Sustainable communities”:</p> <ul style="list-style-type: none"> - Health care: identifying the appropriate model of care and the investments consistent with it - Addressing the demographic and epidemiological challenges faced by the EU <p>Health projects are highly relevant in relation to our social and urban environments; A functioning, efficient and reliable health infrastructure is in fact one of the main pillars of a stable social care system in Europe. At the same time, hospitals and health care providers play a major role in the social and economic fabric of our cities. The availability or absence of good local health care is often a major factor in a town’s attractiveness for national and international migrants.</p> <p>It can also be understood that some important aspects related to health will be considered under this heading, like “Preventive health care”.</p>

Consequently, the Bank can continue to react on promoters’ requests and place health projects under one (or more) of these eligibility heading. But will this only be “Business as usual”?

A choice to make: After a decade of experience with health projects, EIB health financing has arrived at a crossroads. It is looking back at the projects carried out so far and at the collective experience gathered in the field, and deciding how to deal with questions of health in the future. Given that there has been a conceptual uncertainty about how exactly to define and categorise health, the Bank could develop a long-term strategy and find a definitive place for health within its eligibility classification.

When considering all the arguments to draw up a durable future health strategy, the EIB will have to make a fundamental choice: given the broad nature of health and its many relations with different fields, health projects can be viewed under various other headings, as they have been in the past. There is no conceptual problem in considering most health projects under “sustainable communities”, while others could be additionally eligible

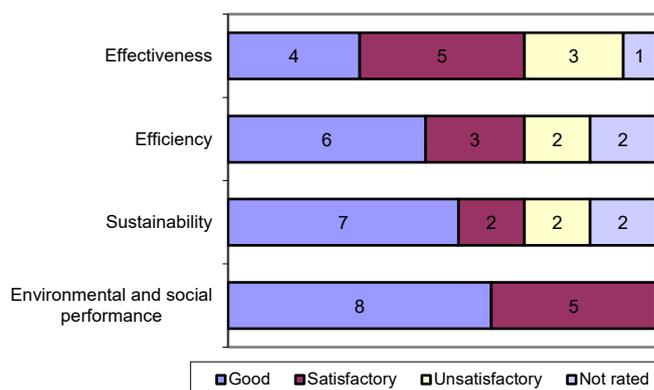
under economic and social cohesion, i2i, etc. This however might shadow the health sector’s major social and economic role.

The increasing priority given to social policy in the EU could, within the years to come, lead the Bank to move health into one of its core priorities. In order to be prepared, the Bank should not avoid the update and clarification of its strategy in the health sector.

3 In-depth evaluation of a sample of 13 projects

3.1. Project performance

Project performance, relating to EIB’s second pillar of value added, is assessed using four core evaluation criteria, namely effectiveness, efficiency, sustainability, and the environmental and social impact -- which are all rated individually.

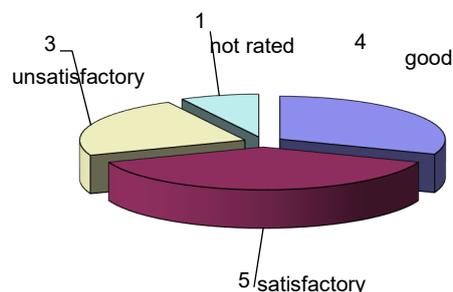


3.1.1. Effectiveness

Definition and methodology:

Effectiveness (or efficacy) relates to the extent to which the project’s objectives have been achieved, or are expected to be achieved, taking into account their relative importance, while recognising any change introduced in the project since loan approval. Key issues addressed are: completion on time/budget; appropriateness of project management and coordination and cooperation with counterparts, quality and safety management.

Effectiveness ratings for sampled projects

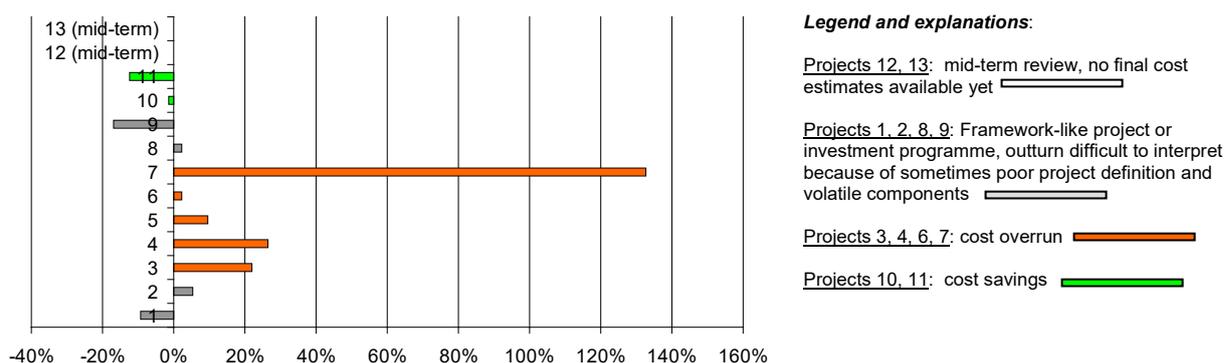


Most projects were implemented without major problems, more or less on time and within budget. Most of the cost overruns were attributed to modifications and additions to the projects, many of which were taken out of the scope of the EIB project and realized in parallel with other resources. Three projects were rated unsatisfactory. In two instances, this rating reflected poor planning and project definition. In the third instance the project experienced significant delays and very substantial cost overruns (see graph below, project 7). These were in part attributed to poor management of the project, with many people responsible but not really anyone in charge. This difficulty had been identified at appraisal but the promoter took a long time to partially implement the remedial actions required by the Bank.

Substantial additions and modifications generated by long time span, political idiosyncrasies and short-term planning

For most of the projects/framework analysed, the entire process from the initial decision, including design, selection of contractors, construction/renovation and transfer of activities, usually took 9 to 13 years. This time span is not unusual for hospital construction projects. With new technologies rapidly affecting clinical processes and demand for care, adaptations were needed at all stages of planning and design flexibility was required. Political considerations and short-term planning approaches were further reasons for the numerous revisions of technical descriptions that led to additional requests, and ultimately resulted in some cost overruns and delays.

Outturn cost in relation to initial estimates at appraisal (variations in %)



In most cases, major additions were already settled before the EIB contract was signed so that modifications to the EIB projects were limited. In other cases, changes were made outside the scope of the EIB projects, based on additional funding and with separate (even parallel) timelines, and had no impact on PCRs and ex-post ratings. In one framework loan, the sub-projects were only very “vaguely” defined when the EIB contract was signed. This led to an Unsatisfactory rating on effectiveness, reflecting poor planning rather than particularly poor implementation.

In light of these experiences regarding modifications and additions, which resulted in delays and cost overruns, upwards and downwards solutions have been proposed (or will be implemented in future projects) by the promoters: reduce time span for implementation using “conceptual-construction” (Projects 7 and 13) or create a “symbolic PPP” to avoid bureaucratic delays (Projects 2, 3 and 5), and design contracts with constructors that best accommodate changes (Project 9). In particular, this evaluation highlighted the need to be extremely cautious when drafting PPP contracts with respect to new specifications/additions/modifications.

Participative planning and experienced project management teams are key success factors. Public promoters often lack experience in hospital construction.

In most successful projects, planning was a participative, consensus driven process, with clear objectives. All the people working in the new/renovated facilities were involved from a very early stage; the objective was to obtain crucial support from all for the design of a functional building. In project 6, this process was particularly important: an 80-100 m² pilot unit with three rooms was created. In this pilot scheme, patient treatment, room cleaning and other services were practiced in advance. Several potential pitfalls were identified and could be corrected before opening the new hospital.

Successful projects were also characterised by a clear delineation of responsibilities for the implementation of the project. The main responsibility was usually given to a management team with long-standing experience in hospital construction projects (Projects 6, 11, 12). For local government and public operators, building a new hospital is often a “once in a lifetime” experience and many delays or cost overruns can be attributed to “beginners’ mistakes”. According to a private partner in a UK PPP, Trusts’ lack of experience in hospital construction projects usually slows the

Project 7

A project manager was appointed, but did not have sufficient autonomy, or his own budget. The mandate of the management team appointed towards the end of project completion was limited to the coordination and management of the new hospital as far as operational issues were concerned. In parallel, a commissioning board was formed by all 5 ministerial departments involved and met weekly to discuss the issues around implementation. No single person was responsible for the project and many had their say in it. Various commissions and officers at the different Ministries were all involved at some stage. Some major adaptations and modifications to the initial contract even had to be approved by Parliament. In such a system, political instability and fragmentation make long-term planning and proactive scheduling difficult. This was exacerbated by the length of implementation, which further increased the chance of changes due to new political realities and/or to new technologies. This situation generated very long delays and cost overrun.

processes; the delays need to be compensated for by fewer contractors’ delays. This was clearly the case in project 5, where signature of the PPP contract was delayed by 9 months. As a consequence, contractors’ risks grow and overall costs increase. However, on the other hand, a site visit of a newly built hospital supported by a charity organization (private non-profit) showed great involvement of its management team: the project was nurtured like a new baby. It was extremely successful in all components assessed and a possible lack of experience did not impact the implementation negatively.

Risks associated with local construction market conditions are very high

According to the promoters, construction costs in some countries have been rising steeply due to local market conditions. This trend was confirmed by EIB internal data. For instance, costs for one maternity project almost tripled during its implementation period. It was estimated by the beneficiary that the new diagnostic centre that was recently opened would have cost twice as much if it had been built now. One concessionaire indicated that project finance deals are released in “waves” and saturate the market, which is limited to very few potential bidders able to take on such large-scale projects and risks associated with PPP bidding processes. In project 10, construction even commenced before financial closure, under an Interim Works Agreement to curb cost increases due to substantial inflation. In another project, saturated construction markets did not just mean higher costs but also real difficulties in finding a contractor willing to take on the contract. The hospital sector is considered relatively risky and when given the opportunity to “pick” their projects, contractors often prefer to avoid this sector. As part of the appraisal process it is crucial that the Bank continues to assess the promoter’s capacity to adapt to rapidly increasing construction costs.

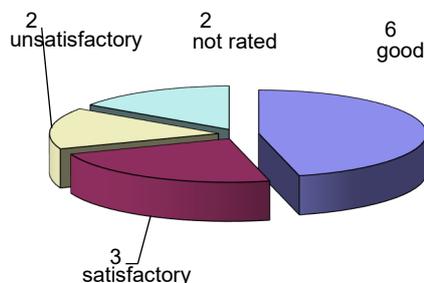
Procurement

For all projects, procurement procedures have been thoroughly checked at appraisal and PCR. The ex-post evaluation team can confirm that there were no major difficulties and that all national and EU regulations on procurement have been complied with.

3.1.2. Efficiency

Efficiency considers whether the project objectives are achieved in a cost effective manner. Usually, the EIB uses two main measures: the Internal Rate of return (IRR) and Economic Rate of Return (ERR). As discussed below, those measures are of little relevance to health projects. Key issues addressed are market/demand aspects, operations, tariffs and operating costs and economic and financial impact - at least as a qualitative appreciation.

Efficiency ratings for sampled projects



The projects were generally characterized by high efficiency (6 “good” ratings). As discussed above (section 2.2.4), major increases in efficiency (cost containment and improvements in quality) to be generated by new constructions and renovations was one of the main objectives of almost all projects. However, it was very often difficult to measure this exactly.

This section is conditioned by the lack of baseline and quantifiable objectives on which to assess the projects' performance. Hence, in most instances, for this ex-post evaluation, a qualitative appreciation was preferred to partially quantified results and the focus is set on "lessons learnt". In one instance (Project 6), the appraisal report correctly indicated that: *"defining the absolute economic benefit of hospitals remains elusive. At a more modest level, however, it is possible, in the specific circumstances of (...) hospital, to make a general assessment of whether the chosen – new – option represents a worthwhile relative choice"*.

In most cases, it is indeed not possible to do a profitability analysis in the health sector. In addition, most outputs – traded or not – are not quantifiable (traded outputs often representing cost rather than real value).

Hence, quantifiable economic objectives and clear indicators to be monitored during implementation and upon completion should be defined at appraisal. It is crucial to precisely identify the impact on financial flows in terms of liquidity and, most importantly, on affordability.

Major role to be played by State-of-the art infrastructure in improving efficiency if associated with new processes to foster cooperation and collaboration within the hospital and across boundaries of care, to optimise patient flows.

All projects evaluated were undertaken with the clear objective of rationalising, renovating and renewing outdated hospital infrastructure. In various stages, new construction and renovation have been used to reduce excess capacity. Other project goals included: improvement of the quality of health services, diagnostic tools and staff working conditions; acquisition and use of new management methods and information and communication technology. As a consequence, overall efficiency was to be improved to decrease unit costs. Based on data available for only some of the projects, the decrease in average length of stay was between 1,5% and 5% per year over the implementation period. Not only did investments in healthcare aim at upgrading infrastructure to the latest standards, but also they were meant to enable major changes to take place in how care was delivered. In all cases, the new/renovated facilities represented a major improvement compared to previous conditions.

However, to be successful, new facilities need to foster and be accompanied by “*new processes of care*”. Hence, quality of the infrastructure needs to be assessed in light of the changes it generates (or could potentially generate), or, at the very least, enables.

The crucial role of capital investments in enabling or creating innovating processes and increasing efficiency was repeatedly put forward. On the one hand, capital investments are needed to enable innovation in processes. On the other hand, innovation in processes creates a need for capital investments. Continuously reviewing processes to decrease the length of hospitalisation and increase throughput creates a need for more facilities for outpatient treatment and diagnostic equipment, more intensive care beds (i.e. projects 3, 4 and 9; Project 7 reproduced the patterns of beds in previous facilities and merely extended the number of specialties). It is not just a “nicer” building and “state-of-the-art” equipment, but (or mainly) the new processes made possible by the new infrastructure that significantly contribute to quality and efficiency of care. Managerial and clinical innovations are expected to be an integral part of the capital investment and have to be explicitly described in the appraisal report.

Integration and continuity of care are major challenges ahead for cost-effective provision of care. Reduction in bed capacity can be achieved if alternatives are available. This has led project promoters in certain cases to integrate both vertically and horizontally or to convert acute care beds into long-term beds. The promoter of project 11 recently acquired polyclinics, nursing care homes and rehabilitation hospitals, and opened geriatric bed units (as in one of the sub-projects within the framework of the EIB loan), thereby already responding to the challenges related to the ageing of the population and specific care to be provided to the very old. The promoter of project 4 gave precedence to a number of formal collaboration agreements with step-down secondary acute care facilities.

Among others, Projects 3, 5 and 13 are health infrastructure projects that do not focus exclusively on *health care as usual*, but that open up new possibilities for the future, i.e., flexibility in design; continuity and coordination of care thanks to innovative information and communication technologies; sufficient infrastructure for day care, designed to absorb further growth in the field. The instrumental role of information technologies (e.g., a single patient record consultable by all actors of the health facility) to modify behaviour and health care management was recognised and developed.

Refurbishments versus new construction

The investment programme (13) builds substantially on the existing infrastructure in order to refurbish it, and no sites are closed. Hence it is by nature somewhat scattered, and the full potential in terms of functionality offered by new facilities cannot be realised. It is likely that the installations renovated within the programme will not, due to their lack of functionality, be able to adapt to future demand. In addition, the affordability of the programme can be questioned. This choice finds justification in light of the promoter's demonstrated involvement in urban revitalization; and with most significant developments taking place on the centre site, which hinders major redevelopments on the greenfield site. The project's city centre location is justified by the desire to group the technical facilities together -which would be impossible on the sites in the outskirts to the North and South- also by the saturation of the road network that makes it difficult to get out of the urban sprawl, by the competition from private clinics primarily located in the centre, and by the desire to regenerate the city centre and encourage other businesses to return there.

Information and Communication Technologies (ICT) has to be used in new and innovative ways

Particularly in rural, not very densely populated regions or in geographic zones that are difficult to access, it will become crucial to bring specialised care closer to the people given that many small and medium-sized hospitals have been closed. ICT can make this possible through telemedicine and networking between hospitals and primary care doctors. With this in mind, telemedicine applications (e.g., telediagnosics and remote monitoring of patients) have already been developed or are planned for the near future in two projects.

In addition, projects 3 and 5 promoted e-health applications to improve the coordination of care and shorten the length of stay (e.g., the GP responsible for a patient has access from his office to the full medical record, while the patient is hospitalised). System-wide integration of hospitals and primary care in a single network is facilitated in national health systems, but it should be a goal for all new hospital developments and needs to be assessed at appraisal as part of the EIB's policy role. The modernisation of the system's management tools or the continuity of care is important, but even more so is to offer a response to the social challenges generated by an ageing population (polyopathologies, chronic diseases) as observed in all European countries. Filling the gap between the health and social sectors will provide better solutions. At the time of any hospital investment, it is important when evaluating the relevance to look at infrastructure investments upstream (primary care) and/or downstream (long- stay institutions, home care, social care) in order to maximise its beneficial effects.

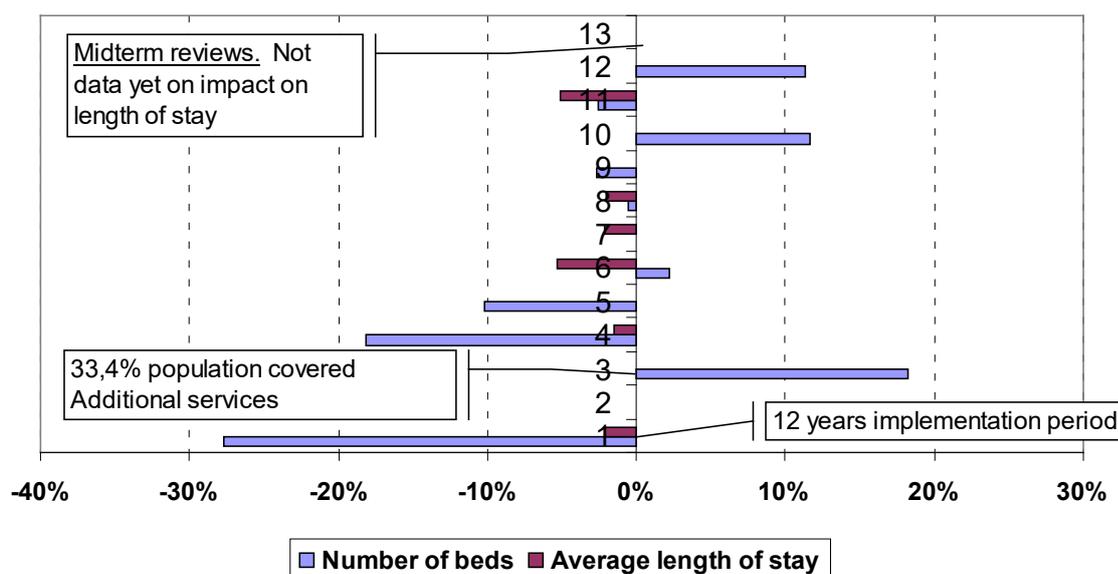
Telemedicine was also used as a response to a lack of highly skilled human resources (e.g., outsourcing the reading of diagnostic imaging – project 9).

However, in many cases, cabling infrastructure was included in EIB projects, but equipment and software were excluded and the schedule for the installation of new IT applications was often delayed (e.g., projects 6, 7, 13). In some PPPs, the concessionaires insisted that IT was considered “too risky” and too related to clinical processes to be taken on as part of the concession. One promoter indicated that the legal and financing frameworks were not yet supportive of telemedicine.

Opportunities to further develop the use of ICT and networking should be thoroughly discussed at appraisal, even if their applications will not be immediate. The economic case should include an estimation of the potential benefits (not necessarily valued in monetary terms) and cost of IT developments and the ex post-completion reports should assess the realization of these objectives.

Number of acute inpatient beds: some more reductions to be expected.

Relative increase or decrease (in%) in bed capacity and length of stay before and after implementation of EIB project



There are no signs that the current trend towards a significant reduction in the number of inpatient beds will slow down. For instance, some believe that a 40% additional reduction in capacity can be expected in

Germany by 2015. Two very innovative hospital projects (projects 4 and 5) -in terms of positioning of the hospital within the health care network and of the extensive collaboration among all partners across organizational boundaries- have demonstrated that it was possible to very substantially reduce beds, even beyond what was expected from them a priori. For project 5, clinical leadership and innovation might have been the key factors that determined why the risks associated with a significant reduction in the number of beds identified at appraisal did not materialize. On the contrary, the promoter of project 5 was able to achieve the maximum performance rating awarded by the national authority for 2 consecutive years, with good results on indicators related to access (waiting times), even during construction work.

For two projects, the increase in number of beds was accepted by local authorities but difficult to justify by demographic trends or new services provided within the facility.

Number of beds per room: for an evidence-based decision with a long-term view

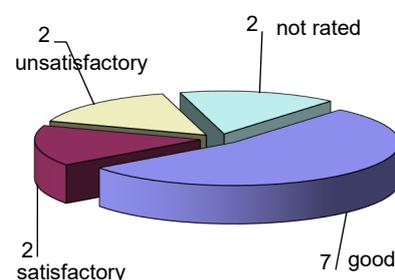
The reduction in the number of beds per room is often used as a justification for the capital investment. It is associated with an improvement in the patients' experience and, more specifically, with their feelings of intimacy. However, the number of beds per room is not only a cultural issue. There are objective arguments to justify a limited number of patients per room. A 2004 report by the EU Health Property Network recommended that: "*guidelines should promote a good practice range of between 50% and 100% single rooms*". This judgement was based on indications that single-bed rooms can significantly contribute to a reduction in cross-infections. Though 4-bed rooms represent a major improvement compared to the previous situation in some countries, the high proportion of 4-bed rooms (that cannot be split in the future) in projects 6 and 10 might rapidly become "out-of-date". It may still be culturally acceptable to stay in 4-bed rooms because it is a standard practice in some countries, but with the opening of borders, patients in future might wish to adopt the same standards as their neighbours.

3.1.3. Sustainability

Definition and methodology:

Sustainability is the likelihood of continued long-term benefits and the resilience to risk over the intended life of the project. Key issues analysed comprised: physical (maintenance and functional adequacy in long-term), financial (e.g. financing recurrent operating costs), demand (impact of ageing population, changing epidemiology and other demographic factors and market share) and staff (attraction and retention of highly skilled staff in a general context of shortage).

Sustainability ratings for sampled projects



Hospitals are of great political importance for local communities. Hospital proximity provides an important sense of security for citizens and it is a major driver for local economies and employment. Hence, hospital closure is extremely difficult because of the political stakes and public resistance. In many projects, the promoters indicated that the scope for closing hospitals was very limited and that their strategy was about redefining missions (e.g., specialisation or long-term care). Hence, in most cases, the physical presence of newly built hospitals is assured for the next 30 years, even if objective arguments suggest that some hospitals should be closed in the future. The main question regarding physical and demand sustainability is how the hospital buildings will be able to adapt to changing demand. All hospital projects have "undesigned wards" that can be used for different purposes. One project even went further in this direction, setting up multidisciplinary wards. The concept of interdisciplinary departments put in place in project 6 is a good tool for a smooth adaptation to variations in demand. On the other hand, departments with a fixed bed allocation and extremely high occupancy rates (e.g., psychiatry) could in future create bottlenecks. High occupancy rates in psychiatry wards were highlighted in several projects.

The evaluation team raised questions regarding building maintenance for only one project (7). Another project (13) builds substantially on the existing infrastructure in order to refurbish it, and no sites are closed. Hence the programme is by nature somewhat scattered, and the full potential in terms of functionality offered by the new facilities cannot be realised. It is not unrealistic to suppose that the installations renovated within the programme will not, due to their lack of functionality, be able to adapt to future demand, which will be characterised by significant technological changes.

Because of the public status of most hospitals, the risk of financial failure (bankruptcy) is relatively low (though the Bank has projects with private hospital companies). Subsidies are major sources of revenue for most hospitals, although mechanisms are currently set up to increase the exposure to financial risks for private and public hospitals, e.g., through Diagnosis-Related Group reimbursement, and to reinforce public accountability. However, it is still unclear how local public authorities will respond should public hospitals go bankrupt. In one country, the preferred response to financial sluggishness has often been to sell public hospitals to private-for-profit groups that make them profitable. Major investments in infrastructure are an integral part of the strategy to turn around hospitals (project 11). Hence, hospital closure should not be avoided at all cost; privatisation can also be a useful tool to improve efficiency.

Projects 4 and 5

Projects 4 and 5 have different roles, the first being a large reference academic hospital and the latter being a local secondary hospital with a teaching mission. But both have demonstrated an extremely focused strategy with great integration in local care network and a 'business-like' market approach with the aim of building a hospital for the future. In both instances, the main feature was a drastic reduction in number of beds (respectively -18% and -10%), which was achieved thanks to outstanding coordination with other care providers in the region, i.e. community services (GPs, home care, etc.), local "step-down" hospitals, etc. and together with an increase in number of cases treated.

Both hospitals are committed to their staff excellence, with training and continuous education in the spotlight. This should ensure they continue to attract high-level staff in a context of staff shortage.

Both also have a sound financial position. Though project 5 is a non-profit hospital, it aims at providing care in a profitable way to invest proceeds in R&D and innovative applications.

From a physical sustainability point of view, project 5 output specification required a strong degree of flexibility in relation to future use, e.g. absence of 'specialty-specific' in-patient bed areas, design of soft areas (e.g. office, recreation areas) adjacent to the key diagnostic and pharmaceutical areas in order to facilitate easy extension of the latter should it be needed in the future, or to facilitate conversion to alternative use. Project 4 contains a large number of features related to environmental protection and energy efficiency.

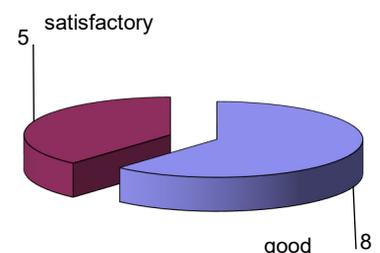
With very few exceptions, shortages of some medical specialties are observed everywhere. In some sites, shortage of highly qualified staff already negatively affected activity. On the other hand, promoters have highlighted the very positive role of new state of the art infrastructure in attracting personnel. Hence, in the short run, EIB projects are somewhat shielded from this problem. Since this trend among most EU Member States is not likely to reverse (quite the contrary), the appraisal process should examine measures to assure staff sustainability.

3.1.4. Environmental and social performance

Definition and methodology:

Environmental and social impact assesses the hospital from an ecological point of view. This criterion goes beyond the impact of the investment on health care provision to extend to carbon emission, energy efficiency, green spaces, involvement of local communities, transport, local employment, social cohesion, urban network, attractiveness of the region, competitiveness of biotech industries, etc.

Environmental ratings for sampled projects



Healthcare projects, according to EU regulations (Directive 97/11/EC), do not necessarily require an Environmental Impact Assessment, but can be considered under Annex II as urban development projects. In the course of the approval process, all projects are subject to an environmental review, in which compliance with local, state and federal law is verified. In this case, all relevant permits were obtained. It was also ascertained that all practices used by the hospitals regarding the disposal of medical waste, radioactive materials and biological waste complied with national legislation and international standards. No project evaluated ex-post raised concerns from this point of view.

All the new buildings included a number of features that greatly improve energy efficiency. However, due to increased surface areas, generalisation of air-conditioning, individual showers, etc., it is difficult to measure the real impact on energy consumption. No data was available and often the ex-ante and ex-post situation could not easily be compared due to a change in activity levels. Some hospitals (projects 3, 4, 9, 12, sub-project at 8) have demonstrated a keen concern for environmental protection and energy efficiency and have taken major steps towards these objectives. The other projects do not seem to have made energy efficiency a priority and treat it as a coincidental "additional advantage" of the new facilities. The appraisal process could be used as an opportunity to discuss these questions and share best practices in the field to raise awareness.

This ex-post evaluation has identified many opportunities for “doing better” and the EIB’s policy role could be exercised with even more ambitious goals.

Bringing high quality care to a local population is of major importance. This explains why the promoters have repeatedly underlined the difficulties associated with hospital closures. In addition, aspects of historic and cultural heritage often have to be taken into account when planning new hospital infrastructure. All the projects have demonstrated – to different degrees – their commitments to urban renewal or rural revitalisation.

Project 2. Rural revitalisation.

The project was an adequate answer to a population scattered throughout rural areas by bringing health and social services closer to the homes of the beneficiaries, with the aim of keeping him/her at home for as long as possible, instead of uprooting him/her if admitted to a residential care unit. Hence, a large number of smaller size “home-like” operations were preferred. This represents a major and very positive change in orientation, since in the past –and in many other places– large units have been built. A modernised health and social care system is an important factor in local quality of life. The project has contributed substantially to creating a new social care infrastructure that is perceived by the population as high quality. The centres had the greatest impact in rural areas where they have significantly contributed to social and economic activity. Elderly people find sufficient infrastructures in their home village and are not uprooted to urban areas. Jobs are created to help retain a younger population that would otherwise probably have to migrate to the cities in search of jobs.

The current trend is to locate new facilities in the peripheral zones of cities, on greenfield/brownfield sites (6 projects), essentially to facilitate access and allow for larger developments that would not be possible in the city centres. Relocation often required new road constructions and was always accompanied by a public transportation plan. Hence, access to peripheral urban areas was greatly facilitated; this has contributed to new development or a revitalisation of the areas. For projects 3 and 13 however, their location within the heart of the city was of major importance and relocation was never really envisaged. This has a great impact on the economic life of the city centre, but created major challenges during construction works (impact for the neighbours, continuation of operations during works).

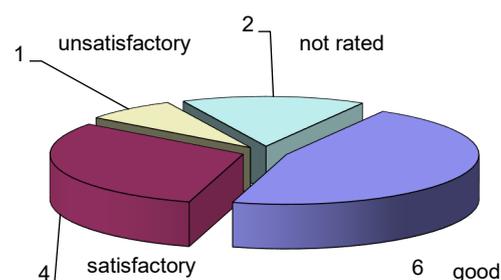
In two projects (8 and 9), the excellence of health care has explicitly been used as a regional marketing tool.

3.1.5. Summary and conclusion on project performance

Based on a sample of 13 projects, this evaluation found that the EIB has generally supported sound projects.

With one distinct exception, projects have been implemented without major difficulties, but delays and cost overruns were repeatedly observed, usually attributed to additions/modifications of the building plans. Conditions of local construction markets sometimes led to volatile prices and need to be taken into account during appraisal. The projects have shown that the health sector is of great political importance locally, regionally/nationally and is thus of great interest. A high level of political attention usually provided ample funding for the sector, but also created some instability; not all decisions were always rational and “evidence-based”. In some cases, promoters could have required a higher degree of technical assistance, because of their inexperience in hospital construction projects. Key success factors for implementation were 1) an experienced team with well-identified responsibilities and 2) a short time frame for implementation. To be successful and ensure realization of objectives it was crucial to have the new construction implemented along with reorganization of process of care and use of information technologies.

Overall performance ratings for sampled projects



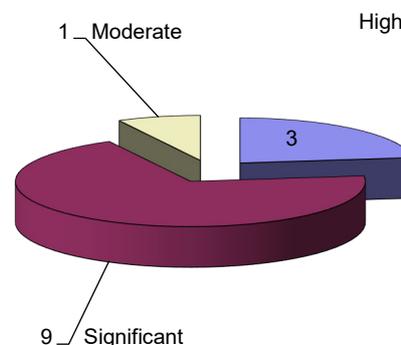
3.2. EIB contribution

3.2.1. Financial value added

Financial value added was very similar across projects, besides the direct financial advantage for the promoters, the longer loan terms (projects 4, 6, 9, 11, 12), the EIB's flexibility (projects 8 and 13), the diversification of the banking base (projects 11, 13), and the availability of funding when access to resources was scarce (projects 2, 4, 9) were mentioned as key criteria. In project 9, the loan was not fully disbursed, as access to the borrower's own funds improved during the course of the project. In some projects, new financial instruments were used, which contributed to reducing the total cost of the loans (5, 8, 10).

Some promoters (projects 6 and 9) remarked that the EIB's funding advantage had decreased and longer terms could now be obtained from commercial banks – both of these are a reflection of the European banking sector's increased competitiveness.

EIB contribution rating for sampled projects
(high/significant/moderate/low)



3.2.2. Other contributions

The international – and especially EU – “flair” of the Bank was considered a plus in three projects, which gave the projects an international dimension.

In one instance, the EIB has provided support for rating agencies.

In some projects, the EIB's involvement was a major factor in attracting commercial funding for the implementation process of PPPs, in particular with its expertise in the set-up and details of the PPP agreements. In one project the EIB's presence was of great strategic importance, both for the EIB (through a signaling effect to other regions) and for the country's health sector (by opening new venues for PPP and contributing to a much needed renewal of health care infrastructure).

Since 1997, the United Kingdom (UK) National Health System (NHS) has embarked upon an ambitious programme to renew its infrastructure: almost 1/3 of the acute general properties and general NHS properties have been replaced; annual capital expenditure has increased from around GBP 1.1 billion to around GBP 5.5 billion in 2007/08; 88 major hospital schemes have been implemented and another 24 are under construction; the NHS 2000 primary care plan called for up to 3,000 refurbished or replaced GP premises by 2004. Private Finance Infrastructure (PFI) was used as a leverage to support this investment programme. Thanks to this extensive programme, the UK NHS has been a leader in Public-Private-Partnerships (PPP) in European healthcare.

There is no consensus within the EIB on the roles and on the expected level of advisory work provided. In EU Member States (especially EU15), EIB involvement begins relatively late in the project process for most projects (sometimes construction has already started). It is often limited in scope, since promoters' responsiveness to and acceptance of external advice is limited.

In the New Member States and countries outside Europe, there are more opportunities to influence decisions and the EIB's value-added is often higher. There is, for instance, some collaboration with the World Bank in Poland, Romania and Hungary, and large funds (FEMIP) are available to provide local assistance in a few countries. EIB lending volume in those countries is very limited but it creates a substantial volume of work for operational staff. In line with the COP, technical assistance and advisory work have already been developed and should be fostered. Greater need for and/or responsiveness to such an approach have been observed in new EU Member States and outside EU.

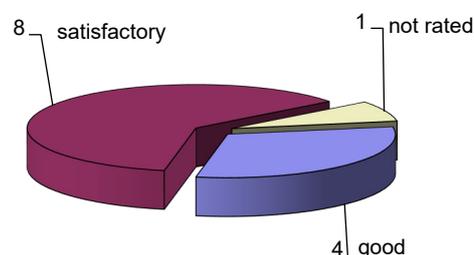
3.3. EIB project cycle management

3.3.1. Project identification and selection

In most instances, the projects were identified through ongoing contacts between EIB and relevant Ministries or their regional equivalents. Health components have often been added more or less incidentally to other public infrastructure investments that were eligible for EIB funding. In general terms, one can say that the sample reflects the Bank's reactive approach, with little scope for an active selection of projects.

Project definition and delineation is an extremely important exercise that has proved to be difficult. As noted above, health projects can be substantially different from one another. It has therefore been problematic to apply the same project appraisal and definition tools that are used for "classic" investment loans with a limited number of sub-projects, to "framework-like" projects, or investment programmes (projects 1, 2, 8, 9) with large numbers of sub-projects or varying sizes. EIB project funding is often different from general budgetary borrowing, which public entities (such as national or regional governments) are accustomed to. It is therefore difficult for them to clearly delineate projects that are separate from their overall activities. In the case of large, framework-like projects, this problem concerns, in particular, the details at the sub-project level. In fact, while all sub-projects were often correctly delineated and described, their real costs did not necessarily coincide with the costs stated in the EIB project documents. Also, overall investment in the projects was sometimes higher than the amount defined as the "EIB project". In order to maintain transparent financial control of projects and sub-projects, extra care should therefore be taken to define the overall project scope and volume, as well as the exact financial dimension of each sub-component. When the EIB funds parts of wider investment programmes, an analysis should be made to determine whether it is advantageous (more transparent) to designate a smaller percentage of the overall investment as an EIB loan, rather than a larger share of an artificially carved-out "EIB-project". Wherever possible the EIB project scope should be identical to the promoter's project scope.

EIB project cycle management rating for sampled projects



3.3.2. Appraisal

Appraisal was generally detailed and usually appropriately identified potential risks and limitations. However, the window of opportunity for the Bank to influence structural designs was often limited, due to late identification of the projects and/or some reluctance on the part of national/local authorities to heed the Bank's advice. In one instance (project 7), shortcomings identified during appraisal led to an unsatisfactory level of effectiveness during and after implementation. In projects 2 and 7, EIB conditions were barely met upon completion. In future, a framework for cooperation with external partners could be set up to provide advice for promoters regarding the best use of funds. The EIB's influence on the design and implementation of projects might thus grow by increasing the willingness of promoters to implement recommendations. One project (7) highlighted the difficulty of monitoring whether EIB conditions were being met in this PPP setting: conditions had been imposed on the promoter, but the contract was signed by the borrower, a Special Purpose Vehicle.

Some of the earlier large framework loans were defined with extremely long project lifetimes (12 years), but this has not been observed in more recent project (4-5 years usually). Confusion around the calculation of ERR and IRR was observed. ERR was estimated in three projects (1, 9, 11), and IRR in another three projects (5, 10, and 11), but most calculations demonstrated the difficulties to apply meaningful assumptions in the sector.

The confusion about profitability calculations could have been avoided by using the guidelines that were defined at an early stage (1999) within the Bank's Project Directorate. These guidelines do not seem to have been applied, and they were probably not even known to many actors, because the relevant document was never referred to in any of the 13 projects. When rates of return were calculated, underlying assumptions and estimates of economic advantages proved to be relatively weak or the economic lifespan of the projects was excessively long (up to 60 to 65 years in some of the PPP projects).

Clear appraisal guidelines should be established in order to avoid inconsistencies. Since clear IRR/ERR calculations cannot always be made, well-defined quantifiable economic objectives and indicators need to be

established at appraisal, which need to be monitored during implementation. It is crucial to precisely identify the impact on financial flows in terms of liquidity and, most importantly, on affordability.

Most promoters have developed sound, ongoing relationships with the EIB and in many cases subsequent projects by the same promoters have also been financed with EIB loans. This is a clear sign that the promoters were satisfied with the EIB's services. In fact, they have mostly been very content with EIB staff and have repeatedly praised the EIB's level of competency, professionalism, support and flexibility. Promoters have also made it clear that the main factor that will determine the feasibility of future collaborations is whether the EIB will be able to offer financial advantages.

3.3.3. Project implementation – Financial arrangements

In all projects, financial arrangements were judged satisfactory by the promoters and the whole financial process was considered to be smooth. There were no major discussions regarding this point. As discussed above, long maturity was considered crucial for many borrowers. The loan terms were 14-15 years for all projects, except for PPPs which had significantly longer terms to match the concession periods (from 20 – 33 years). For PPP structures, loan duration is clearly linked to the concession and does not necessarily take into account the expected economic life, which is largely dependent on satisfactory maintenance.

3.3.4. Monitoring

Although six promoters considered the EIB's reporting and administrative requirements to be tough in comparison with commercial banks, especially during the first stages of the process, four of them went on to indicate that, though initially reluctant to comply with all requirements, they now saw the benefits as well. Two promoters however (projects 7 and 11) considered EIB administrative and reporting requirements as "too detailed and over-sophisticated".

Few borrowers have been reluctant to provide data for the PCR. However, the situation for PPPs was not satisfactory. One promoter has not provided any data, so assessment of the economic and financial impact on the final beneficiary and the soundness of the project was made based only on publicly available data. In PPPs, there is no contractual basis requiring the final beneficiary to provide monitoring evaluation.

In the healthcare services sector, physical implementation is only partially related to achievement of construction objectives. A full PCR would be best compiled one to two years after completion and ex-post indicators compared to ex-ante targets defined at appraisal and, where relevant, to a baseline in the old/former facility. A partial PCR (implementation review) could be carried out very shortly after completion of the project. This approach is more demanding on staff resources, but would be extremely useful for knowledge management within EIB. This could be limited to projects in monitoring category B and to projects considered particularly innovative for the sector or for the Bank.

There were no major discrepancies between ratings in the frame of this ex-post evaluation and PCR ratings.

ANNEX 1: Evaluation Process, Criteria And Methodology

EIB's Operations Evaluation (EV) carries out independent ex-post evaluations on projects that have been financed by the EIB. Those evaluations are primarily aimed at the EIB's governing bodies to support the formulation of Bank policies and strategies and at the Bank's Lending, Risk Management and Project Directorate. Evaluation being a tool for improvement, the synthesis report derives clear recommendations to relevant bodies or directorates of the EIB.

The general objectives of the evaluations correspond to the three pillars of value added as described in the Corporate Operational Plan (COP). Relevance of EIB operations, EIB contribution and project performance are assessed. According to the Terms of Reference (ToR) of the specific evaluation of financing of health projects, the three general objectives can be respectively translated in questions A and B, C to F, and G (figure 1 below).

The evaluation has been developed in four phases – scope, review, in-depth evaluation and synthesis.

- Development stage: The main output of this stage is an issue paper, which focuses the evaluation by clearly delineating the objectives of the evaluation and serves as a basis for the Terms of Reference for external consultants. The issue paper included a portfolio review of major trends in financing health projects. The sample chosen for evaluation is supposed to be representative of the geographical distribution of loans (although some countries could be less represented, loans being signed more recently). Hence, to balance the sample to better reflect geographic distribution and to reflect recent changes in the appraisal methodology and approach, additional projects for “mid-term review” were included in the final list of potential projects. At this stage, the list was made up of 25 projects with an additional place available for a French project.

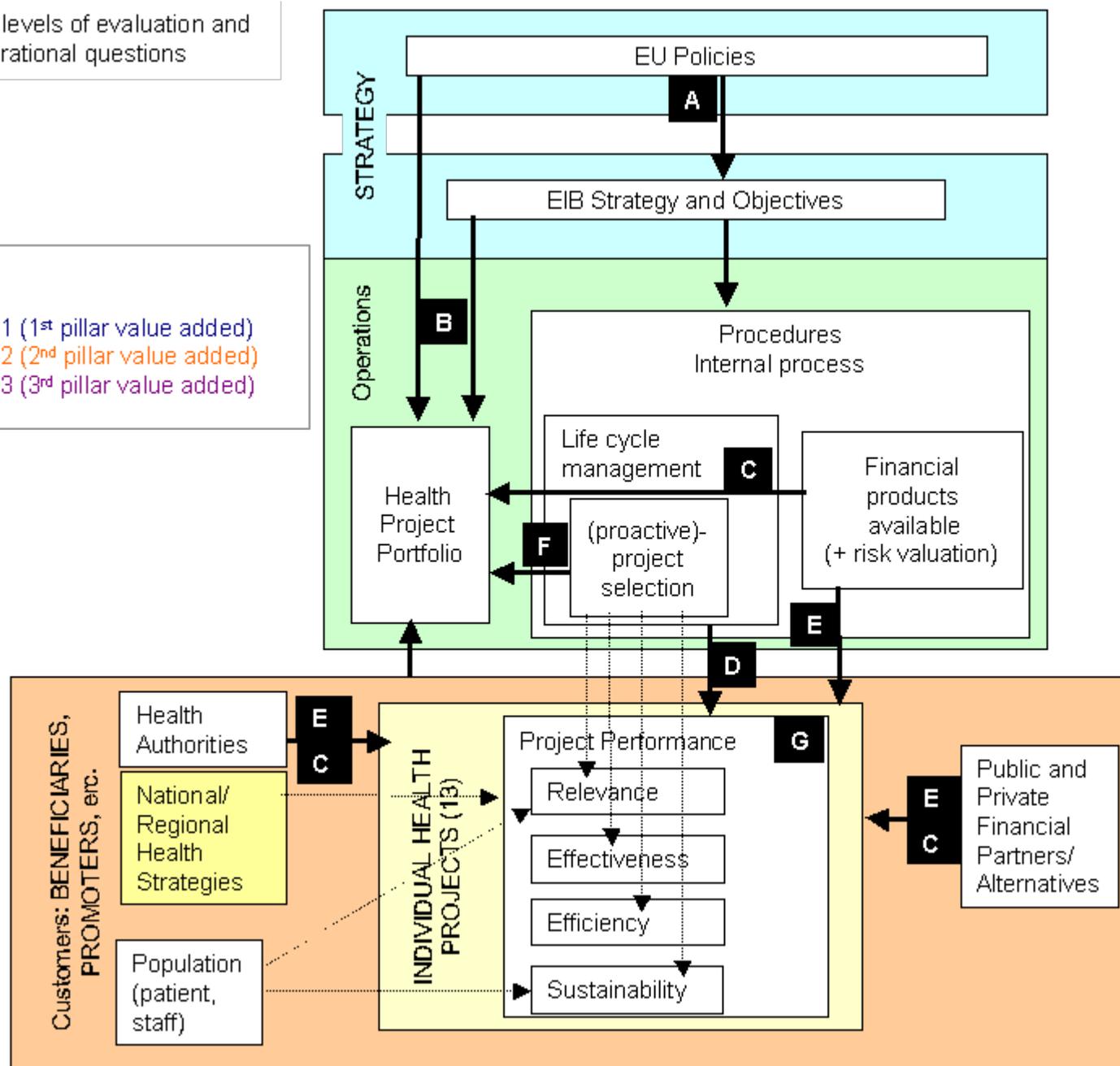
At a later stage, an analysis of EU policies regarding health was made to identify priority areas to be assessed as part of the in-depth individual evaluation.

- Review: During this phase, ex-post analysis starts with internal documentation, information in the public domain and information with relevant EIB staff from the operational directorates. Detailed desk reviews are produced for all 25 projects eligible for individual in-depth evaluation. This desk review is conducted to get a better understanding of the central issues of the evaluation.
- Final sample selection was based on the in-depth desk review of all 25 eligible projects. It was made with the aim of obtaining a set of projects representative in terms of geographical representation, loan volume, regional development objectives, signature year, framework and investment programmes vs. single investments, and renovation vs. construction on green belt sites. The objective was also to gain a maximum number of lessons learnt. Hence, projects with PPP and social care or innovative models of care are slightly over-represented. In this sense, there might be a very moderate selection bias.

Figure 1: levels of evaluation and main operational questions

Legend :

- Objective 1 (1st pillar value added)
- Objective 2 (2nd pillar value added)
- Objective 3 (3rd pillar value added)



A How is EIB strategy and objectives aligned to EU Health policies ?

B How does the project portfolio reflect EIB's human capital strategy and EU priorities regarding health?

F How does the selection criteria (and risk valuation) contribute to a balanced portfolio in regard to (B)?

What is the quality, effectiveness and relevance of EIB operations in support of health projects?

C How is EIB's product offer responding to the needs of health sector?

D What is the financial value added of EIB?

E What is the quality and contribution of the ex-ante appraisals and project follow-up? How was each phase of the project cycle managed by EIB?

G What is the relevance, effectiveness, efficiency and sustainability of the 13 selected health projects?

ANNEX 2: Health Eligibility Components (2004)

Domains	Categories of investment / indicator	1999 paper	Comment Portfolio analysis
Addressing inadequate supply of health funding	1. Facility, or non facility, community-based arrangements attempting to provide care in innovative or most cost-effective way;	YES	
	2. Focus on research and development projects	YES	
	3. Special attention to mental illness and disability and health care for the elderly	YES	Made even more relevant in light of recent EU orientations and the explicit recognition of the need for adequate infrastructure for the elderly population and the white paper on mental health.
	4. Setting up and sustaining networks and systems for the surveillance and monitoring of communicable diseases and other public health challenges in the EU and internationally	NO	NEW. Very relevant to EU policy. But no projects of this nature were financed by EIB.
Repairing deficiencies in the legacy of healthcare infrastructure and, in the process, endeavouring to increase the future robustness of investment	5. Rationalisation schemes aimed at reducing surplus capacity	YES	Second most important objective in the current and past EIB health portfolios.
	6. Upgrading existing capacity where the quality of the property is poor	YES	Common objective for all 13 projects in sample. Major objective for capital investment in health infrastructures.
	7. Focus on university and teaching hospitals	YES	Compared to COP 1999 policy paper, the condition to have "strong research role and catering to complex caseload" has been dropped. As these hospitals can also be financed under i2i/education or i2i/R&D. Hence, redundant, there is no need to specifically focus on those hospitals; the important role of smaller community hospitals should not be overshadowed by large tertiary facilities. In most cases the most cost-effective treatment is provided by primary or secondary care centres.
	8. Support for medical and paramedical schools	YES	
	9. Developing skills for the provision and management of healthcare	NO	NEW. No projects of this nature were financed with EIB loans.
	10. Procurement of IT and medical equipment to assist in the provision and management of services	NO	NEW. Support for most projects, but IT stand-alone project within EIB portfolio. These could be financed under i2i. Unusually small-scale -- but a great number of facilities could benefit from such approaches; could be proposed for global or framework loans.
	11. Establishing and maintaining e-health infrastructure and services		
Identifying the appropriate model of care and the capital facilities consistent with it	12. Improving preventive services and health education	NO	<p>General comments to 12-19:</p> <ul style="list-style-type: none"> - Very relevant to EU policy. - No project with these components as primary objective was financed. - Not capital-intensive. Financing such types of projects would suppose that EIB agrees to provide loans for intangible assets. Alternatively, EIB could participate by sponsoring bodies/agencies supporting evidence-based policy-making. - Should be assessed as part of appraisal process. These aspects should be discussed with the promoter as part of EIB's policy role, even if impact on final design of the appraised project is only marginal (or even nil). It could provide insights for future projects for the promoter. <p>Specific comments:</p> <ul style="list-style-type: none"> - <u>Item 16</u> is somewhat redundant compared to item 1, except that one is hospital-based and the other is home-based. - <u>Item 17</u> is an objective in itself that should be taken out of the "health" eligibility sphere and brought forward to the level of EIB-wide strategy, to occupy a position similar to EIB environmental impact due diligence. - <u>Item 19.</u> Most important is to ensure that these findings/methods are applied within EIB-financed projects.
	13. Developing rationale and equitable financing mechanisms		
	14. Strengthening cooperation in medical and health system research		
	15. Improving health information systems to provide policy makers, health professionals and the general public with key health data and information		
	16. Adapting and developing primary, community and other non-acute care to complement hospital care		
	17. Furthering environmental health in the definition and implementation of other Community policies and activities		
	18. Focussing social protection systems to ensure maximum health gains		
	19. Developing methods to evaluate medical treatment, health care products and health care systems		

EUROPEAN INVESTMENT BANK OPERATIONS EVALUATION (EV)

In 1995, Operations Evaluation (EV) was established with the aim of undertaking ex-post evaluations both inside and outside the Union.

Within EV, evaluation is carried out according to established international practice, and takes account of the generally accepted criteria of relevance, efficacy, efficiency and sustainability. EV makes recommendations based on its findings from ex-post evaluation. The lessons learned should improve operational performance, accountability and transparency.

Each evaluation involves an in-depth evaluation of selected investments, the findings of which are then summarized in a synthesis report.

The following thematic ex-post evaluations are published on the EIB Website:

1. Performance of a Sample of Nine Sewage Treatment Plants in European Union Member Countries (1996 - available in English, French and German)
2. Evaluation of 10 Operations in the Telecommunications Sector in EU Member States (1998 - available in English, French and German)
3. Contribution of Large Rail and Road Infrastructure to Regional Development (1998 - available in English, French and German)
4. Evaluation of Industrial Projects Financed by the European Investment Bank under the Objective of Regional Development (1998 - available in English, French and German)
5. An Evaluation Study of 17 Water Projects located around the Mediterranean (1999 - available in English, French, German, Italian and Spanish).
6. The impact of EIB Borrowing Operations on the Integration of New Capital Markets. (1999 – available in English, French and German).
7. EIB Contribution to Regional Development A synthesis report on the regional development impact of EIB funding on 17 projects in Portugal and Italy (2001 – available in English (original version), French, German, Italian and Portuguese (translations from the original version)).
8. Evaluation of the risk capital operations carried out by the EIB in four ACP countries 1989-1999 (2001 - available in English (original version), French and German (translations from the original version)).
9. EIB financing of energy projects in the European Union and Central and Eastern Europe (2001- available in English (original version), French and German (translations from the original version))
10. Review of the Current Portfolio Approach for SME Global Loans (2002 – available in English (original version), French and German (translations from the original version)).
11. EIB Financing of Solid Waste Management Projects (2002 – available in English (original version), French and German (translations from the original version)).
12. Evaluation of the impact of EIB financing on Regional Development in Greece (2003 – available in English (original version) and French (translation from the original version)).

EUROPEAN INVESTMENT BANK OPERATIONS EVALUATION (EV)

13. Evaluation of Transport Projects in Central and Eastern Europe (2003 – available in English (original version).
14. EIB Financing of Urban Development Projects in the EU (2003 – available in English (original version), French and German (translations from the original version)).
15. Evaluation of the Projects Financed by the EIB under the Asia and Latin America Mandates (2004 – available in English (original version), French, German and Spanish).
16. Evaluation of EIB Financing of Airlines (2004 – available in English (original version) French and German)
17. Evaluation of EIB Financing of Air Infrastructure (2005 - available in English (original version) German and French)
18. EIB financing with own resources through global loans under Mediterranean mandates (2005 - available in English (original version) German and French.)
19. Evaluation of EIB Financing of Railway Projects in the European Union (2005 - available in English (original version) German and French.)
20. Evaluation of PPP projects financed by the EIB (2005 - available in English (original version) German and French).
21. Evaluation of SME Global Loans in the Enlarged Union (2005 - available in English (original version) and German and French.)
22. EIB financing with own resources through individual loans under Mediterranean mandates (2005 - available in English (original version) and German and French.)
23. Evaluation of EIB financing through individual loans under the Lomé IV Convention (2006 - available in English (original version) German and French.)
24. Evaluation of EIB financing through global loans under the Lomé IV Convention (2006 - available in English (original version) German and French.)
25. Evaluation of EIB Investments in Education and Training (2006 - available in English (original version) German and French.)
26. Evaluation of Cross-border TEN projects (2006 - available in English (original version) German and French).
27. FEMIP Trust Fund (2006 - available in English.)
28. Evaluation of Borrowing and Lending in Rand (2007 - available in English.)
29. Evaluation of EIB Financing of Health Projects (2007 - available in English.)

These reports are available from the EIB website: <http://www.eib.org/publications/eval/>.
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