

# The European Semester and Roma health

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## Abstract

This paper provides an overview over key elements of the European macroeconomic governance framework (European Semester) and the implementation of Country Specific Recommendations (CSRs), with focus on Roma health and inclusion in three countries of the CEE region: Slovakia, Bulgaria and Romania. It proceeds with the identification of gaps in regard to the implementation of the National Roma Integration Strategies (NRIS) and makes recommendations for future monitoring and policy development.

## The European Semester in a nutshell

The European Semester is an annual cycle of economic and fiscal policy coordination between the European Commission and the Member States. Each year, it starts with the Commission's publication of the Annual Growth Survey that highlights economic priorities for Member States in November each year and culminates in the publication of Country Specific Recommendations (CSRs) at the end of May. While primarily an instrument to ensure fiscal discipline and macroeconomic stability in the Member States, the European Semester is also in place to monitor policies set by the Europe 2020 jobs and growth strategy.

An earlier publication of the Country Reports. The executive summary of the Country Reports broadly includes all key issues that will be addressed in the CSRs.

Efforts to strengthen national ownership, by providing more time and opportunities to engage with national stakeholders, such as e.g. in the elaboration of National Reform Programmes

Fewer CSRs (3-4 per Member State), with focus on the most pertinent economic and social priorities

Since mid-2015, the European Semester has undergone several modifications that were initially introduced in the Five Presidents Report as a key step within a wider strategy primarily designed for achieving closer coordination between countries in the Economic and Monetary Union (EMU)[1]. Furthermore, a better balance between the **Semester's financial and social dimensions** was outlined as a key commitment in the Report, as well as promoting stronger inclusion of national stakeholders in a move towards better political accountability and enhanced national ownership of the European Semester process. Key updates to the Semester include, inter alia, a single

Table 1: European Semester key updates

assessment per Member State, an earlier and partially more detailed publication of the Country Reports, and fewer Country Specific Recommendations (CSRs). Less CSRs imply a refocussing on key policy issues, roughly grouped under fiscal, macro-economic and social



priorities. While inconsistencies in the formulation of CSRs still prevail and embody an inherent tension between the call to rationalise spending while simultaneously work towards the reduction of poverty and social exclusion, a number of CSRs also have improved in quality in regard to their social dimension. In support of a broader social integration, the European Commission has also launched another key initiative: the European Pillar of Social Rights. The final Pillar of Social Rights, to be fully launched in 2017, will outline essential norms and principles to support well-functioning and fair labour markets and welfare systems while functioning as a reference framework to screen employment and social performance of Member States [2]. Concurrently, however, the Pillar of Social Rights is to be seen in a context of a closer integration of the EMU. It is therefore primarily valid for the countries in the Eurozone.

## References to Health in the European Semester

With regard to health, the European Semester considers health systems to be a key issue for the sustainability of public finances, with the rise of ageing-related spending most frequently evoked as a 'risk' in the long term. However, references and recommendations relevant to health investment and public health as such, including a stronger focus on improving public funding, access, quality, and health outcomes have become more pronounced in the 2015 and 2016 European Semester cycles, specifically in the Country Reports and CSRs including preambles. For example, a focus on health promotion and disease prevention were emphasised in the case of Latvia and Portugal, and the need to advance Universal Health Coverage (UHC) was raised for Latvia and Cyprus. Access, quality and sustainability have been dominant issues raised in the European Semester for several Central and Eastern European (CEE) member states (CZ, BG, RO, LT, LV,) as well as for Cyprus and Ireland. Concurrently, it should be noted that contrary to the fiscal surveillance mechanism under the European Semester, its recommendations in the social realm lack clear targets and remain largely non-binding.

## Looking back at implementation

Overall, the implementation of the recommendations in the framework of the European Semester has not been particularly effective [3]. According to an assessment issued by the European Parliament, a mere 4% of CSRs were fully implemented in 2015 [4]. A significantly higher percentage rate was assessed with '*limited or some progress*', however a closer look at accompanying explanations reveals that such progress rarely implies actual implementation. Looking at a sample of three CEE countries (see table below) is a case in point. '*Some progress*' mostly refers to reform plans that have been envisaged but without concrete steps taken to date, including the approval of various strategies or an adopted legislation with delayed implementation.



The assessment of CSRs for Bulgaria, Romania and Slovakia give a mixed picture<sup>1</sup>

■ full progress    
 ■ some/limited progress    
 ■ no progress

	2013	2014	2015	2016*	
Bulgaria	0	0	0		
	1	0	3		
	6	6	2		
Romania	1	0	0		
	2	1	1		
	5	7	5		
Slovakia	0	0	0		
	2	1	1		
	4	5	3		
total CSRs combined	21	20	15		11

\* to be assessed

Table 2: CSR implementation 2013 – 2016.

While it is not always clear in how far the European Semester recommendations can retroactively provide value added to plans Member States decided to carry out anyway, there is also a considerable number of strategies put forward where implementation is clearly lagging behind. Governments of Member States, especially those which depend on EU funds, have become professional at designing strategies that are imperative for, inter alia, accessing European Structural and Investment Funds (ESIF). On the implementation front however, progress is often lagging behind. In addition, implementation is also impacted by the absorption rates of Structural Funds that can vary significantly between Member States. According to the evaluation of the cohesion policy programmes in the previous programming period (2007-13) [5], lower absorption has been recorded in Italy, Czech Republic, Malta, Slovakia, Bulgaria and, in particular, Romania.

## Investments in Roma inclusion and the need for policy coherence

By addressing key objectives in the fields of employment, education, poverty and social exclusion, the Europe2020 strategy for smart, sustainable and inclusive growth provides a general framework that is relevant for Roma inclusion across Member States. The progress towards the Europe2020 strategy, which is implemented and monitored in the context of the European Semester [6], has also guided the development of the EU Framework for National Roma Integration Strategies (NRIS) that focus on four key areas: education, employment, healthcare and housing.

<sup>1</sup> Based on EC assessment of CSRs (Staff Working Papers) and extended from Hradsky M., Ciucci M., Kumsare S. (2016), Country Specific Recommendations for 2014 and 2015. European Parliament (EGOV)



Furthermore, the CSRs adopted by the European Council in the years 2012, 2013 and 2014 have formed an entrance point for the identification of funding priorities for ESIF [7]. To reiterate the link with the European Semester process, a series of CSRs in 2012 and 2013 urged Member States to implement the NRIS and mainstream it with other policies. Finally, the 2014-2020 ESIF regulatory framework includes an explicit ex-ante conditionality for health investments that includes a focus on Roma, requiring a Roma Integration Strategy to be in place to address Roma integration goals in the different fields, including in relation to healthcare [8].

### Ex-ante conditionality 9.2. on Roma inclusion requires that a national Roma inclusion strategy is in place that sets achievable national goals for Roma integration addressing the EU Roma integration goals including in relation to healthcare

In its recent assessment of the NRIS (2016)[9], the European Commission highlighted the relevance of the European Semester to Roma inclusion as a tool to further streamline Roma policy under the Europe2020 inclusive growth target and as a key monitoring framework for assessment of the implementation progress across Member States. The assessment also put forward that in terms of Roma integration, no real improvement can be recorded on the ground. In terms of funding received by the respective priority areas as defined in the NRIS, inclusive education and employment were the two primary investment areas, with housing also receiving significant allocations. However, the amount allocated for health investments was much lower.

A number of reasons help to explain the implementation gap. In the first place, it is widely acknowledged that the implementation of the National Roma Inclusion Strategies suffer from a lack of accountability and monitoring mechanisms. To make indicators operational, they would need to refer to valid existing data, benchmarks and target values [10]. However, practical obstacles to data collection continue to persist across many member states. Data collection at national level is neither comprehensive nor systematic, while the absence of ethnically disaggregated data makes it substantially harder to develop measures specifically targeting Roma inclusion, making it significantly harder to address health inequities. In addition, addressing Roma inclusion requires policy coherence and the streamlining of meaningful indicators across other governmental strategies. For instance, the indicators framework of the Romanian Health Strategy (2014-2020) does not take into account Roma specific targets, which could make a better connection to the Romanian NRIS. Furthermore, the decentralization of Roma community services such as the Roma Health Mediators programme can make it overly dependent on municipal capacity [11]. While the programme is certainly considered as an empowering tool for Roma, the lack of effective supervision in the absence of a central strategy also bears the risk of augmenting differences in service provision between different regions. A recent study on cost-



effectiveness of Roma health mediation programs in Romania in the time frame 2007-2013 could not establish an overall cost-effectiveness of the programme, while in terms of health outcomes, communities with health mediators did not perform better than communities without health mediators<sup>2</sup> [12]. However, it should also be noted that effective Roma inclusion does not necessarily have to trigger an ‘economic case’. For example, Roma mediators frequently engage in activities related to health literacy and hygiene, which provide effective peer education related to health. In addition, it can be hypothesized that Roma health mediation would be cost effective if the ‘dose’ of coverage, i.e. higher intensity with better supervision were in place.

The CSRs in the framework of the European Semester are most likely to focus on education and employment when it comes to Roma, which can be considered in line with the ‘growth and jobs’ agenda of the European Commission. For example, the 2014 CSR for Bulgaria explicitly mentions Roma in this particular context, even if in 2015 the CSR is reformulated



to refer to ‘groups at the margin of the labour market’. For Slovakia, the 2011 preamble to the CSRs stated that low education achievements of the marginalised Roma communities are a major factor contributing to long term unemployment in the country. Starting with 2012 and including 2016, each round of Roma related CSRs for Slovakia has almost exclusively focussed on education, even though no overall progress has been recorded.



In the case of Romania, the European Commission recommends to step up reforms in the health sector to increase its efficiency, quality and accessibility, including for disadvantaged people and remote isolated communities. The 2015 CSR further urges to increase the provision and quality of early childhood education and care, in particular for Roma. The Romanian National Reform Programme (NPR) submitted by the government in the framework of the European Semester addresses those recommendations briefly, but only refers to the implementation of prophylactic and curative health programs for women and children and the development of pilot medical centres to increase access to medical services for people from remote and isolated communities. Other planned measures largely deal with the modernisation of healthcare infrastructure, according to information provided in the NPR. In parallel, the Romanian Health Strategy [13] largely focusses on

<sup>2</sup> As the focus of the study was on services related to maternal and child health, the measurements primarily refer to the preventable mortality rate in the 0-4 age group.



infrastructural improvements alongside development and scaling up of telemedicine solutions when it comes to reaching out to populations in isolated communities. The strategy features a separate section on Roma health which nearly exclusively focusses on decentralized health services on community level and also mentions the importance of Roma health mediators.

## Conclusion and recommendations

- The European Semester, while an important tool to keep Roma inclusion high on the agenda, is not a sufficient mechanism to achieve changes on the ground.

**In order to create adequate conditions for comprehensive Roma inclusion, the NRIS need to be streamlined across all policy areas.**

This requires an intersectoral approach that accounts for each specific area defined by the NRIS, underpinned by a monitoring framework. Efforts to reduce access barriers and address socio-economic determinants of health also require a stronger involvement of central government bodies. While the communities remain a key actor in implementing Roma inclusion measures, relegating all managerial and budgetary responsibility to local authorities bears the risk of increasing social and territorial inequalities, while weakening accountability and political commitment.

- The fact that health remains the most underfunded area is a worrisome development. It is known that Roma suffer significantly higher physical and mental health disparities than the rest of the population, exacerbated by strong exposure to a range unfavourable social and environmental determinants that influence health outcomes [14-16] . Roma children cognitive and socioemotional development, significantly aggravated by poverty, also hinders their ability to attend school and participate in activities with their peers [17]. In the area of health, the assessment of the NRIS implementation (2016) notes that the “**tackling** of health inequalities endured by Roma remains an ongoing challenge, in particular in the most **deprived areas**” [9]. The European Semester, despite having maintained a focus on Roma integration, has not specifically addressed Roma health in its recommendations so far. If the Semester is to remain a key precedent to define priorities for social and health investments, a better coordination with the NRIS is needed.
- While investments in health infrastructure are commonly cited measures for reaching out to isolated communities, it is often unclear how such measures can benefit Roma specifically. Some proposed solutions, such as telemedicine, are futile for people that lack basic access to sanitation and insurance. Furthermore, investments in health infrastructure



(e.g. new medical centres) can quickly become unsustainable without adequate staff put in place to manage it, underpinned by administrative and institutional capacity. Broader organizational and institutional capacity building, together with development of staff capacity, should be an integral part of what Commissioner Moscovici has termed as the ‘new generation of structural reforms’[18]. As the European Commission has put forward in its 2014 assessment on Roma integration, “Member States should also put in place measures that address the low skill levels of Roma job seekers through vocational training and counselling”[19]. However, it would be important to highlight that such measures need to be designed in a participative way together with the Roma and foster domestic political dialogue, including in the field of health.

- As recently presented by the Fundamental Rights Agency at the United Nations Economic Commission for Europe, mainstream inclusion indicators cannot sufficiently monitor the specifics of Roma exclusion.

The integration of the Sustainable Development Goals (SDGs) in all relevant policy frameworks, implementing and monitoring instruments are of particular relevance for Roma.



World Health Organization - Health in the SDG Era

The development of new indicators on a national and international level should further aim at mainstreaming existing SDG indicators into their own indicator development [20], which is not yet the case in Europe. Yet, a series of SDG indicators are of utmost importance for Roma inclusion and strongly intertwined with health outcomes, such as Goal 1 on poverty reduction, Goal 2 on food security, Goal 6 on the availability of water and sanitation for all, and many more. In addition to the SDGs interdependent nature, SDG Goal 3 represents an explicit health target. While the reduction of NCDs by a third is a critical Sub-goal (3.4) and highly relevant for Europe as a whole, a higher burden of communicable disease (Goal 3.3.) and neonatal mortality (Goal 3.2) are persisting challenges needed to be addressed in the case of marginalised Roma populations. Another key target for Roma inclusion is also exemplified through Sub-Goal 3.8:

Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all





Roma across Europe face disproportionate barriers to access to health services, which is exacerbated by the lack of insurance or ID documents [21] but also due to distance, discriminatory attitudes and significantly higher financial barriers. As a recent EPHA paper on Universal Health Coverage puts forward [22] the achievement of genuine UHC has the potential to address some of the vast inequalities which exist between regions and social groups in Europe, but only if implemented in a holistic manner. A commitment to ‘leaving no one behind’ must explicitly address vulnerable groups by making them visible in the first place, paired with a genuine political commitment and resource allocation to implement UHC and accompanied by adequate monitoring indicators streamlined across all relevant policy frameworks, including the European Semester and the upcoming European Pillar of Social Rights.

## References

1. Juncker J-C., Tusk D., Dijsselbloem J., Draghi M., Schulz M. (2015). Completing Europe's Economic and Monetary Union. European Commission, Available from: [https://ec.europa.eu/priorities/sites/beta-political/files/5-presidents-report\\_en.pdf](https://ec.europa.eu/priorities/sites/beta-political/files/5-presidents-report_en.pdf)
2. European Commission, Towards a European Pillar of Social Rights. (2016).
3. Leandro A., Darvas Z. (2015). The limitations of policy coordination in the Euro area under the European Semester. Bruegel Policy Contribution, 2015/19, Available from: [http://bruegel.org/wp-content/uploads/2015/11/pc\\_2015\\_194.pdf](http://bruegel.org/wp-content/uploads/2015/11/pc_2015_194.pdf)
4. European Parliament (EGOV) (2016). Implementation of the 2015 Country Specific Recommendations. Available from: [http://www.europarl.europa.eu/RegData/etudes/ATAG/2016/574398/IPOL\\_ATA\(2016\)574398\\_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/ATAG/2016/574398/IPOL_ATA(2016)574398_EN.pdf)
5. European Commission (2013). Cohesion policy: Strategic report 2013 on programme implementation 2007-2013. The European Commission, Available from: [http://ec.europa.eu/regional\\_policy/sources/how/policy/doc/strategic\\_report/2013/strat\\_report\\_2013\\_en.pdf](http://ec.europa.eu/regional_policy/sources/how/policy/doc/strategic_report/2013/strat_report_2013_en.pdf)
6. European Commission (2016). Making it happen: the European Semester. 31/05/2016; Available from: [http://ec.europa.eu/europe2020/making-it-happen/index\\_en.htm](http://ec.europa.eu/europe2020/making-it-happen/index_en.htm).
7. European Commission, Report on the implementation of the EU Framework for National Roma Integration Strategies 2015. (2015).
8. European Commission (2014). Draft thematic guidance fiche for desk officers - HEALTH 10/03/2014. Available from: [http://ec.europa.eu/regional\\_policy/sources/docgener/informat/2014/thematic\\_guidance\\_fiche\\_health\\_investments.pdf](http://ec.europa.eu/regional_policy/sources/docgener/informat/2014/thematic_guidance_fiche_health_investments.pdf)
9. European Commission (2016). Assessing the implementation of the EU Framework for National Roma Integration Strategies and the Council Recommendations on effective Roma integration measures in the Member States 2016. The European Commission, 27/06/2016. Available from: [http://ec.europa.eu/justice/discrimination/files/roma-report-2016\\_en.pdf](http://ec.europa.eu/justice/discrimination/files/roma-report-2016_en.pdf)
10. Brüggemann C. (2012). Roma Education in Comparative Perspective. Analysis of UNDP/World Bank/EC Regional Roma Survey 2011. Roma Inclusion Working Papers. Bratislava. United Nations Development Programme.
11. Open Society Foundations (2011). Roma Health Mediators. Success and Challenges. Available from: <https://www.opensocietyfoundations.org/sites/default/files/roma-health-mediators-20111022.pdf>
12. M Schaaf, et al., (2016) The costs and benefits of Roma Health Mediation in Bulgaria and Romania. The European Journal of Public Health 26(suppl 1). Available from: [http://eurpub.oxfordjournals.org/content/26/suppl\\_1/ckw174.105.full#](http://eurpub.oxfordjournals.org/content/26/suppl_1/ckw174.105.full#)
13. Romania Ministry of Health (2014). *Strategia Națională de Sănătate 2014-2020*. Available from: <http://ms.gov.ro/upload/Anexa%201%20-%20Strategia%20Nationala%20de%20Sanatate%202014-2020.pdf>
14. Eric J. Lee, et al., (2014) Mental health disparities between Roma and non-Roma children in Romania and Bulgaria. *BMC Psychiatry*,14(1):
15. World Health Organization (2006). Health and economic development in South-Eastern Europe. Available from: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/74748/E89184.pdf](http://www.euro.who.int/__data/assets/pdf_file/0003/74748/E89184.pdf)
16. European Roma Rights Center (2013). Health Inequalities and Disaggregated Data. Available from: <http://www.errc.org/cms/upload/file/hidden-health-crisis-31-october-2013.pdf>
17. Gatti RV et al. (2016). Being fair, faring better : promoting equality of opportunity for marginalized Roma. Directions in development; human development. Washington D.C. World Bank Group. Available from: <http://documents.worldbank.org/curated/en/292771468196732276/Being-fair-faring-better-promoting-equality-of-opportunity-for-marginalized-Roma>



18. New Europe (2016). *Moscovici 2.0 targets new 'progressive' structural reforms*. 10/06/2016; Available from: <https://www.neweurope.eu/article/moscovici-2-0-targets-new-progressive-structural-reforms/>.
19. European Commission (2014). *Roma Integration – 2014 Commission Assessment: Questions and Answers*. 04/04/2016; Available from: [http://europa.eu/rapid/press-release\\_MEMO-14-249\\_en.htm](http://europa.eu/rapid/press-release_MEMO-14-249_en.htm).
20. Till-Tentschert U. et al. (2016). *Measuring Roma inclusion strategies - a fundamental rights based approach to indicators* Fundamental Rights Agency. Working Paper 20. presented at United Nations Economic Commission for Europe. Available from: [https://www.unece.org/fileadmin/DAM/stats/documents/ece/ces/ge.15/2016/Sem/WP20\\_FRA\\_ENG.pdf](https://www.unece.org/fileadmin/DAM/stats/documents/ece/ces/ge.15/2016/Sem/WP20_FRA_ENG.pdf)
21. European Commission (2014). *Health status of the Roma population. Data collection in the Member States of the European Union* Available from: [http://ec.europa.eu/health/social\\_determinants/docs/2014\\_roma\\_health\\_report\\_en.pdf](http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf)
22. European Public Health Alliance (2016). *Universal Health Coverage, Sustainable Development and the European Pillar of Social Rights*. Available from: [http://epha.org/wp-content/uploads/2016/09/Universal-Health-Coverage-report\\_final.pdf](http://epha.org/wp-content/uploads/2016/09/Universal-Health-Coverage-report_final.pdf)

## 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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