



EuroHealthNet

EUROPEAN PARTNERSHIP FOR IMPROVING HEALTH, EQUITY & WELLBEING

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The European Semester 2018 from a health equity perspective



Contents

- Executive Summary 1**

- Part One: Why is the European Semester relevant and important for health and social equity? 5**
 - 1.1 The European Semester and related EU instruments..... 6
 - 1.2 Realising the European Pillar of Social Rights: implementation and synergies matter... 7
 - 1.3 Linking the European Semester cycle with the European Structural and Investment Funds 8
 - 1.4 Increasing support for structural reforms of key health-related sectors 9

- Part Two: Addressing the challenges of the annual cycle of the European Semester 11**
 - 2.1 Lack of awareness – the important role of providing health equity evidence into the European Semester debate..... 11
 - 2.2 The implementation delay of health- and long-term care recommendations 13
 - 2.3 Reductionist, medicalised and siloed approaches to health and social equity 15

- Part Three: Examples of engagement in the European Semester as experienced by members of EuroHealthNet 17**

- Part Four: 2018 Country Specific Recommendations for health and social equity 19**

- Part Five: The Country Specific Recommendations 2018 from the perspective of national experts 23**

- Top Ten Suggestions for Improvement 32**

- Conclusion 36**

- References..... 37**

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Executive Summary

This report summarises EuroHealthNet’s analysis of the Country Specific Recommendations (CSRs) of the European Semester cycle 2018 from a health equity perspective.

Although designed to steer EU Member State governments’ economic and fiscal policies, increasingly the Semester is used to review the macro-economic dimension of social protection systems funded through public budgets. Healthcare, early childhood education and care, unemployment, and social transfer and pension systems are considered in these reviews. When designed through participatory and cross-sector-coherent approach the European Semester process can mobilise Member States’ action towards addressing social and health needs across the social gradient.¹ **By providing recommendations to Member States on both economic *and* social aspects, the European Semester process is relevant for health equity.**

The semester addresses such fundamental determinants of health as timely and affordable access to high-quality healthcare services (both curative and, critically, preventive) and out-of-pocket healthcare payments. It also makes suggestions for social investments in community-based care and improvements in the conditions in which people are born, live, learn and work. Through these suggestions important health gains can be identified, addressed, and achieved. **The European Semester cycle can offer and guide Member States and stakeholders towards integrated policies, investments, and reforms impacting on key social and economic determinants of health.**

While it is key to highlight the opportunities of the process, it is equally essential to address the challenges experienced by stakeholders who have engaged with the Semester’s procedures. **The European Semester development process often overlooks health professionals and public health concerns and neglects the cross-sectoral collaborative approach.** In so doing, the European Semester may risk recommending fiscal measures that are incoherent with article 3.1 of the EU Lisbon Treaty which states the EU’s aim to promote the well-being of its peoples. For this reason, it is important that the European Semester process relies on direct input from key health and social stakeholders to make the recommendations representative of the realities faced at national and regional level.

This report consists of five parts. In the first part, we outline our rationale behind applying a health equity lens to the European Semester process. In the second part, we address the challenges of its processes and procedures, based on experiences of engaging with it. Next, we present some examples of our member organisations’ engagement in the European Semester process. In part four we analyse the Country Specific Recommendations of the European Semester in 2018. We include the responses of our national, regional, and local members to

¹ Social gradient defined by WHO as “in general the lower an individual’s socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum.” See: http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/ (7 November 2018)

them. Finally, we propose suggestions for improvements to the Semester's contribution to the health equity objective of a Social Europe.

The report has been **developed on a basis of a participatory and consultative methodology** that puts a specific emphasis on:

- Analysis, awareness-raising, country exchanges and capacity building activities by EuroHealthNet among its members, stakeholders and partners;
- The feedback to our consultations which provided the specific views of our members on the 2018 Country Specific Recommendations;
- Extensive discussions held in 2018 at the EuroHealthNet General Council and Executive Board Meetings;
- Our members' active participation in the session on health and long-term care at the DG Employment-organised Seminar on the European Pillar of Social Rights and the European Semester as tools for delivering Social Europe (in October 2018 in Brussels).

The report contains guidance for both the European Commission and public health actors aimed at constructively presenting practical steps learned from the 2018 experience which could improve future use of the European Semester instrument. It is to help assess and enhance the joint efforts of the European Commission and public health actors to take full advantage of the Semester, the European Pillar of Social Pillar and EU funding mechanisms to advance public health and health equity.

For public health actors the report explains how the Semester process works, how they can use it, and how it can support their work on key determinants of health, vulnerable groups and strengthening the public health response to addressing health inequalities.

For the Commission and other EU bodies and agencies the report includes feedback from national experts on how Country Specific Recommendations are being considered by public health and civil society actors and the impact they have on the ground.

In conclusion, EuroHealthNet offers **ten suggestions** for improving the European Semester's potential to contribute to health equity. We recommend that they be integrated by EU Institutions and wider stakeholders in preparing the 2019 cycle so that health equity will be improved.

1. **Address the wider determinants of health.** Social, environmental and economic factors influence health of individuals, populations and systems. Health and equity should be seen in the context of integrated approaches for sustainable societies and economies throughout Europe.
2. **Health systems are key for long-term sustainable growth and development.** The health sector is a major economic driver in most Member States and should be acknowledged as key for long-term sustainable growth and development, particularly in the context of

digital transformation of services and workplaces, where new skills for the future of health and work will be crucial.

3. **Improve the quality and comparability of metrics and strengthen monitoring and reporting.** Furthermore, indicators relating to cost-effectiveness (which are often too superficial) should incorporate a health promotion and disease prevention dimension in accordance with universal commitments to reduce the burden of diseases and inequalities.
4. **Quality is better than quantity.** The European Semester Process should acknowledge and support the long-term nature of reforms in healthcare and related sectors. It should also promote consistent implementation and follow-up on the recommendations and reforms that have been introduced already.
5. **Consistent implementation and follow-up on recommendations and reforms.** A Country Specific Recommendation can be appropriate in principle, but partial implementation in reality may bring unintended side effects. Consistency is needed, with better early engagement and planning of all stakeholders, as well as addressing issues of country capacity to put reforms in place.
6. **Capacity-building and support for participation of all relevant stakeholders throughout the process.** It is evident that there is a need for inclusive early dialogue with civil society and public authorities within the field of health and long-term care, so they can better contribute with their existing expertise and knowledge.
7. **Careful assessment of governance levels of competence on health and social issues is needed.** Local and regional actors should be involved in the process from the beginning in order to assess at which governance level actions should be taken.
8. **Don't 'reinvent the wheel'; use the existing knowledge and expertise of civil society and public bodies.** There is a need for inclusive early dialogue with civil society and public authorities within the field of health and long-term care, so they can better contribute with their existing knowledge.
9. **Acknowledge added value of EU strategic support to national health and social protection systems' reforms, not least by EU funding mechanisms.** This point is especially crucial for states and regions where resources and capacities may be limited in many aspects.
10. **Acknowledge public health areas which are currently overlooked in macro-economic considerations.** Mental health contributes to a growing strain on health care and social protection systems' fiscal sustainability. This, and other increasing public health issues, should be better addressed in the CSRs.

Part One: Why is the European Semester relevant and important for health and social equity?

The European Semester is an annually-applied mechanism for EU level policy coordination, via actions in Member States. It is used to analyse and coordinate EU Member States' economic and social situations, and to monitor progress on and provide tailored country specific recommendations (CSRs) towards meeting the EU's agreed political priorities and strategic objectives. Although originally designed to steer and enhance national economic and fiscal policies, it is increasingly used to review and develop macro-economic dimensions of social protection systems funded through public budgets. These include health and care systems, education, employment, social transfers and pension systems.

To this end – if designed through participatory and cross-sector-coherent approaches - the European Semester process can help to mobilise Member States' actions towards meeting the social and health needs of people across the social gradient. By providing recommendations to Member States on both social and economic aspects, the European Semester process is beneficial for health equity.

By addressing fundamental determinants of health not only within health and care systems but, crucially, the conditions in which people are born, study, work, live and age, the European Semester contributes to wellbeing, cohesion and sustainable development. Studies show that investments in preventive public health interventions (especially at regional and local level) and boosting social protection systems (especially in times of economic crisis) bring a much higher and more sustainable return on investment (ROI).ⁱ

While it is key to highlight the opportunities of the process, it is equally essential to address challenges or unintended negative consequences of fiscal interventions that prioritise cost-effectiveness of public services such as health and social protection by cutting down budgets. This, usually, increases the risk of lower quantity and quality of public services that low-income people use, creating a well-documented phenomenon of 'poor services for poor people'. For this reason, the European Semester process must be representative of the realities faced at national and regional level, with key health and social stakeholders providing input into the process. This would help to avoid such consequences and uphold the EU commitment to high-quality health and social services.

1.1 The European Semester and related EU instruments

The 2018 European Commission (EC) proposals for a new ‘Social Fairness Package’ include strengthening the social dimensions of the Semester to include monitoring of the implementation of the European Pillar of Social Rights (the Social Pillar) and its associated Social Scoreboard.ⁱⁱ The Scoreboard tracks trends and performances across EU countries in three areas related to the Social Pillar’s principles: (1) equal opportunities and access to the labour market, (2) dynamic labour markets and fair working conditions, and (3) public support/social protection and inclusion. The Scoreboard’s set of indicators under each of these areas feeds directly into the European Semester to “*assess progress towards a social ‘triple A’ for the EU as a whole*”.ⁱⁱⁱ

Proposals for the next EU long-term budget (the Multiannual Financial Framework - MFF) offer prospects and increased resources for strengthening the Semester’s outcomes that are more impactful and socially inclusive. From a public health perspective these could be ‘game changers’ for health and social equity – but evidence-based and effective pro-health focus and implementation of the actions recommended will be key to turn words into realities for all the people living in the EU.

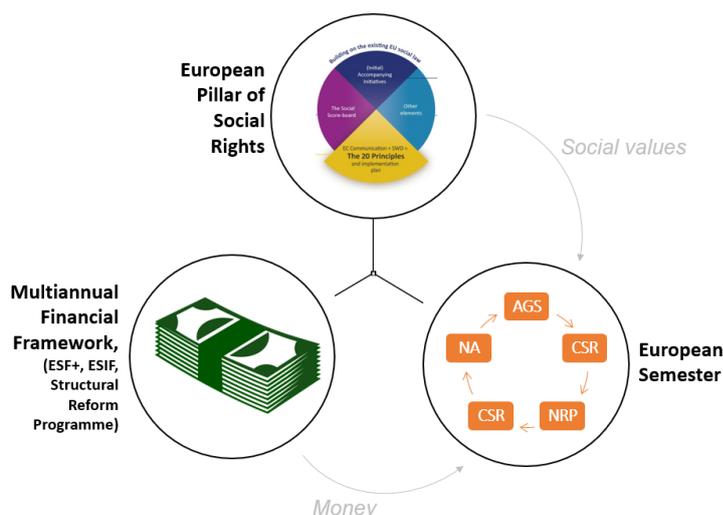


Figure 1: Relationship between the European Pillar of Social Rights, the European Semester and the Multiannual Financial Framework

EuroHealthNet welcomes the recent development within the European Semester process to move from being a “*framework for the coordination of economic and financial policies across the European Union*”, to address “*economic and social policies*”^{iv} and to strengthen the connection between the European Semester and the application of the Social Pillar.

1.2 Realising the European Pillar of Social Rights: implementation and synergies matter

The Social Pillar offers an important set of principles (20 in total, see Figure 2 below) as the basis for EU and national actions to ensure good and equitable opportunities for health and wellbeing. In Principle 16, the European Commission, European Council and the European Parliament are committed to ensuring that *“everyone has the right to timely access to affordable, preventive and curative health care of good quality.”* The other 19 principles, covering such areas as gender equality, work-life balance, inclusion of people with disabilities, and childcare and support to children -being social determinants of health – are also intimately connected to health inequalities and health outcomes.

The potential for the Social Pillar to tackle structural health inequalities across the social gradient is crucial to its opportunity to make a real impact. As the World Health Organization (WHO) explains *“The poorest of the poor, around the world, have the worst health. Within countries, the evidence shows that in general the lower an individual’s socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon, seen in low, middle and high-income countries. The social gradient in health means that health inequities affect everyone.”^v*

While not legally binding, nevertheless the Social Pillar sends strong political messages throughout the European Union’s Member States calling for a more inclusive and healthier Europe. It reflects shared commitment to address structural socio-economic determinants of health – most of them being out of direct control of individuals.

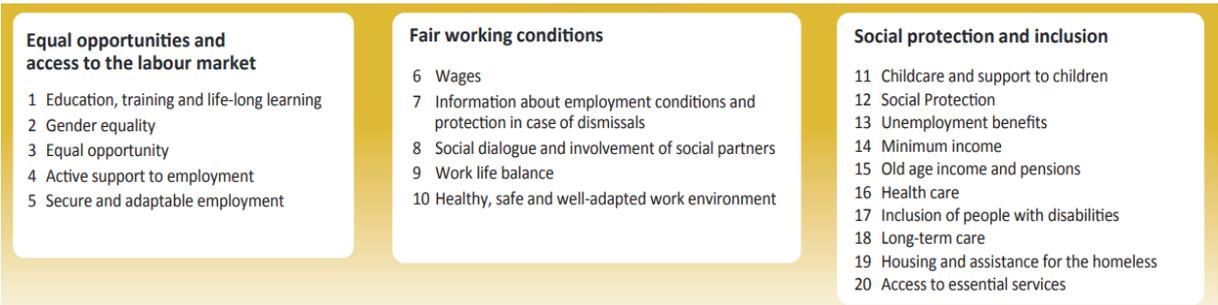


Figure 2: The 20 principles of the European Pillar of Social Rights

When implemented successfully, the Social Pillar offers a baseline of rights for levelling up disparities between and within Member States and can support countries and regions in addressing health inequalities in a coordinated way across the EU. The provisions in the Social Pillar for health care refer clearly to the role of health promotion and disease prevention measures which can help to ensure the sustainability of health (and social protection) systems. The provisions in relation to childhood education and care, for

instance, prioritise early access to quality child education and care systems. Other provisions in relation to social protection, wages, unemployment, sickness, or disability allowance clearly take forward rights and actions which would impact significantly on health, equity, and wellbeing if implemented according to principles of proportionate universalism, which combines universal rights and targeted actions according to need. The European Semester offers a systematic, structured public process to measure and achieve that.

Linking the Social Pillar and its Scoreboard with the European Semester cycle, and objectives of good health and equity is crucial. This will increase political and societal awareness of the use of macro-economic and public budget analysis to catalyse action towards addressing social and health needs.

1.3 Linking the European Semester cycle with the European Structural and Investment Funds

Throughout the European Semester process the EU will increasingly encourage its Member States to apply **European Structural and Investment Funds (ESIF)** and future European Social Fund (ESF+) programme to address – as a matter of priority and pre-condition for accessing the funds - their relevant **Country Specific Recommendations (CSRs)**.^{vi} EU funds can therefore be used to achieve the structural reforms of ‘social infrastructure’ systems and services considered ‘public good’ and ‘public right’ such as health-, child-, or long-term care.



Photo 1. EuroHealthNet delegation to DG EMPL Seminar on The European Semester and the European Pillar of Social Rights as tools for delivering Social Europe, 2 October 2018, Brussels

The recent European Commission seminar with civil society (that included two of our members in expert role, see photo) has also recommended for the European Structural Investment Funds (ESIF) to be linked to the implementation of CSRs targeting improvement of public health from a long-term perspective of focusing on quality of care. “For most countries, the CSRs refer to cost-efficiency of health provisions, with recitals stipulating that quality and access should not

be impacted negatively by the reforms. Nevertheless, the superficial understanding of cost efficiency when implementing the CSRs might bring adverse effects.”^{vii} As further outlined in Parts Three, Four and Five of this report, this is also confirmed by the experience of our member organisation from Finland.

Our members from Slovenia have been linking the Semester, the Social Pillar and EU funds to bring evidence on the social determinants of health to the attention of decision makers in charge of reforms. In the specific case of strictly health-related CSRs, it is mostly considerations of accessibility, affordability, cost-effectiveness, and deinstitutionalisation of care that receive the most attention every year. However, through the more ‘blended’ funding mechanism

envisaged for EU funding post-2020, greater integration between health and social services may be supported. This would provide an opportunity for those in the field of health promotion and disease prevention to work with other sectors on addressing the determinants of health in new ways. Moreover, with the Semester’s guidance and EU funding proposals such as Invest EU, innovative social infrastructure or community-based interventions may become more ‘bankable’ and ‘less risky’ in the future, thereby enhancing financial actors’ (health and social insurers, banks) interest in preventive health measures with proven high return on investment (ROI).² With this envisioned financial support mechanism, the European Semester can more effectively encourage positive reforms towards meeting national and local health and social objectives.



Source: EuroHealthNet Seminar Report.^{viii}

1.4 Increasing support for structural reforms of key health-related sectors

Beyond ‘mere’ sending of recommendations on where the reforms are needed, the European Commission also supports the countries in their capacity to execute the reforms systematically and in a timely manner. To this end, the **EU Structural Reform Support Programme** can be used

² Simultaneously contributing to greater added value and sustainability of EU funds and projects

to support Member States in their efforts to respond to their CSRs, both through technical and financial support. **The Reform Support Programme is being extended to help Member States design and implement institutional, administrative and structural reforms that are closely linked to European Semester's priorities and to encourage the effective use of available EU funds.**

It covers reforms in several policy areas including labour market, education, health, and social services.^{ix} The programme, which has a budget of up to €222 million during 2017-2020, is available to all EU Member States upon their request and provides tailor-made expertise on the practical aspects of reforms. The first monitoring report on the implementation of the programme shows substantial use of funding and technical expertise in the last 3 years to support reforms in Member States' labour, education, healthcare and social services – of all assistance requests received in 2017 and 2018, 29% and 21% respectively were in these areas, precisely.^x In 2017, 9% of all support measures implemented via the EU Structural Reform Support Programme were to make healthcare systems more accessible, effective and resilient.^{xi}

The new Reform Support Programme 2021 onwards is proposed to comprise an increased budget of €25 billion, which promisingly offers new dynamics for support to Member States and public authorities. The Programme will be comprised of three different elements:

- a Reform Delivery Tool, to provide financial support to implement reforms identified in the context of the European Semester;
- a Technical Support Instrument, providing tailor-made, case-by-case technical expertise; and
- a Convergence Facility, to assist Member States seeking to join the Euro-zone.

It is vital to ensure that public health stakeholders are included in this, and that evidence and knowledge they bring is recognised and utilised.^{xii}

Part Two: Addressing the challenges of the annual cycle of the European Semester

At the EuroHealthNet Partnership - consisting of public bodies working at local, regional, and national levels - our work includes a focus on systemic and sustained awareness-raising about the potential benefits of the European Semester and its related instruments for the use of the public health community to advocate for better health and wellbeing. EuroHealthNet shares important analyses and ways of engaging with the European Semester process amongst our members and, perhaps more importantly, strives to stimulate and facilitate related policy and practice dialogues and actions at national, regional and local levels. We relay the information and contribute by capacity building activities on the Semester when we speak at member's events, during study and country exchange visits, as well as through our thematic working groups. However, despite the important opportunity the European Semester represents, it faces various challenges which we outline below.

2.1 Lack of awareness – the important role of providing health equity evidence into the European Semester debate

The European Semester is not yet sufficiently known as a policy-coordination instrument among health promotion practitioners and officials. Recently EuroHealthNet spoke at a major national health promotion conference in an EU Member State capital, where we presented the potential of using the European Semester for health equity objectives. During an initial survey of the audience (134 people responded), we found that only 6% of respondents were aware of the European Semester, and only 13% had heard of the Social Pillar.

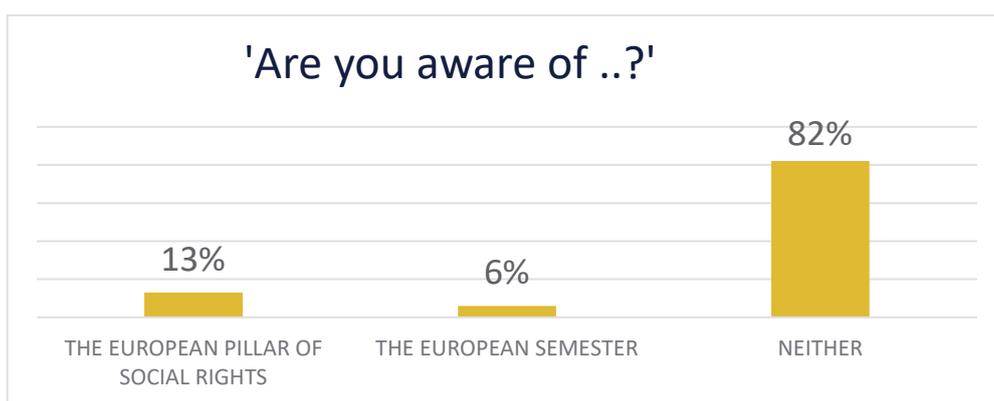


Figure 3: Mentimeter poll amongst health professionals on awareness of the European Semester and the European Pillar of Social Rights (June 2018)

We believe this to be indicative of generally **insufficient awareness and, subsequently, insufficient capacity for engagement with the Semester processes amongst public health officials, sub-national authorities, and civil society actors in most EU Member States.** The European

Semester has not yet been adequately communicated and promoted to a diverse range of stakeholders internationally, nationally or locally. Furthermore, for health actors familiar with the Semester, it is not always evident why some countries are issued health-CSRs and others are not. Also, it is not evident why certain issues within the health-CSRs are selected while omitting others – even though a health situation described in a preamble to national CSRs would form a sufficient rationale for doing so. This is a situation sketched by our Hungarian and Romanian experts. This confusing approach could be also derived from the 2018 CSRs' way of addressing child poverty, as explained later in the report.

Furthermore, evidence from other members who have engaged with the Semester suggests that the **process works best when the highest level of transparency and openness to in-the-field expert knowledge is ensured**. In Part Three, an example from one of our Dutch members illustrates how the process can be used to elevate voices and lived experience of people with mental health problems as the Semester process at (sub-)national level unveils. We also describe how some of our members from Finland and Sweden engage with their national and EU counterparts – including as part of a wider group of stakeholders. Yet these national examples are still relatively new. To better promote the Semester in Member States, all stakeholders – including cross-sectoral stakeholders at (sub-)national level - must adopt co-operative, early and systematic monitoring and communication procedures to help to make the Semester's cycle a fully inclusive policy coordination cycle, all the way from Annual Growth Survey (AGS) to Country Profiles to National Reform Programmes (NRPs) to CSRs.

The European Commission's Joint Report on Health Care and Long-term Care Systems and Fiscal Sustainability (2016) recommended that "*evidence-based policy reforms are necessary in order to improve the performance of the health care and long-term care systems and ensure that it remains fit for purpose in a changing context*".^{xiii} Public health professionals and authorities are well-positioned to deliver such evidence. In many cases, budgeting officials and officials in charge of health and social systems may not be equally informed, nor have the same incentives, which makes it complicated to determine the most cost-effective solutions for improving the systems' sustainability. **Improved governance and more consultation or co-decision between the authorities in charge of both budgeting and health would be helpful.**

As an example, from our Slovenian member, the existence of EU tools such as the European Semester may prove beneficial for prioritising certain reforms and ensuring continuity across changing political climates. The Semester may therefore represent a particularly valuable opportunity as a silo-breaking tool in political processes in certain EU Member States where decision-making remains a very fragmented process.



Given the challenges of low awareness and lack of understanding of the legal context of the Semester – as well as who holds responsibility for implementing CSRs – there is a risk their implementation may be delayed or may never occur in some Member States. This can be best illustrated through some of key messages of the recent European Commission’s event:

“Some CSRs can be best addressed at the local level, which may not be made aware of the European Semester process by the respective national government. It is thus important to involve local and regional actors, also when identifying challenges and disparities within a country as national averages may not fully capture the situation in certain regions and areas.”^{xiv}

As our members experiences – and the previous years’ CSR implementation – demonstrate, we agree with this assessment.

2.2 The implementation delay of health- and long-term care recommendations

Another barrier to the success of the European Semester is the slow rate of implementation of structural CSRs related to health- and long-term care.

While an increasing number of Member States have received *poverty and social inclusion* CSRs over the years, the number of Member States that received CSRs pertaining to health in 2018 (12 EU Member States) rather experienced a lack of continuity. There was an increase in 2014, a dip in 2015, and increase in 2016, another dip in 2017, and another increase in 2018: an unhelpful ‘zig-zag’ pattern (Figure 3).

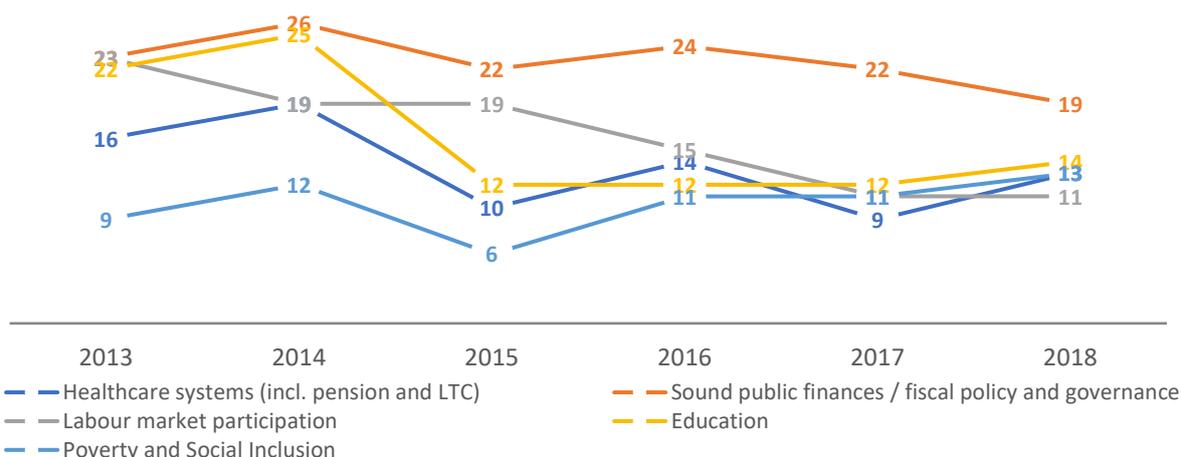


Figure 3: Number of Member States who received CSRs in the field of health or social determinants to health areas (2013-2018)

Source: based on EC Communication on the European Semester Country Specific Recommendations Annex 1 from 2013-2018.

Originally, the health- and long-term care sector was placed in the grouping of recommendations concerning *public finances*; later it was moved to the grouping of *labour market, education and social policies*. Regardless of their placement, health- and long-term care CSRs face challenges in terms of implementation rate.^{xv}

The Commission expects recommendations to be fully implemented in 12 to 18 months following adoption by the Council. For health and long-term care reforms to fully take effect, this period is unfeasible. This helps to (partly) explain why health-related CSRs are shown as among the least successfully implemented of all sectors at a rate of 55%, according to the European Commission’s own analysis for 2013-2017.^{xvi} ‘Alternative’ analysis suggests an even lower – 36% implementation rate for health and long-term care.^{xvii} **Deep reforms take time and require implementation analysis – a period that would clearly require a much longer time than the Commission’s envisaged 12-18 months period.**

Likewise, the European Court of Auditors’ evaluation found it a “*challenging timeframe for implementation*”.^{xviii} As an example from one of our member organisations from Sweden showed, this is reflected at (sub)national levels. Before recommending new activities in a framework of the Semester, efforts should be made towards implementing (and monitoring implementation of) recommendations that have been already made. The reality is that complex policy-practice-evaluation cycles and resource shifts are not impossible but need longer periods and careful *ex-* and *post-ante* impact assessments to be effective. The suggested reforms require substantial capacity building both in ‘hard’ (technical, legal and budgetary) and ‘soft’ skills of cross-sectoral and negotiation-facilitating nature.

2.3 Reductionist, medicalised and siloed approaches to health and social equity

In addition to the lack of awareness of the European Semester and poor levels of implementation of the health and long-term care CSRs, it is also concerning that **health and long-term policy priorities are only considered from a narrow medicalised and curative health view in the CSRs.**

To date, the specific focus of the European Semester-linked social review has been placed on looking into the long-term sustainability and ‘cost-effectiveness’ (on a superficial level) of health systems and pensions and, in some cases, accessibility (unmet medical health needs) and affordability (out-of-pocket payments) of healthcare. However an overzealous focus on cost-efficiency, in the short-term, could have adverse effects on quality and access of health- and care-services over the long-term. A similar observation has been made by the Fundamental Rights Agency’s report on *Combating child poverty: an issue of fundamental rights* that stated “fiscal policies suggested under the European Semester have often resulted in austerity measures that cut social services, as often criticised by the European Parliament and civil society”.^{xix}

In addition, the issue of health-related out-of-pocket payments and the Semester’s recommendations in the matter could be bolstered through the WHO Europe Regional Office’s 2018 study “*Can people afford to pay for health care? New evidence on financial protection in Europe*”^{xx}. This study offers a set of proposed actions on social protection for vulnerable families, low-paid workers, and older people, which remains broadly in line with the EU Social Fairness Package, the Social Pillar and the Semester scope. The evidence from this report should be heeded in the 2019 European Semester cycle. Our experts from Romania, Austria, Finland, and Hungary also put particular emphasis on these important issues, which would require longer-term commitment and investments (see Part Five).

While the CSR formulations were similar across countries, the national contexts (as outlined in the preambles) demonstrated a much wider variety of influencing factors.

The Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability (2016) already mentioned health care as “*only one contributor to good health, next to wider socio-economic determinants of health, such as education, income and environmental factors*”. The report states that more emphasis is needed on health promotion and disease prevention to delay the onset of non-communicable diseases (with life-long consequences) and of age-related conditions: health promotion and disease prevention will “*maximise the system’s potential to deliver better health outcomes and improve population health status while promoting efficiency and cost containment*”.^{xxi}

For this reason, **we argue that it is time for serious investments in health promotion and disease prevention as a key part of the transformative process towards achieving good health for all.**^{xxii} Health promotion is successful when it comprehensively addresses the root causes, namely the wider determinants of health. **The European Semester cycle can offer and guide Member States and stakeholders towards integrated policies, investments and reforms impacting on key social and economic determinants of health.** This would also broadly be in line with objectives of linking the ESI Funds with concrete health- and social inclusion-related CSRs. Some of our member organisations involved in the Semester process have pioneered such approaches: our Slovenian members utilise the Semester-Social Pillar-EU funds link to address systems' reform by tackling social determinants of health and our Finnish members attempt to shape the Semester process by bringing non-health perspectives to health systems reforms.

Finally, it is important to acknowledge that health-related CSRs are often subject to competing priorities which can result in an inconsistent reform approach. On the one hand, it may be recommended that healthcare systems focus on fiscal consolidations of public health care spending, while on the other hand they are told to expand coverage and availability of services – necessarily requiring health systems to do more with less funds available. When funding is scarce, urgent 'life or death' medical treatments must be covered as a matter of priority, which usually means cutting access to and ambitions of preventive, long-term measures.

Part Three: Examples of engagement in the European Semester as experienced by members of EuroHealthNet

The following examples illustrate the experiences of some EuroHealthNet members working with the European Semester.

National Public Health Institute (NIJZ), Slovenia

In recent years, the European Semester's Country Specific Recommendation (CSR) to Slovenia on healthy and active ageing initiated a much stronger collaboration between the Ministry of Health, the Ministry of Labour, Family, Social Affairs and Equal Opportunities, the Social and Employment Ministry, and the National Institute of Public Health (NIJZ) alongside many other key stakeholders. NIJZ follows CSRs regularly to use the potentials opportunities for health promotion arising from the Semester processes.

The CSRs were one of the key drivers for the Ministry of Health to make ageing a priority. With EU co-funding, NIJZ led the two-year project AHA.SI (2014-2016) addressing the social determinants of health and applying 'health in all policies' principles to promote healthy ageing.^{xxiii} Specifically, it focused on three key priorities: 1) prolonged employment and delayed retirement; 2) tools promoting and supporting active and healthy ageing in all population groups; and 3) long-term care, integrating social and health services at local level. The EU policy focus has provided an opportunity for our Slovenian members to strengthen integrated strategies and actions for active and healthy ageing, particularly within the framework of the EU2020 Strategy, the European Semester process, and the Social Investment Package.^{xxiv}

More recently, our Slovenian member organisation was invited to play an expert role in the European Commission's seminar reflecting on civil society's experience with the European Semester. Our member explained that *"health and long-term care have had more prominence in the European Semester more recently, which has allowed [us] (...) to build more forms of cooperation at national level. It is not always easy to influence at national level due to short policy cycles. The Semester process can provide a longer timeframe that national policy development can be hooked onto. Sectors other than health and long-term care are seen to be more sensitive to CSRs as they are linked to funding."*^{xxv}

Social and Health Association (SOSTE), Finland

SOSTE is involved in the European Semester process through its collaboration with the European Commission's Representation in Finland (the country desk office). The European Pillar of Social Rights has accelerated the Finnish EC Representation's interest to collaborate with wider stakeholder groups. SOSTE produces a shadow report with recommendations based on the Country Report of Finland. SOSTE's report is then published at the same time as the European Commission's Country Specific Recommendations. The EC's Representation regularly

invites SOSTE to give commentary on the CSRs, which allows SOSTE's expertise on health and social policies to be heard by national policy makers and other stakeholders.

Alongside their Slovenian colleague, our Finnish member took part in the European Commission's seminar reflecting on civil society's experience with the European Semester and the European Pillar of Social Rights. Our expert stressed that *"NGOs have a significant role in service delivery in Finland. One of the CSRs asks Finland to ensure the adoption and implementation of a big reform on health and social policy. Many academics, service users and municipalities in Finland strongly oppose the proposed reform, believing it will not lead to more cost effective and integrated services. Whilst a reform of the present model is needed, there are big differences on what the new model should be. SOSTE is very involved with the Semester delegation from the European Commission. In general, the Semester process is not known by the general public: media coverage focusses mostly on economic issues."*^{xxvi}

Mental Health Care Association (GGZ Nederland), the Netherlands

Through the European Alliance on Mental Health, GGZ Nederland (the Dutch Association for Mental Health and Addition Care) is following the European Semester. For some years, long-term care and health were addressed in the Netherlands' County Specific Recommendations. GGZ Nederland made use of the EU's recommendations, alongside other major reports (e.g. OECD and WHO), in their own strategy to advise the Dutch government. The recommendations strengthen their voice in promoting mental health care. GGZ Nederland has noticed less of a focus on health and long-term care in recent years, but also acknowledges that the situation in the Netherlands has progressed following reforms.

Association of Local Authorities and Regions (SALAR), Sweden

SALAR has an ongoing dialogue with both the European Semester Officers in Stockholm and with the Prime Minister's Office regarding the European Semester. The Government generally has four-five consultations throughout the year relating to the different steps in the European Semester. SALAR is also consulted by the European Commission during the autumn in their preparation of the country reports and issues including healthcare. This consultation dialogue process helps to ensure that SALAR's expert knowledge in the field is taken into account.

Part Four: 2018 Country Specific Recommendations for health and social equity

Extract from the 2018 CSRs related to health	Theme of the recommendation
Austria (CSR no. 1) Ensure the sustainability of the health and long-term care and the pension systems, including by increasing the statutory retirement age and by restricting early retirement.	Sustainability
Bulgaria (CSR no. 3) In line with the National Health Strategy and its action plan, improve access to health services, including by reducing out-of-pocket payments and addressing shortages of health professionals.	Access to health services, health professionals
Cyprus (CSR no. 5) Take measures to ensure that the National Health System becomes fully functional in 2020, as planned.	Reform progress
Finland (CSR no. 1) Ensure the adoption and implementation of the administrative reform to improve cost-effectiveness and equal access to social and healthcare services.	Reform progress (cost-effectiveness, access to social + HC services)
Ireland (CSR no. 1) Address the expected increase in age-related expenditure by increasing the cost-effectiveness of the healthcare system and by pursuing the envisaged pension reforms.	Cost-effectiveness, demographic ageing / pension
Latvia (CSR no. 2) Increase the accessibility, quality and cost-effectiveness of the healthcare system.	Accessibility, quality and access
Lithuania (CSR no. 2) Improve the performance of the healthcare system by a further shift from hospital to outpatient care, strengthening disease prevention measures, including at local level, and increasing the quality and affordability of care.	Affordability and disease prevention
Malta (CSR no. 2) Ensure the sustainability of the health care and the pension systems, including by increasing the statutory retirement age and by restricting early retirement.	Sustainability of health care and pension systems
Portugal (CSR no. 1) Strengthening expenditure control, cost effectiveness and adequate budgeting, in particular in the health sector with a focus on the reduction of arrears in hospitals.	Cost-effectiveness
Romania (CSR no. 2) Improve access to healthcare, including through the shift to outpatient care.	Outpatient care
Slovakia (CSR no. 1) Implement measures to increase the cost effectiveness of the healthcare system and develop a more effective healthcare workforce strategy.	Cost-effectiveness & health workforce
Slovenia (CSR no. 1) Adopt and implement the healthcare and health insurance act and the planned reform of long-term care.	Reform progress

Figure 4: DG Sante: European Semester 2018 Country Specific Recommendations on health and long term care for 12 EU Member States

- **HEALTH AND LONG TERM CARE**

In 2018, 12 countries received health-related CSRs. Figure 4 gives examples of such health-CSRs in the 2018 cycle. While there is evidence that supporting access to high-quality health care, together with effective health promotion, disease prevention and social protection policies, can help reduce health inequalities, social exclusion and poverty, CSRs rarely, if at all as Figure 4 above shows, refer explicitly to effective health promotion measures. The primary focus revolves mainly around quality, access and health workforce. We agree that timely access to health care can increase the productivity of the workforce, support people to actively participate in society, and avoid higher costs for healthcare and social dependency in the long run.^{xxvii} Tying it better with preventive health measures and health promotion as argued before, would boost these efforts more. In addition, as we see health and wellbeing irrevocably linked to and affected by other social determinants, we focus below on three other structural determinants that are key to good health and wellbeing.

- **EARLY CHILDHOOD EDUCATION AND CARE**

Country Specific Recommendations of the 2018 cycle related to early childhood conditions, education and care refers to childcare services, education, or inclusive education. The European Semester gives little consideration to the rights of the child and to child poverty. More needs to happen to address the multiple challenges experienced by vulnerable children in a more comprehensive way.^{xxviii} For example, our Finnish member organisation emphasised the fact that lives of low-income families with children have deteriorated, due in part to a reduction in housing subsistence and other essential social services. In this context, families and their children may find themselves unwillingly entering a cycle of intergenerational poverty and social exclusion. Not enough has been done regarding accessible and quality early childhood education and care; in fact, in Finland these essential services have been targeted for budget cuts (see Part Five). The evidence states that early childhood education and care are key drivers of health and social equity. Adversity in the early stages of life tends to have negative effect on all the different domains of child development – cognitive, communication and language, social and emotional skills – and vice versa.^{xxix} It is therefore fundamental to consider early childhood education and care when setting out to tackle health inequalities.^{xxx} More flexible and part-time work and parental leave provisions, for instance, can be key to buffering families and children against some of the most difficult scenarios they may face during the early childhood period.^{xxxi} Addressing early childhood conditions, such as inadequate socio-economic conditions, care, health, and education is essential to reduce the intergenerational transmission of poor health outcomes. It also provides the most cost-effective impact on health equity.^{xxxii} OECD work on the social outcomes of learning shows that high quality early childhood education and care brings a range of social benefits to individuals – especially the most disadvantaged ones. These include better health, reduced likelihood of individuals engaging in risky behaviours and stronger civic and social engagement.^{xxxiii} Another consideration for

education came from our Romanian expert, who stressed the importance of improving upskilling and the provision of quality mainstream education, particularly for Roma and children in rural areas. Finally, as part of the early childhood education and care efforts, the issue of childhood vaccination should be also addressed.

- **POVERTY AND INCOME INEQUALITIES**

Although some progress has been made, CSRs do not give sufficient visibility to poverty and inequalities nor do they provide a coherent strategy to address the poverty- and income inequality-related principles of the European Pillar for Social Rights. Spending reviews and recommendations to tackle financial stability can jeopardise the proper delivery on social policies which suffer from review-recommended cuts.^{xxxiv} In general, the European Semester gives little consideration to child poverty. None of the 2017 CSRs addressed it and in the 2018 cycle only one CSR stressed the need to improve family support and address coverage gaps in income guarantees (CSR for Spain).^{xxxv} Another CSR contained a preamble clause referring to child poverty, while the actual CSR addressed poverty only in general terms.

And yet, evidence demonstrates that more should and could be done to address poverty and income inequalities. Reducing inequalities in health is closely linked to social protection policies: countries providing higher levels of minimum income benefits and more equitable social transfers mechanisms have lower mortality rates. Social protection policies determine – to a large extent – the income and material living conditions available to vulnerable members of society. Fiscal support to single parents and families with numerous children can also be equalisers of health opportunities and outcomes across social gradients. Adequate unemployment benefits are linked with better health, especially for those with a lower level of education. An important contribution is made to levels of health and health inequalities by both coverage and replacement rates associated with social protection policies as well as active labour market policies designed to get people (back) into work.^{xxxvi} Finally, a growing phenomenon of in-work poverty and insecure working arrangements (zero-contract hours, temporary contracts, the platform/gig economy) should be taken into account, not least for its effects on mental health of such employees. This is one of primary areas of focus for the European Mental Health Alliance: Work & Employment, of which EuroHealthNet is a founding member. The Alliance issued a set of recommendations to put greater emphasis on mental health aspects of the European Semester process in its labour markets, work-life balance, and prevention of chronic diseases approaches.^{xxxvii} These suggestions were supported by our member organisations from Austria (increase of investments in workplace health promotion and disease prevention), Spain (fostering transition towards open-ended contracts an income guarantee schemes), Sweden (addressing poverty and income inequalities through

reducing households debts and a better housing market) and Romania (setting the income reform and minimum wage based on objective criteria).

- **SKILLS, EDUCATION AND LABOUR MARKET PARTICIPATION**

Education levels and participation in the labour market, amongst other factors, have a highly significant impact on the prevalence of health problems, especially for vulnerable and isolated individuals. Country Specific Recommendations of the 2018 cycle, however, address (un)employment challenges mostly though proposing ‘active labour market’ measures that usually pay little to no attention to the inclusiveness of labour markets and the quality of employment. Education, although mainly addressed as a labour market tool, also shows a good degree of attention to inclusiveness and quality.^{xxxviii} Our member organisation in Finland stressed the importance of using the Semester towards investing in the long-term unemployed. The expertise gathered showed the active labour market policies – as recommended by previous CSRs in Finland – has caused a rather negative result through the reduction of unemployment benefits and the newly introduced penalty scheme. Neither the numbers of the unemployed, nor their general situation and wellbeing were improved following the reforms. Our expert stated that the reforms must fully include the farthest from the labour market, support their access to high-quality services, offer adequate coaching, and wage subsidies. The health and social services should be capable of addressing multiple health and social needs, such as substance abuse, elder care, child protection, disability, and mental health problems, including whilst in employment. Our member organisation from Spain agreed with the CSR issued in the European Semester in 2018 calling for capacity building of the employment and social services to provide effective support for jobseekers and their families. Higher levels of unemployment tend to unequally affect various groups in society and are more likely to disadvantage those in lower socio-economic positions. These factors determine the resources individuals can access and the environment they live in, which, ultimately, affect their life chances, risk of material deprivation and overall wellbeing, with consequences on people’s health throughout the life-course.^{xxxix}

Part Five: The Country Specific Recommendations 2018 from the perspective of national experts

EuroHealthNet members and associate members are statutory national and regional authorities and expert institutes or civil society bodies within the field of public health, health promotion, and disease prevention, as well as health and social equity. We asked the experts to examine their national health CSRs in particular, and the health- and society-related CSRs in the current Semester cycle generally; then to respond to these specific aspects:

- Do CSRs and their preambles reflect the realities for health and social equity?
- Do CSRs suggest appropriate reform priorities?
- Are there aspects that are overlooked?
- Are health promotion and inequalities sufficiently addressed?

Austria

Health Systems CSR

(CSR no.1) Ensure the sustainability of the health and long-term care and the pension systems, including by increasing the statutory retirement age and by restricting early retirement.

Social Determinants of Health CSR

(CSR no. 2) Improve labour market outcomes of women. Improve basic skills for disadvantaged young people and people with a migrant background.

Our country experts informed us that an increase of the statutory retirement age and restricting early retirement would not affect all reasons for the current low retirement age. More viable contributions to raise the factual retirement age and to lower healthcare expenditures (short- and long-term) would be stimulated by an increase of investments in health promotion and disease prevention programmes, especially in workplace health promotion (WHP). This includes healthy and active ageing measures, physical health, and mental health promotion. Additional provisions for health equity in the workplace are needed, for instance, addressing gender-related inequities in health; taking the education and income gradient into account, as well as employment status.

There is a national quality-management programme on workplace health promotion in place, yet a lot of companies still do not invest in workplace health promotion according to the quality criteria defined by the Luxemburg Declaration of Workplace Health Promotion (cf. ENWHP

1997). In particular, a gap between larger companies and small companies has been identified in Austria.

There is a strong need specifically for capacity building between companies, addressing issues such as how to best plan, run, and evaluate workplace health promotion projects and programmes. This can be done through information, support, funding schemes, and training programmes on how to manage WHP, healthy leadership, as well as providing tools and methods in WHP. Moreover, the interplay between the different spheres of action in workplace health management (i.e. statutory employee protection, voluntary workplace health promotion and reintegration management after long-term absence from work) should be improved. Workplace health promotion is currently minimal compared to secondary/tertiary health system-based prevention; more investment in workplace health promotion would increase public health and workplace health expenditures in the short run, but the return on investment would quickly result in cost savings.^{xi}

Finland



(CSR no. 1) Ensure the adoption and implementation of the administrative reform to improve cost-effectiveness and equal access to social and healthcare services.

Our country experts raised the need to address the number of people at risk of social exclusion and poverty and the positive influence this would have on people’s health and wellbeing. In turn, this would also improve the efficiency and quality of the health systems. In general, the country expert notes that while Finland has committed to decrease the amount of people at risk of social exclusion and poverty, the number has largely stayed the same due to cuts and freezing of public finances.

The recently launched ‘SOTE’ reform³ should narrow welfare and health inequalities and increase the availability of quality services. Particular attention is needed towards the performance of services for disadvantaged groups of the population.

The SOTE reform should also aim for better social and health care integration, as failing to achieve this would risk citizens falling in service provision gaps. Furthermore, there is a need to increase the SOTE Centres capacity for dealing with substance abuse, mental health, elder care, child protection, and disability services. Quality assurance measures, such as customer experience documentation, are also called for in SOTE Centres. Our experts emphasized the need to empower citizens, including targeted democratic and civic participation by different

³ The Finnish government’s proposed largest ever social and healthcare reform (SOTE)

groups of citizens. The reform’s aim of freedom of choice should be to strengthen the basic services and to ensure faster access to care.



(CSR no. 2) Improve incentives to accept work and ensure adequate and well-integrated services for the unemployed and the inactive.

Our country expert stressed the importance to investing in long-term unemployed people. Current activities are insufficient. The expert criticised the failed attempt of active labour market policies and explained that the model has caused negative results due to the reduction of unemployment benefits and the newly introduced penalty scheme. This has neither reduced the amount of long-term unemployed people nor has it improved their general situation and wellbeing. Reforms must ensure that those who are in weak positions in the labour market are supported with accessible high-quality services and sufficient resources for coaching and support, work and training support services, and wage subsidies.

In particular, lives of low-income and un-/underemployed families with children have deteriorated, due in part to a decrease in housing subsistence and other social security services. Child poverty and negative social heritage (i.e. social exclusion over a period of several generations) are serious concerns that should be tackled. Accessible and quality child and infant care and education, as well as increased efforts in health education are important elements. It is important for all families to be able to afford full-time high quality early childhood education, and our expert stressed that the cuts in the education sector are unjustified: i. Studies show that early childhood employment is a profitable investment as it affects children’s later achievements in school as well as in employment in adulthood.

Also see some of our Finnish member’s experience included in Part Three of this report.

Hungary



(CSR no. 3) Unlock labour reserves through improving the quality of active labour market policies. Improve education outcomes and increase the participation of disadvantaged groups, in particular Roma, in quality and inclusive mainstream education. Improve the adequacy and coverage of social assistance and unemployment benefits.

Our country expert informed us that Paragraph 16 in the preamble of the Country Specific Recommendation for Hungary describes the situation accurately:

"Despite ongoing efforts to improve public health, poor health outcomes, aggravated by unhealthy lifestyles, persist, having a negative impact on human capital. Low levels of healthcare spending, coupled with an inefficient allocation of resources, limit the effectiveness of the Hungarian healthcare system. This, together with a high reliance on out-of-pocket payments, has negative equity implications for the timely access to affordable, preventive and curative healthcare of good quality. Shortage of healthcare workers also hampers access to care, although recent salary increases have mitigated this challenge. Ongoing reform efforts are focused on tackling excessive use of hospital care services, a key cause of which is that primary care providers are not appropriately equipped to act as effective gatekeepers. Further rationalisation of hospital resources use, together with targeted investments to strengthen primary care services, would enable the reduction of disparities in access to care, drive efficiency gains and effectively improve health outcomes." (Preamble of Hungary's CSRs 2018)

It was further elaborated that Hungary recently appointed a new Minister of Human Capacities so new approaches are anticipated.

Italy

Social Determinants of Health CSR

(CSR no. 1) Shift taxation away from labour, including by reducing tax expenditure and reforming the outdated cadastral values... Reduce the share of old-age pensions in public spending to create space for other social spending.

Social Determinants of Health CSR

(CSR no. 4) Step up implementation of the reform of active labour market policies to ensure equal access to effective job-search assistance and training. Encourage labour market participation of women through a comprehensive strategy, rationalising family-support policies and increasing the coverage of childcare facilities. ...

Our country expert reiterated that the high cost of old age pension is indeed an issue as raised in CSR 1 and elaborated in section 11 in the preamble:

"Italy's old-age pension expenditure, at around 15 % of GDP, is now among the highest in the Union. Implicit liabilities arising from population ageing were curbed by past pension reforms, improving Italy's long-term sustainability also by gradually adjusting retirement age to life expectancy. However, both the 2017 and the 2018 budgets contained provisions that partially reversed those reforms. Italy has a larger share of population above 65 than the Union average. This is projected to further increase over time, worsening Italy's old-age dependency ratio. Hence, pension expenditure is projected to increase over the medium term. The high share of old-age pensions in public spending also restrains other social spending, including to fight poverty, and growth-enhancing spending items like education." (Preamble of Italy's CSRs 2018)

The expert further elaborated that the challenges addressed in the preamble have already been addressed with a five-year-old reform but led to a strong intergenerational inequality.

According to the expert, the CSRs' priorities are not the most appropriate ones; the Italian priorities should revolve around reducing the cost of public administration and initiating a justice reform, including improving the judicial credibility and trial time.

The expert agrees with the need to increase efforts to further the participation of women on the labour market.

The Netherlands



(CSR no. 2) Reduce the incentives to use temporary contracts and self-employed without employees, while promoting adequate social protection for the self-employed, and tackle bogus self-employment. ... Ensure that the second pillar of the pension system is more transparent, intergenerationally fairer and more resilient to shocks.

Our country expert highlighted that over the years the Netherlands has continuously had CSRs addressing health and long-term care, which has improved the efforts within the government through reforms and strategies. These are currently being implemented, with results to be revealed in time.

Also see the experience of one of our Dutch members included in Part Three of this report.

Poland



(CSR no. 2) Take steps to increase labour market participation, including by improving access to childcare and by fostering labour market relevant skills, especially through adult learning, and remove remaining obstacles to more permanent types of employment. Ensure the sustainability and adequacy of the pension system by taking measures to increase the effective retirement age and by reforming the preferential pension schemes.

Our country expert informed us that the Country Specific Recommendation, in principle, is appropriate. Perspectives to strengthen expenditure control, cost-effectiveness, and adequate budgeting, particularly in the health sector with a focus on improvement of primary health care, specialist care and hospital care coordination and management, are important to address.

The expert would, however, add that *“preventive medicine and public health needs further development and better financing in order to prolong healthy life years (HLY) in males and females”*.

Portugal

Health Systems CSR

(CSR no. 1) ... Strengthen expenditure control, cost effectiveness and adequate budgeting, in particular in the health sector with a focus on the reduction of arrears in hospitals ...

Social Determinants of Health CSR

(CSR no. 2) Promote an environment conducive to hiring on open-ended contracts, including by reviewing the legal framework in consultation with social partners. Increase the skills level of the adult population, including digital literacy, by strengthening and broadening the coverage of the training component in adult qualification programmes. Improve higher education uptake, namely in science and technology fields.

Our national expert reports, in accordance with the national country profiles, that per capita health expenditure is 30% lower than the European average. There is a chronic under-funding of the services which entails systematic recourse to extraordinary budget increases to cover expenditure and delays in payments to suppliers. Out-of-pocket financing is among the highest in the EU at approximately 700 € a year/per person and is associated with co-payments for pharmaceutical products and laboratory tests. There is also a significant shortage of human resources, resulting in 800 000 Portuguese without family doctors/GPs and a low ratio of nurses to doctors.

Although life expectancy increased considerably, this improvement was not accompanied by an increase in healthy life expectancy above 65 years of age. Portuguese women can expect only 6.6 years of healthy life above the age of 65 compared to Norwegian women who can expect 15.4 years. Approximately 5.4 million people in Portugal have one or more chronic disease. Portugal has one of the highest mortality rates due to diabetes in the EU as a consequence of the high prevalence of type-2 diabetes. In another example, the number of people dying from Alzheimer's has almost tripled from 2000 to now, reflecting an ageing population (as well as better diagnosis of this illness).

The increasing need for long-term care will lead to an exponential increase in costs. In this sense, measures should be taken to guarantee the financial sustainability of the health system in the short-, medium- and long-term. A transition from the centralised hospital paradigm to the person-centred paradigm should be envisaged. In this sense, and in the medium- and long-term, a clear investment in:

- **Health promotion** by introducing a health component into all policies, the only way to consistently reduce morbidity. One of the effective tools in this context is Health Impact Assessment; another is investment in health literacy.

- **Integrating care** with the involvement of people and communities in health care is mandatory, based on a greater awareness of health risks and the establishment of strong networks of informal caring.
- **Research to support the introduction of new technologies** to support health promotion and to provide care to communities and in people's homes, creating conditions for the participation of people and families in care. Self-management of individual health can be a powerful tool for the sustainability of the health system and effective management of chronic diseases.

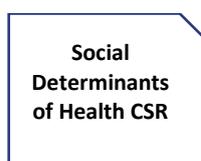
Short-term measures should include

- Improved financing of health services
- Improved policy and programme planning and evaluation areas using external and transparent evaluations
- Adequate human resources planning taking into consideration health workforce dimension, distribution, training and new forms of remuneration (a fraction of the salary according to performance-based pay)
- Production of reliable information to support evidence-based planning and policy decisions
- Promote local cross-sectoral and inclusive planning based on municipalities (incorporation of the health component) – there may be a need to allocate funds in this sense

Romania



(CSR no. 2) ... Improve access to healthcare, including through the shift to outpatient care.



(CSR no. 2) Complete the minimum inclusion income reform. Improve the functioning of social dialogue. Ensure minimum wage setting based on objective criteria. Improve upskilling and the provision of quality mainstream education, in particular for Roma and children in rural areas.

Our country expert agreed with the recommendations and stated that he/she would have raised the same issues independently. In addition, the expert called for more attention to waste management, particularly for environmental health and sustainability, and infrastructural investment. Additionally, issue of childhood vaccination should be addressed (coverage and access), as part of efforts to reform early childhood education and care system. Finally, our expert regretted that the 2018 Country Specific Recommendations missed out on a tremendous structural challenge facing the Romanian healthcare system: critical shortages of healthcare professionals.

Slovakia



**Social
Determinants
of Health CSR**

(CSR no. 2) Reinforce activation and upskilling measures, including quality targeted training and individualised services for disadvantaged groups, in particular by delivering on the action plan for the long-term unemployed. Foster women's employment, especially by extending affordable, quality childcare. Improve the quality and inclusiveness of education, including by increasing the participation of Roma children in mainstream education from early childhood onwards.

Challenges within long-term care and health in Slovakia are serious. In particular, the situation for long-term chronically ill patients within psychiatric care is bad and calls for better solutions. Currently, care for long-term chronically ill psychiatric patients suffers from a lack of hospital beds and community care, independent of age.

Deinstitutionalisation and reintegration into society of this group of patients can continue, when and where it has been possible to teach and coach the patients to look after themselves and their physical and mental health. Moreover, the access to healthcare treatment and preventative care should be ensured. The lack of clear division of responsibility to reintegrate and deinstitutionalise this group of patients causes additional issues.

It is estimated that many people do not get treatment or help in Slovakia to tackle mental health issues. Our country expert deemed that people in Slovakia are in need of improved preventative measures, including an attitude-change towards the mental health sphere, which ought to be brought about with anti-stigma training or education in school or college. It is also necessary to take up mental health in workplaces in order to improve employers' knowledge of which factors at work play into the prevalence of mental health issues.

Slovenia



**Health
Systems
CSR**

(CSR no.1) Adopt and implement the healthcare and health insurance act and the planned reform of long-term care.

The European Semester's CSRs for Slovenia on healthy and active ageing have been issued for some time already. Their existence initiated a much stronger collaboration between the Ministry of Health, and the Ministry of Labour, Family, Social Affairs and Equal Opportunities, the Social and Employment Ministry, and the National Institute of Public Health (NIJZ) – EuroHealthNet's member - alongside many other key stakeholders. The CSRs were one of the key drivers for the Ministry of Health to make ageing a priority. The EU policy focus has provided an opportunity for our Slovenian members to strengthen integrated strategies and actions for

active and healthy ageing, in particular within the framework of the EU2020 Strategy, the European Semester process, and the Social Investment Package. NIJZ follows CSRs regularly and contributes to ensure that they reflect the Slovenian reality and that, despite political changes, the Semester policy cycle influences policy on health- and long-term care at national level. As previously noted, CSRs embedded in the European Semester process can provide a longer timeframe for national policy developments to hook onto. They can be used to develop useful measures that contribute to reducing inequalities among population groups (in this case, among older people). Reforms suggested for health- and long-term systems have been linked with pensions and employment market's reforms, and a greater focus on integration of older workers.^{xli}

See also our Slovenian member's experience included in Part Three of this report.

Spain

Social
Determinants
of Health CSR

(CSR no. 2) Ensure that employment and social services have the capacity to provide effective support for jobseekers, including through better cooperation with employers. Foster transitions towards open-ended contracts. Improve family support and increase the effectiveness of income guarantee schemes. ... Reduce early school leaving and regional disparities in educational outcomes, in particular by better supporting students and teachers.

Our country expert was fully in agreement with the issued recommendations, as these reflect the situation experienced by the healthcare sector on the ground.

Sweden

Social
Determinants
of Health CSR

(CSR no. 1) Address risks related to high household debt by gradually reducing the tax deductibility of mortgage interest payments or increasing recurrent property taxes. ... improve the efficiency of the housing market, including by introducing more flexibility in setting rental prices.

Our country experts broadly agreed with the views of the European Commission on their CSR and stressed that many measures have been taken in the last couple of years and that it will take more time before clear results can be shown. First, these actions need to play out before new measures should be taken for the stability of the economy as a whole.

Also see the experience from one of our Swedish members included in Part Three of this report.

Top Ten Suggestions for Improvement

EuroHealthNet suggests that the following **Top Ten Suggestions** for improving the European Semester's potential to contribute to health equity. We recommend that they be integrated by EU Institutions and wider stakeholders in preparing the 2019 cycle so that health equity will be achieved:

- 1. Address the wider determinants of health.** Effective and sustainable implementation of health- and long-term care CSRs should address the root causes of the challenges. It should be recognised that health and wellbeing is achieved through wider policy developments that impact on health. This is clearly stated in Article 168 of the Treaty on Functioning of the European Union and by the evidence and recommendations from the WHO Commission on Social Determinants of Health as well as subsequent related national and EU co-funded studies. Social, economic, environmental, and other factors influence the health and wellbeing of individuals, populations, and systems. It is equally well-established that health is a key part of sustainable development, and an essential component in meeting these universal goals for 2030 in every EU Member State. Therefore, **health should be seen in the context of integrated approaches for sustainable economies and societies throughout Europe.** This can be much better reflected in EU Semester analyses and processes.
- 2. Health systems are key for long-term sustainable growth and development.** In addition to the health outcome impacts, health systems are usually major employers nationally, regionally, and locally. Work underway by WHO Europe (in which EuroHealthNet is involved) is identifying the huge economic 'footprints' of health systems, including 'anchor institutions' in communities and as part of wider social infrastructure. Economic impacts are being evaluated, for example, through procurement, transport, jobs, skills, and environments. This includes the wider public health workforce but also the direct employment of health practitioners and support to workers. EuroHealthNet is keen to work with members to link the Semester's recommendations and national action plans with relevant EU Programmes to build those capacities and create jobs and skills across social gradients to help improve health, wellbeing, equity, cohesion, and sustainable development. **This is particularly vital in the context of digital transformation of health systems and workplaces generally, where new skills for the future of work will be crucial.**
- 3. Improve the quality and comparability of metrics and strengthen monitoring and reporting.** It is said that "*what gets measured gets done*". The economic indicators linked to the CSRs are too superficial and lacking in specificity to be meaningfully applied to the health sector. This may be related to the comparatively low levels of

implementation of health-related CSRs for different countries and policy areas in the recent years. The Social Scoreboard could offer new opportunities to improve this, with social and economic benefits. Expanding on the self-reported unmet need for medical care, 'on the ground' reality could be better addressed by incorporating the Scoreboard's metrics for 'out-of-pocket payments', healthy and disability-free life-years impacting significantly on working participation, active ageing and long-term care burdens for systems and people. Metrics need to be improved to ensure quality, effectiveness, safety, and equity, plus appropriate continuity, especially bearing in mind potential transformative or disruptive models which require a cautious yet innovative approach. **Indicators for (cost-)effectiveness of health promotion and disease prevention dimension⁴ can be incorporated in accordance with commitments to reduce disease burdens.** This is also reflected in the recommendations and conclusion of our Semester analysis from 2016 and 2017.^{xlii}

4. **Quality is better than quantity.** Health- and long-term care reforms require time. Considerable health system reforms have already taken place or are in-progress in most countries, not least since post-financial crisis analyses indicated unsustainability. This process is also closely monitored by the OECD and included in EU country profiles on the state of health. Deep reforms take time and require implementation analysis – a period that would clearly require a much longer time than the Commission's envisaged 12-18 month period. **The European Semester process should target limited CSRs carefully and allow for and support the long-term nature of reforms.** Again, this continues our recommendations and conclusions from the previous European Semester analyses in 2016^{xliii} and 2017.^{xliv}

5. **Consistent implementation and follow-up on recommendations and reforms.** Feedback from national experts indicates that the detailed implementation of the Semester, including revised priorities and fiscal or resource shifts, has significant consequences, some of which may not be foreseen. A CSR can be appropriate *in principle*, but partial implementation *in reality* may bring side effects or cause other unintended problems. While, on one hand, increasing access to healthcare is encouraged, a push for cost-effectiveness usually is recommended. In practice, it often leads to service reductions (in particular of preventive health measures) and health systems doing more with less resources available. This risks adverse impacts on the very metrics which the CSR and Social Pillar aim to address, including health and social inequalities and life expectancies. **Consistency is needed, with better early engagement and planning of all stakeholders, and addressing issues of capacity of countries to put in place reforms and electoral cycles.**

6. **Capacity building and support for all relevant stakeholders throughout the process.** It became evident that significant parts of public health communities are still behind or

⁴ By investigating its comparative return on investment (ROI)

excluded from full engagement in the European Semester's discourse. This includes understanding the process and its entry mechanisms, use of EU tools to implement the recommendations (such as the ESI and EFSI Funds), and contributing meaningful input (e.g. evidence of impactful outcomes across social gradients, indicators, cross-sector messaging). To this end, **substantial awareness raising, support to, and capacity building of public health authorities health professionals at all levels should be invested in nationally, sub-nationally, and internationally.** A bi-directional information flow is needed: top-down from the EU to national/regional level but also bottom-up. EU institutional offices in Member States could work together with EuroHealthNet and other organisations to enable this. This can build on meetings held in Brussels to-date so that key stakeholders are able to engage, share and validate experience. To this end, the Commission and its relevant Directorates could play a greater role in supporting such processes.

7. **Careful assessment of governance levels of competence on health and social issues is needed.** Even though the health-CSRs are drafted and negotiated with national policy-makers, many issues under health and social inclusion CSRs remain a competence of regional or municipal and local authorities. Numerous EU Member States operate decentralised public health systems and deliver health promotion and preventive interventions at population level. Political priorities often differ, impacting on inequalities and effectiveness. Much of the dynamism of change is initiated, piloted and implemented at city, regional, or municipal levels. It is therefore often this level that would logically implement at least some of recommendations suggested through the Semester process, as well as benefit from the use of the ESI Funds. **Given the future plans to enhance EU added value and increase synergies between the European Semester, the implementation of the European Pillar of Social Rights, and the use of EU funds, local and regional actors should be involved in the process from the beginning in order to assess at which governance level actions should be taken.** In case of the Semester's recommendations that go beyond the original intent of the Macroeconomic Imbalances Procedure (MIP) by becoming more 'social', the national policymakers will not pay due attention to their successful implementation if the process remains poorly evidence-based, too general and lacking in participatory and/or awareness capacity of the most appropriate governance level. Health and social inclusion policies are exemplary to these remarks.
8. **Don't 'reinvent the wheel'; use the existing knowledge and expertise of civil society and public bodies.** Several expert opinions refer to specific areas that ought to be addressed more strongly; our members are knowledgeable about existing strategies, programmes, and practices that already exist and can be applied. This indicates that successful implementation of CSRs – for instance, through specific areas within public health such as workplace health promotion – may not require entirely new reforms, but rather

make use of existing instruments. This point emphasises the **need for inclusive early dialogue with civil society and public authorities within the field of health and long-term care, so they can better contribute with their existing knowledge**. Such a habit offers additional potential of establishing and further investigating possible gaps in and synergies between evidence, policies, and practice, moving the process beyond what's known to work. It is important to learn not only from successful experience of health-CSRs and national, regional, and local stakeholders' involvement, but also collect evidence for when such engagement in the process and its implementation failed in order to help overcome barriers and reduce failure replication.

9. **Acknowledge added value of EU strategic support to national health and social protection systems' reforms, not least by EU funding mechanisms.** Where justified, it is important to recognise the value of sustaining national health and social protection systems' reforms, especially in cases where such reforms were long overdue (for example long-term care reform in Slovenia, mental health care reform in Slovakia) or politically sensitive (access to healthcare for refugees, uninsured, and Roma peoples as in Romania). **The added value of EU-process' support and experience-sharing is considerable, especially for states and regions where resources and capacities may be limited in crucial aspects**, including availability of national knowledge and expertise. The European Commission's **Structural Reform Support Programme (SRSP) and relevant EU funding mechanisms should be used for support to a transition to health promoting health systems** and acknowledge a wider pool of experts including public health and health promotion experts. EuroHealthNet's recent analysis of the next EU budget proposals from a health equity perspective offers valuable insight to this end.^{xlv}
10. **Public health areas overlooked in macro-economic considerations.** Mental health and wellbeing were raised several times in various thematic combinations when talking about the impacts of chronic preventable diseases. This contributes to growing strain on health care and social protection systems fiscal sustainability, including impacts on workplace health promotion, deinstitutionalisation of chronically ill psychiatric patients and overall mental health. Such challenges are an increasing public health issue and should be addressed better in the CSRs.

Therefore, EuroHealthNet calls for EU Institutions, Member States governments and all key stakeholders in the European Semester 2019 and beyond to take this learning into account to help improve the quality of governance, inclusivity, and outcomes of the Semester. We will continue to work toward that objective with our members, partners, and stakeholders in the context of our work co-financed by the EU EaSI Programme Framework 2018-21.

Conclusion

For this report, EuroHealthNet has engaged with its national, regional, and local health experts active in key areas under the scope of the European Semester and the Social Pillar. This has helped to identify in real terms the barriers which prevent the European Semester process from exerting a more beneficial and effective influence on health, wellbeing, and equity in the EU. It also enabled us to jointly outline some opportunities to improve the process in the future, with particular attention paid to the use of the Semester and its associated tools to improve health equity.

Our top ten suggestions in this paper are aimed at constructively showing practical steps learned from this experience, which could make a difference from 2019 in the number of health-related CSRs which are effectively implemented and contribute towards EU and global goals and objectives.

That is only part of the wider solution needed to tackle the real causes of ill health, diseases and inequalities, which persist within and between all EU Member States. The European Semester is a potentially vital process to tackle those social, economic, environmental, and demographic factors which impact on how well people in the EU are born, grow, live, work, and age. Unreformed, it will not reach its full potential and may even serve as a hindrance and a barrier to those solutions.

The crucial game-changing factor through 2018 has been the commitment of the EU Institutions to take forward a European Pillar of Social Rights, with the EU Semester as a key implementing process. Progress has been made, but much of the implementing responsibilities lie with Member States and devolved authorities, particularly for health and care systems.

Therefore, our suggestions are made with the intention of strengthening actions on the ground in 2019 and beyond as we approach the next EU Multi-Annual Financial Framework period from 2021. We urge all EU Institutions and stakeholders to work with us to build a world-class process of attaining social, economic, and health equity that will be a model of integrated solutions to help achieve the global Agenda 2030 Goals.

References

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- ⁱ Masters, R. et al. (2016). Return on investment of public health interventions: a systematic review. *Journal of Epidemiology and Community Health*, vol.71(8) <https://jech.bmj.com/content/71/8/827>
- ⁱⁱ <http://www.europarl.europa.eu/legislative-train/theme-deeper-and-fairer-internal-market-with-a-strengthened-industrial-base-labour/package-social-fairness-package>
- ⁱⁱⁱ European Commission. Social Scoreboard 2018, country reports. https://ec.europa.eu/commission/sites/beta-political/files/social-scoreboard-2018-country-reports_en.pdf
- ^{iv} European Commission Communication on the CSRs 2018 https://ec.europa.eu/info/publications/2018-european-semester-country-specific-recommendations-commission-recommendations_en
- ^v WHO Key concepts. https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/
- ^{vi} European Commission (2018). Proposal for a regulation of the European Parliament and of the Council laying down common provisions on the ERDF, the ESF+, the Cohesion Fund, and the EMFF and financial rules for those and for the AMF, the ISF and the BMVI, (p.7) https://ec.europa.eu/commission/sites/beta-political/files/budget-may2018-common-provisions_en.pdf (7 November 2018)
- ^{vii} European Centre of Expertise (ECE) in the field of labour law, employment and labour market policies. The European Pillar of Social Rights and European Semester as tools for delivering Social Europe – a reflection with civil society. Tuesday 2 October 2018 - Summary Report.
- ^{viii} EuroHealthNet (2018). Smart investments? Let's talk prevention. Innovative financing and investments for health promotion. <https://eurohealthnet.eu/media/events/smart-investments-let%E2%80%99s-talk-prevention-innovative-financing-and-investments-health> (21 November 2018)
- ^{ix} European Structural Reform Support Programme https://ec.europa.eu/info/sites/info/files/srsp-policy-areas_en_0.pdf
- ^x https://ec.europa.eu/info/sites/info/files/report-on-the_3-years-of-the-srss_en_.pdf (21 November 2018)
- ^{xi} European Commission (2018). Annual Monitoring Report on the implementation of Structural Reform Support Programme 2017. https://ec.europa.eu/info/sites/info/files/file_import/annual-monitoring-report-implementation-structural-reform-support-programme-2017_en.pdf (21 November 2018)
- ^{xii} EuroHealthNet MFF briefing on the Reform Support Programme (2018) <https://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/Consultation%20Response%20MFF%20Regulation%20for%20establishing%20the%20Reform%20Support.pdf>
- ^{xiii} Commission services (Directorate-General for Economic and Financial Affairs), Economic Policy Committee (Ageing Working Group) (2016) Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, available at: https://ec.europa.eu/info/publications/economy-finance/joint-report-health-care-and-long-term-care-systems-fiscal-sustainability-0_en (7 November 2018)
- ^{xiv} European Centre of Expertise (ECE) in the field of labour law, employment and labour market policies. The European Pillar of Social Rights and European Semester as tools for delivering Social Europe – a reflection with civil society. Tuesday 2 October 2018 - Summary Report.
- ^{xv} European Commission Communication on the CSRs 2018 https://ec.europa.eu/info/publications/2018-european-semester-country-specific-recommendations-commission-recommendations_en

^{xvi} Ibid

^{xvii} http://bruegel.org/reader/European_Semester#do-countries-comply-with-recommendations

^{xviii} European Court of Auditors (2018). Audit of the Macroeconomic Imbalance Procedure (MIP). Special Report 03/2018 <https://www.eca.europa.eu/en/Pages/DocItem.aspx?did=44765>

^{xix} Fundamental Rights Agency (2018). Combating child poverty: an issue of fundamental rights. <http://fra.europa.eu/en/publication/2018/child-poverty> (21 November 2018)

^{xx} WHO Europe (2018). Can people afford to pay for healthcare? New evidence on financial protection in Europe. http://www.euro.who.int/_data/assets/pdf_file/0006/378825/68id01e_IDCanPeopleAffordHealthCare_180444.pdf (7 November 2018)

^{xxi} Commission services (Directorate-General for Economic and Financial Affairs), Economic Policy Committee (Ageing Working Group) (2016) Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, available at: https://ec.europa.eu/info/publications/economy-finance/joint-report-health-care-and-long-term-care-systems-fiscal-sustainability-0_en

^{xxii} <https://eurohealthnet.eu/media/news-releases/eurohealthnet-calls-new-and-improved-approaches-financing-health-promotion-and>

^{xxiii} <http://www.staranje.si/aha-si/izdelki-projekta-project-outputs> (21 November 2018)

^{xxiv} Study visit on cross-sector collaboration for healthy and active ageing (AHA.SI Project), Ljubljana, 4-6 July 2016. EuroHealthNet http://www.staranje.si/sites/www.staranje.si/files/upload/files/report_ehnet_slovenia_study_visit_2016.pdf (21 November 2018)

^{xxv} European Centre of Expertise (ECE) in the field of labour law, employment and labour market policies. The European Pillar of Social Rights and European Semester as tools for delivering Social Europe – a reflection with civil society. Tuesday 2 October 2018 - Summary Report. (p.9)

^{xxvi} Ibid

^{xxvii} Eurofound (2014). *Access to health care in times of crisis*, Publications Office of the European Union, Luxembourg

^{xxviii} Eurochild (2018). Making social rights work for children. 2018 Eurochild Report on the European Semester. https://www.eurochild.org/news/news-details/article/making-social-rights-work-for-children/?no_cache=1 (9 November 2018)

^{xxix} Goldblatt P, Siegrist J, Lundberg O, Marinetti C, Farrer L & Costongs C (2015). Improving health equity through action across the life course: summary of evidence and recommendations from DRIVERS project. Report produced as part of 'DRIVERS for Health Equity project', <http://health-gradient.eu/Brussels>: EuroHealthNet.

^{xxx} Marope PTM, Kaga Y, editors. Investing against evidence: the global state of early childhood care and education. Paris: United Nations Educational, Scientific and Cultural Organization; 2015 <http://unesdoc.unesco.org/images/0023/002335/233558E.pdf>

^{xxxi} Goldblatt P, Siegrist J, Lundberg O, Marinetti C, Farrer L & Costongs C (2015). Improving health equity through action across the life course: summary of evidence and recommendations from DRIVERS project. Report produced as part of 'DRIVERS for Health Equity project', <http://health-gradient.eu/Brussels>: EuroHealthNet.

^{xxxii} Dyakova M, Hamelmann C, Bellis MA, Besnier E, Grey CNB, Schwappach A et al. Investment for health and well-being: a review of the social return on investment from public health policies to support implementing the

Sustainable Development Goals by building on Health 2020. Copenhagen: WHO Regional Office for Europe; 2017 (Health Evidence Network (HEN) synthesis report 51).

^{xxxiii} OECD briefing Investing in high-quality early childhood education and care (ECEC). <https://www.oecd.org/education/school/48980282.pdf> (22 November 2018)

^{xxxiv} <https://www.eapn.eu/wp-content/uploads/2018/06/EAPN-2018-CSR-Response-Main-Messages-EAPN.pdf>

^{xxxv} Fundamental Rights Agency (2018). Combating child poverty: an issue of fundamental rights. <http://fra.europa.eu/en/publication/2018/child-poverty> (21 November 2018)

^{xxxvi} Goldblatt P, Siegrist J, Lundberg O, Marinetti C, Farrer L & Costongs C (2015). Improving health equity through action across the life course: summary of evidence and recommendations from DRIVERS project. Report produced as part of 'DRIVERS for Health Equity project', <http://health-gradient.eu/Brussels>: EuroHealthNet.

^{xxxvii} European Mental Health Alliance: Work&Employment (2018). https://eumhalliancedotcom.files.wordpress.com/2018/08/eumhalliance_emplwork_mental-health-in-european-semester_final.pdf

^{xxxviii} Ibid

^{xxxix} European Commission (2018). VulnerABLE: Pilot project related to the development of evidence based strategies to improve the health of isolated and vulnerable persons Scientific Report, available at:

http://www.health-inequalities.eu/wp-content/uploads/2017/11/vulnerable_scientific-report_final_october2017-lowres-compressed.pdf

^{xl} Masters, R. et al. (2016). Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health, vol.71(8) <https://jech.bmj.com/content/71/8/827>

^{xli} Study visit on cross-sector collaboration for healthy and active ageing (AHA.SI Project), Ljubljana, 4-6 July 2016. EuroHealthNet http://www.staranje.si/sites/www.staranje.si/files/upload/files/report_ehnet_slovenia_study_visit_2016.pdf (21 November 2018)

^{xlii} EuroHealthNet (2016). EuroHealthNet analysis of the Country-Specific Recommendations – Will the 2016 EU Semester process contribute to improving health equity?, available at: <https://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/final%20CSR%20analysis%202016.pdf> and

^{xliii} Ibid

^{xliv} EuroHealthNet (2017). EuroHealthNet's 2017 analysis of the European Semester - Will the 2017 European Semester process contribute to improving health equity?, available at: <https://eurohealthnet.eu/publication/european-semester-health-inequalities-perspective>

^{xlv} EuroHealthNet (2018). Analysis of the Multiannual Financial Framework 2021-2027 from a health and health equity perspective. <https://eurohealthnet.eu/publication/analysis-multiannual-financial-framework-2021-2027>



EuroHealthNet

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