2015 Country Reports

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european public health alliance

2015 Country Reports: EPHA Analysis

Contents

Introduction

2015 is the first year in which the European Commission has issued Country Reports in this form, but they are not an entirely new component of the European Semester. The Reports provide an overview of the economic situation of each member state, along with its progress in implementing structural reforms, fiscal measures and budgetary requirements as part of its national economic policy. They build upon the Annual Growth Survey (AGS), the publication of which launches the European Semester each November, and inform the drafting of the National Reform Programmes (NRPs) – the next step in the Semester cycle – and the Country Specific Recommendations (CSRs), which are adopted by the Council of the EU in July, signalling the end of the current Semester. In this form, the Country Reports replace the Staff Working Documents (SWDs) which were, until this year, published alongside the CSRs each May.

Unlike the SWDs, the Country Reports also include 'in-depth reviews' for countries in which concerning macroeconomic trends were identified in the Commission's Alert mechanism Report (AMR) in November. This year, 16 member states had such imbalances highlighted, prompting the beginning of a Macroeconomic Imbalance Procedure (MIP) in which each was assigned a 'level' of concern – following the reviews and changes in the level assigned for some states, five countries (Portugal, France, Croatia, Italy and Bulgaria) remain at the highest level. These states will now be required to initiate more urgent reforms to bring their macroeconomic indicators into line.

The Country Reports are part of the new approach to the Semester and are published earlier than the SWDs to allow more time for engagement of member states, national parliaments, civil society, the European institutions and other stakeholders. The objective of the new approach is to give member states, as well as broader stakeholders, greater ownership of the Semester process with the goal of increasing implementation of and compliance with the CSRs.

The next step of the Semester cycle will see member states adopt their NRPs, outlining their intended programmes of structural reform to boost jobs and growth, and stability and convergence programmes (SCPs), detailing their proposed fiscal policies for sound public finances. On the basis of these, the Commission will publish its proposals for the CSRs in May, to be discussed by the legislative institutions and adopted by the Council in July.

Health in the Country Reports

The 2015 Country Reports follow the trend of previous SWDs and CSRs in their inclusion of health and contain reference to health and/or long-term care for 25 member states. Having been largely overlooked in the early Semester documents, references to health have grown exponentially in subsequent cycles, with the most recent set of CSRs containing health-related or long-term care-related recommendations for 19 member states[1]. The Country Reports now provide detailed information on healthcare systems, long-term care systems, poverty and social exclusion and tax structures (Figure 1).

Report contains information on	Number of member states
Health	20
Long-term care	15
Roma inclusion	6
Growth-friendly tax	18

Figure 1: Content analysis, 2015 Country Reports.

By comparison, 15 member states received recommendations relating to health in 2013, six in 2012 and four in 2011, when the Semester process was first introduced (Figure 2). Furthermore, countries subject to economic adjustment programmes (EAPs) and memorandums of understanding (MOUs) as part of financial assistance programmes have consistently received recommendations relating to health. The relevance of this sector for sustainable and inclusive growth is thus increasingly recognised and framing the discussion of health in the context of macroeconomic policy has become a vital tool for the health community.

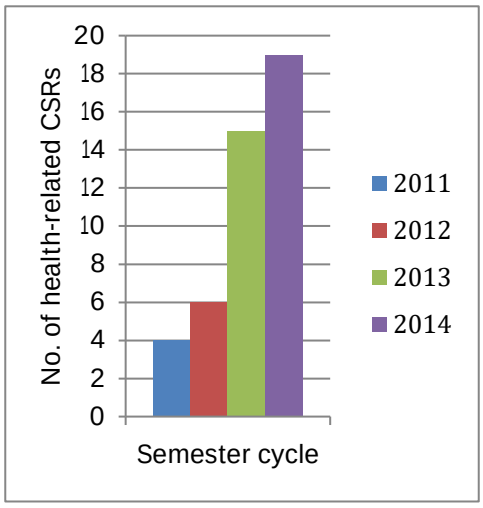

Figure 2: Number of health-related CSRs issued from 2011-2014 (Source, see footnote 1).

[1] Azzopardi-Muscat, N., Clemens, T., Stoner, D. and Brand, H. (2015) 'EU Country Specific Recommendations for health systems in the European Semester process: Trends, discourse and predictors' Health Policy Volume 119 pp. 375-383. Excluding countries subject to an Economic Adjustment Programme (EAP) or a Memorandum of Understanding (MOU).

Specific health references

As the level of detail in the CSRs has increased so too the references and recommendations relating to health have become much more exhaustive. For almost every country the Country Reports now contain a comprehensive description of the health system and its main features, along with an analysis of any identified problems or weaknesses and, where appropriate, recommendations as to how these might be addressed. In the initial cycles of the Semester, such references were to vague concerns about the 'cost-effectiveness of the healthcare system' or the 'sustainability of long-term care provision'. Implementation was difficult to perform and to evaluate and so progress reports from early cycles find minimal compliance with the heath-related recommendations made[2].

The same cannot be said of the latest series of assessments made in the Country Reports. In addition to detailed description of individual health systems, the Reports contain analysis of: the balance between primary and secondary care; access to and availability of services for different population groups; trends relating to the health workforce and professional migration; provision of prevention and health promotion programmes; the effectiveness and sustainability of specific funding models and; the potential gains to be made from implementing eHealth technologies and health-friendly taxation. As well as suggesting more targeted areas of action for member states, any recommendations made at this level of specificity are likely to facilitate closer monitoring and evaluation, thus increasing the pressure upon member states to implement. Whilst the CSRs remain non-binding, the growing commitment to their full application makes it increasingly difficult for national governments to justify any failure to address the issues highlighted. The following section identifies some of these more specific references to health.

Access and availability

Reference to access to and availability of care was made in the Country Reports of nine member states (BE, BG, CR, LV, PL, PT, RO, SI and ES). In Belgium, over-capacity of beds in long-term care institutions is being addressed via an increase in the availability of home care and other community-based services. To overcome barriers to equitable access in Bulgaria, the Country Report suggests that administrative capacity should be strengthened so as to allow of the development of better strategies for increasing access and return on health investment. Restrictions to access for vulnerable groups are noted in the Reports of Latvia and Spain – the latter has introduced an insurance mechanism for those not covered by the national system, including undocumented migrants, but only a couple of hundred of such contracts have been signed to date. Poland faces challenges in terms of the adequacy and coverage of its social protection system, whilst in Croatia both access and availability of care are improving, but waiting lists for nursing homes remain long, privately provided services are not accessible to the majority of the population, and patients still report having to travel long distances to access the care they need.

[2] European Parliament 'Implementation of Country Specific Recommendations' October 2014.

"The healthcare system fails to address the issues of equitable access. Unmet medical needs for cost reasons for the lowest-income quintile of the population in Bulgaria are the second-highest among EU Member States…In addition, the incidence of bribery and informal payments in Bulgaria are above the EU average. Given that the private cost of healthcare is already a substantial barrier to equitable access, this particularly jeopardises access for the most disadvantaged population groups."

Country Report Bulgaria 2015

The Country Report for Portugal notes that 14% of the population have no family doctor and waiting times for certain surgeries have lengthened in recent years, prompting a spike in unmet medical need. In Romania, informal payments hinder the accessibility of the system and in Slovenia, the number of patients on waiting lists rose steeply in 2014, suggesting deterioration in access to health services.

Effectiveness and efficiency of services

Comments about the efficiency and/or effectiveness of health services were made in six Country Reports (AT, HU, LT, PL, RO and SK). Assessments of cost-efficiency in the health system, a common feature of European Semester documents, are a little more specific, identifying particular sources of inefficiency or areas for efficiency gains. For example, in Austria the reliance on hospital-based care is identified as a drain on resources and the Country Report indicates that a shift towards outpatient services could produce cost-efficiency gains. In Hungary, high out-of-pocket payments, health inequalities and the hospital-centred nature of the care system are identified as damaging structural inefficiencies – the ongoing health reform aims to tackle such characteristics of the system but cannot yet be evaluated, having only recently been launched. The effectiveness of the system is also questioned, in light of high prevalence of premature mortality, particularly among the working age population.

"Premature mortality, measured in terms of potential years of lives lost is not just among the highest, but is declining slowly in Hungary in international comparison, particularly among males. This is largely attributed to persistently high levels of mortality from diseases of the circulatory system. High mortality rates among the working-age population are prevalent***."***

Country Report Poland 2015

Similarly, costly inpatient treatments are identified as a key source of cost inefficiency in Lithuania, where a shift to primary care, day treatment and nursing care, as well as the introduction of more prevention initiatives, are encouraged. The Country Report for Poland notes that little progress has been made in increasing the cost-effectiveness and efficiency of the health system, where weak governance, deficient transparency and

difficulties in providing the right mix of care produce inefficiencies. The decentralised governance of hospitals is identified as a root cause of inefficiency in the Romanian system, whilst poor health outcomes point to a lack of effectiveness. Finally, in Slovakia, overall health system efficiency is low and effectiveness of services uncertain but analysis of the problem is hampered by irregular tracking of patient pathways and an absence of data.

Primary and secondary care

References to particular care models generally focus upon the efficiency of the mix of care (primary to secondary) and the balance between institutional- and community-based care. Hospitals are by far the most commonly identified problem areas, representing a high proportion of expenditure – they are mentioned in the Country Reports of nine member states (AT, BG, CR, CZ, HU, PL, PT, SK and SI) whilst primary care is examined in only four cases (BG, PL, SK and SI).

"...pressure could be somewhat eased by addressing inefficiencies in the healthcare sector, which are largely due to misdirected incentives. For example, hospital outpatient consultations per capita are among the highest reported in the EU, pointing to ineff***ective screening by general practitioners'***

Country Report Czech Republic, 2015

In Bulgaria, the funding and referral systems in primary and outpatient care exacerbates the trend for informal payments, whilst both the Polish and Slovenian Country Reports note that primary care could be strengthened and the mix of care could be improved. The Slovakian healthcare reform targets primary care and seeks to foster an integrated care model, though it is too early to assess its success.

Several countries are flagged as relying too heavily upon hospital-based care (AT, BG, CZ, HU and PL). An oversized hospital sector or too many acute care beds is identified as a problem in Austria, Bulgaria and Poland, whilst hospitals are targeted as cost-inefficient or 'in arrears' in Hungary, the Czech Republic, Portugal, Slovakia and Slovenia. The Polish and Slovakian Country Reports suggest consolidating and rationalising hospital care and the hospital network and most others point to a better balance between primary and secondary care as a crucial next step.

Long-term care services

In Slovenia, the average pension is not enough to cover the costs of LTC and in the first 10 months of 2013, three per cent of institutional care users left care and either returned home or were taken into care by their relatives.

In addition to assessments of national health systems, this year's Country Reports make reference in many cases to member states' long-term care (LTC) systems. In light of the

ageing population, these are a particularly important element of social policy expenditure and raise some concerns with regards to sustainability. The Country Reports for 10 states make reference to LTC (BE, BG, CR, IT, LU, MT, PL, RO, SI and ES).

*"An ins*ufficient supply of long-term care has been shown to lead to situations where acute hospital beds are taken up inappropriately. Community-based care is still underdeveloped. The lack of formal long-term care services may hinder progress in improving labour *market participation of women, especially at older ages..."*

Country Report Malta, 2015

In Belgium, over-capacity of LTC beds is identified as a cause of cost-inefficiencies whilst in Italy, an over-reliance on cash benefits for those not able to support themselves in older age, often inappropriately assigned, is highlighted. In Luxembourg, the number of dependent persons receiving benefits from the LTC system more than doubled between 2000 and 2010, generating serious sustainability concerns – it is anticipated that the insurance fund will be in deficit from 2015 onwards. The absence of a coherent LTC system is noted in the Reports for Bulgaria, Croatia, Poland and Romania. Provision of LTC services is deemed inadequate in Bulgaria, Croatia and Malta and in most cases the fragmented nature of LTC governance is identified as a root cause, with authority often dispersed between the health and social care sectors. Finally, a negative impact upon labour market participation, particularly among older women, is identified in the LTC structures of Bulgaria, Croatia, Malta and Spain.

Health promotion and disease prevention

Health promotion and disease prevention has historically been overlooked in Semester documents but this year appears in the Country Reports of four member states (BE, LV, LT and ES). Though reference is limited in scope, in the Spanish and Lithuanian Reports prevention is identified as one of the key approaches to improving efficiency by reducing the burden upon expensive inpatient care. In Belgium, preventative measures in LTC are encouraged and in Latvia, an absence of sickness prevention and health promotion is identified as a major challenge to be faced in the coming years.

"A stronger focus on prevention and rehabilitation policies, improved conditions for independent living, a further shift away from institutional care and stronger care coordination between the different actors would be useful for increasing cost-effectiveness and limiting future needs and their related costs."

Belgium Country Report, 2015

Pharmaceuticals and access to medicines

Amongst the references to improving cost-efficiency and reducing expenditure on health, the cost of pharmaceuticals has been specifically highlighted in many recent debates. In the 2015 Country Reports, the level of pharmaceutical spending is highlighted in five countries (CR, IE, PT, SI and ES). Despite a CSR urging the reduction of pharmaceutical expenditure in 2014, spending has increased in Spain and looks set to further rise with the introduction of new and innovative medicines. Slovenia has recently introduced therapeutic groups for drugs with the aim of rationalising expenditures, whilst the Country Report for Portugal notes that prices for drugs might be reduced by greater emphasis on negotiations with industry. In Croatia, expenditure on pharmaceuticals is identified as a chief source of the health system's arrears and measures have been introduced to increase the volume of drugs purchased via a central procurement process. In Romania, a country where barriers to accessing medicine were previously identified as a concern, measures have been taken to improve the situation and an evidence-based review of the list of reimbursed medicines is underway. Finally, Ireland has taken steps to bring spending on medicines down and has begun to make savings as a result.

Health workforce

References to challenges in the health workforce are made in the Country Reports of seven member states (CR, FR, HU, LV, PL, PT and ES). A shortage of healthcare workers is noted in the Reports of Hungary, Poland and Latvia.

"A significant number of healthcare professionals have left the country and there are significant skills shortages, which are threatening the sustainability of the provision of healthcare services"

Country Report Hungary 2015

The Spanish Country Report notes a consensus on the need to improve the career development of healthcare personnel, including incentives for mobility throughout the entire national health system, whilst initiatives to encourage such mobility have already been introduced in Portugal. The Polish Report states that the number of practising doctors per capita is the lowest in the EU and the number of general practitioners is also below the optimal level. Croatia has similarly low levels of healthcare professionals but the 'National Plan to Develop Human Resources in Healthcare' is due to be implemented in May 2015 and should help address this issue. The Latvian Report notes that there is no strategy in place to address low salaries, skill shortages and insufficient personnel in the health workforce. Finally, a revision of the laws regulating the health profession is due to be discussed in the French Parliament in 2015.

"'In the health sector, the draft law on healthcare, which is expected to be discussed in Parliament in the first half of 2015, should notably lead to a revision in the regulations for some health professions. However, based on the information included in the current draft, presented on 15 October 2014, the ambition of the *government seems limited in this respect."*

Country Report France, 2015

eHealth

Another specific policy measure targeted as part of the Country Reports' emphasis on increasing cost-efficiency is eHealth. Five member states received Reports which mention eHealth (CZ, IE, SK, SI and ES). Planned introduction of eHealth systems in Slovakia and Ireland are aimed at increasing cost-efficiency but have experienced delayed implementation. The Czech Republic is noted in its Report as under-performing in the area of eHealth, in particular the use of medical data exchange and ePrescription services. The Slovenian Report encourages the use of interoperable eHealth to gain efficiencies whilst the Spanish Report notes that greater use of eHealth is an agreed policy goal in the ongoing measures to reform the health system.

Growth-and health-friendly taxation

The SWDs have historically included an analysis of member states' taxation systems, with a focus on areas of untapped revenue, fraud and flaws in the collection system. More recently, they have also highlighted the need to ensure that tax systems are growth-friendly – i.e. that they assign tax burden in a way which does not stifle economic activity or work to the detriment of growth. The Country Reports maintain this trend, with 18 states receiving Reports which indicate a need to shift the burden of taxation in order to create a more growth-friendly model. Growth-friendly taxation is often also health-friendly taxation, since in shifting the burden away from labour it tends to reassign it to the consumption of goods such as tobacco, alcohol and energy. In 2015, the Reports of seven countries made specific reference to the use of consumption taxes in a more growth-friendly tax system (BE, EE, FR, DE, IE, IT and NL). Several countries have already raised taxes on items such as alcohol and tobacco in recent years – the Report for the Czech Republic, for example, notes that there is limited scope for any further revenue increase using this method, since such rate have been increased several times in recent years.

"The way the policy of restricting alcohol consumption, designed mainly from a ***public health "perspective, is implemented appears to inadvertently impact on*** competition;"

Country Report Finland, 2015

However, the Reports also acknowledge that consumption taxes can be difficult to design in a way which respects the principles of the single market and does not disproportionately those with lower incomes, for whom such goods compromise a greater proportion of personal income.

Health in Roma communities

As progressive Semester cycles have taken place, the inclusion of analysis and guidance on the integration of Roma communities has increased. Six of the Country Reports published in 2015 contain reference to Roma communities (BG, CZ, HU, RO, SK and ES) – for the most part, this is broad analysis of national strategies for inclusion, focusing primarily on access to the labour market and participation of children in the school system. In other cases, it is related to poverty and social exclusion, and the particular vulnerabilities of the Roma population.

As regards health, the Report for Bulgaria notes that the national Roma integration strategy needs more systematic measures in healthcare, at both national and local level, in order to be effectively implemented.

"Almost 80% of Roma households have disposable income below the national at-risk-of-poverty threshold, the lowest among the EU Member States. Many have no health insurance but difficulties in accessing social services and face poor housing conditions. In particular, 84 % of Roma households report lack of water, sewage or electricity."

Country Report Romania, 2015

The Reports for Spain and Hungary do not mention health specifically but note indicators on severe material deprivation and at risk of poverty, which are particularly high for Roma communities.

Administration of health and long-term care systems

In addition to analyses of specific policies and care delivery, the Country Reports include, in several cases, reference to the administration of national health and LTC systems. In most cases, this relates to the division of responsibility between national, regional and local governments, administrative practices and processes, and procurement policies. Mention of health and LTC administration is made in the Reports of eight member states (AT, BG, CR, CZ, FI, IT, PL and SK).

Croatia and the Czech Republic have introduced measures to improve various elements of administration – their Country Reports note these efforts but highlight potential difficulties in implementing them effectively. In Finland, reform has come in response to a

CSR in 2014 to improve the administrative system, which currently places the majority of authority for health and social care with small municipalities. In Italy, health administration is identified in the Country Report as a barrier to the implementation of the digital agenda strategy, since inter-operability standards are particularly low in public administration of health.

"The complex governance structure with many responsibilities divided among the different layers of government is not conducive to reorganising the system notably by adjusting current cost-sharing among administrations to encourage better use of more effective and cost-*effective service"*

Country Report Austria, 2015

The Polish Country Report highlights lack of administrative capacity in the health sector as a challenge to the full absorption of EU funds which might be used to address other

issues in the health system. The difficulties posed by the absence of an integrated LTC system are highlighted in the Reports of Bulgaria, Croatia, Poland and Italy, where fragmented service delivery and administration between institutions and levels of government damage the quality of care provided.

Financing of health and long-term care systems

The 2015 Country Reports make reference to the financing models used in the health and LTC systems of around half of member states. In the majority of cases, analysis focuses on the sustainability of the funding system, the balance between public and private financing, the rate of out-of-pocket payment and the structure of health and LTC insurance funds.

The cash-benefits system of LTC in Austria is identified as in need of streamlining, whilst low funding is highlighted as a challenge to the future sustainability of the Bulgarian health system, where private expenditure for outpatient medical goods is disproportionately high and between 10 and 20 per cent of the population do not pay into the national health insurance fund. The Croatian Report details recent measures designed to reform the financing of hospitals and to encourage financial discipline in the broader health sector, including the relocation of health revenues from the Treasury to the insurance fund and the introduction of a diagnosis-related groups (DRG) financing system. The Czech Republic has undertaken similar measures to address the weaknesses in its hospital funding system and the Finnish model of financing via local municipalities is also under review, due to concerns about its efficiency.

"Financial management systems reforms have yet to be completed. A key deliverable is the introduction of a common chart of accounts across the hospital sector, which has not yet been achieved. The introduction of an activity-based funding model for budget allocations in statutory hospitals has begun on a shadow basis, but a full switch to activity-based funding to make the hospital sector more efficient, will take some years to ***complete."***

Country report Ireland 2015

Plans to introduce universal health insurance in Ireland have been delayed and the Country Report warns of the impact of this postponement upon the private insurance sector. Changes to the German health insurance system were designed to stimulate competition between insurers and lower contribution costs but, the Country Report notes, have effectively left the contribution rate unchanged for most insured people. In Portugal, a rise in out-of-pocket payments as a share of total health expenditure of 4.5 per cent was recorded between 2007 and 2012. High out-of-pocket payments are also highlighted in the Hungarian and Latvian Reports – in the latter, the low proportion of public financing for health is identified as a source unmet medical need. Whilst additional funds were made available in 2014, the Country Report states that they are unlikely to make a difference to health outcomes, since they were mainly used to reduce co-payments and waiting times.

Delays in the implementation of the DRG payment system are identified as a cause of inefficient resource-allocation in the Slovakian health system, whilst outstanding plans to update the payment models with regard to healthcare providers in Slovenia are identified as a future challenge. Slovenia is also in the process of introducing a reform of the funding system for LTC, which includes the creation of a compulsory public insurance. In Luxembourg, it is noted that the LTC insurance system is likely to be in deficit by 2015 and that measures to secure the necessary financing for coming years have not been introduced. Similarly, spending on LTC in Italy has increased greatly over recent years and is mostly redistributed as cash payments which, the Country Report notes, are inefficiently assigned.

Expenditure in health and long-term care systems

Unsurprisingly, projections for increased spending on health and LTC are noted in the Country Reports for almost every member state. The Commission, in cooperation with the Member States, is currently preparing updated data on the budgetary impact of ageing on pension and healthcare spending, which will be published in the first half of 2015.

"The National Health Strategy 2014-2020 sets the strategic base for health sector reforms. Fiscal controls have been put in place, w*ith monthly monitoring of hospitals' budget execution and* registering of arrears, monitoring of pharmaceutical expenditure via e-prescription and *setting clear spending limits."*

Country Report Romania, 2015

The Croatian Report identifies a mismatch between revenues and health expenditure, regularly resulting in arrears in the hospital sector which have to be addressed via unsustainable ad hoc payments. Similar situations are identified in Hungary and Romania, both of which regularly face arrears in the health sector. Reduction of public health spending in Ireland, which is comparatively high, focuses for a large part on pharmaceutical expenditure. The Report for Latvia notes low public expenditure and inefficiencies which prevent higher spending from achieving better outcomes. In Malta, where public health and LTC expenditure is projected to increase dramatically in coming years, new measures of financial governance and internal cost control are being introduced, along with improvements in procurement and distribution processes.

The public share of health spending in Portugal remains among the lowest in the EU but recent health budgets have continued to reduce the overall debt of the system. In Slovakia, the main challenge identified is the prevention of public debt accumulation in the hospital sector, where budgeting, monitoring and assessment are lacking. Measures to reduce health expenditure in Spain have been successful, though the Country Report notes that the pace of adjustment has moderated in 2014, but expenditure on LTC has increased continually over recent years. Fostering responsibility and efficiency is hampered by the design of the regional financing system. Similarly, in France, short term health expenditure has been brought within target levels, but medium and long term trends remain concerning.

Looking ahead: EPHA recommendations for health in the 2015 CSRs

The 2015 Country Reports contain the most detailed overview of health systems seen in the Semester to date, making reference to health and LTC in over two-thirds of member states. The range of health issues addressed has dramatically increased over four Semester cycles from vague, financially-orientated statements about cost-efficiency and sustainability, to analysis and recommendations which now cover healthcare systems, long-term care systems, poverty and social exclusion and tax structures. The 2015 Reports flag up a number of concerning trends, such as reported corruption and high prevalence of informal payments in the health system (BG, HU, LT, RO) and threats to health from dangerous levels of air pollution (BG, CZ, LU, RO, SK, ES). They note flaws in the qualification system for disability benefits in Italy and highlight worrying mortality rates among the working-age population in Hungary. As such, the Semester has come to encompass a broad range of health policy objectives and indicators.

Whilst the increasing breadth of coverage follows previous trends, it is the growing detail which holds the greatest potential impact. The 2015 Reports make reference, for example, to diagnosis-related group (DRG) financing – this uses patient classification to assign the price of a given treatment and is the prevalent model in many member states. Two Country Reports, those of Slovakia and Croatia, note the implementation of a DRG system as a next step to ensuring the sustainability of hospital spending. In another example, the Report for Latvia states that:

> "Primary care and referral systems are not sufficiently strong; clinical guidelines are not in place; waiting times for specialist consultations and cancer diagnostics are relatively high; performance incentives for general practitioners are insufficient; there is a lack of sickness prevention and health promotion; a healthcare workforce strategy to address ageing, shortages, low salaries and skills is not in place."

These analyses go to the core of policies for the organisation and delivery of health services and medical care, a national competence protected by the founding treaties. Though neither the Reports nor the CSRs are binding, the political pressure upon their implementation has steadily grown over successive Semester cycles and the significance of the recommendations made should not be underestimated.

The impact of previous recommendations is difficult to assess and a number of national factors have to be considered but the Reports note current or upcoming reform processes in 20 member states, indicating a broad understanding of the need to strengthen health systems against the mounting challenges of demographic change and financial pressure. Slovenia, for example, is working with the WHO and the European Observatory on Health Systems and Policies to conduct a comprehensive health spending review, encompassing financing, expenditure, the benefits basket and the role of health technology assessment in achieving sustainability. The Country Reports and

CSRs are important tools for the promotion and protection of health and should take full consideration of the EU's objectives in this area.

As such, EPHA offers the following recommendations ahead of the drafting of the 2015 CSRs:

- The Semester, and in particular the CSRs, should take full account of the Health in All Policies (HiAP) principle. The health implications of recommendations in all sectors should be evaluated to ensure that individual policies do not conflict with one another, or with the overarching objectives of the Health Strategy.

- Similarly, the HiAP principle should be used to ensure that all available levers are used to the benefit of health. Policies in tax, employment, education and the environment are crucial in fostering good health and should be fully utilised to support health objectives.

- Specific analysis and recommendations should be made in support of groups at risk of vulnerability – the elderly, children, the disabled, those on low-income, the homeless, the unemployed, undocumented migrants, Roma communities and other minorities must be assured access to health, housing, education and other basic services.

- In pursuing bottom-line objectives, the CSRs should not overlook the value of disease prevention and health promotion programmes and the long-term savings offered by investment in key areas of public health such as these.

- In light of the barriers highlighted in the Country Reports, the CSRs should encourage the collection of data and the measurement and monitoring of key indicators in the health and LTC sectors. Lack of such data hinders comprehensive assessment of issues and progress over time.

- The CSRs must contribute to the institutionalisation of a Semester dialogue between stakeholders, including the European Parliament, national parliaments, social partners and civil society. Greater ownership of the recommendations can only grow from an inclusive preparation and drafting process.

- Despite previous calls to rectify the situation, there remains considerable scope to better link the Country Reports and subsequent CSRs with the objectives of the Europe 2020 Strategy. Macroeconomic targets must be designed in a way which supports the achievement of social and employment targets on equal footing.

- Finally, the CSRs must strive to balance economic recommendations with social ones. Inclusive and sustainable growth can only be achieved if the social crisis which has gripped Europe since the recession hit is addressed within the context of economic policy coordination. Health is frequently identified as a sector in which structural reforms are necessary, but such reforms must be undertaken with social and not just economic priorities in mind.

Further information

The full list of Country Reports submitted by the Commission can be found on the European Commission website, along with the accompanying Communication.

Further EPHA analysis of economic governance documents can be found below:

- Health in the 2013 country specific recommendations
- Health in the 2014 country specific recommendations
- Health in the Europe 2020 Strategy
- Health in the 2014 annual growth survey
- Health in the 2015 annual growth survey
- Health in the European Semester

About EPHA

EPHA is a change agent – Europe's leading NGO advocating for better health. We are a dynamic member-led organisation, made up of public health NGOs, patient groups, health professionals, and disease groups working together to improve health and strengthen the voice of public health in Europe. EPHA is a member of, among others, the Social Platform, the Health and Environment Alliance (HEAL), the EU Civil Society Contact Group and the Better Regulation Watchdog.
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