EuroHealthNet

EUROPEAN PARTNERSHIP FOR IMPROVING HEALTH, EQUITY & WELLBEING

Will the 2016 EU Semester process contribute to improving health equity?

EuroHealthNet analysis of the Country- Specific Recommendations

2016

Acknowledgements

EuroHealthNet is a non-profit partnership of public bodies accountable for public health and working from local to regional, national and international levels across Europe. Its mission is to help build healthier communities and tackle health inequalities within and between European states. See: www.eurohealthnet.eu.

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Authors: Cristina Chiotan, Cathrine Hernandez Festersen, Caroline Costongs

Contact: Cristina Chiotan, Policy Senior Coordinator, EuroHealthNet (c.chiotan@eurohealthnet.eu).

Address: EuroHealthNet, Rue de La Loi, 67, Bruxelles 1040, Belgium

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Table of contents

Figures

Tables

Executive summary

The European Semester is the EU's economic policy coordination mechanism of the Europe 2020 Strategy. It undertakes a detailed analysis of EU Member States' reforms plans and provides them with Country Specific Recommendations (CSRs) following extensive consultation with stakeholders at European and national levels. The publication of the CSRs entails a potential political programme for each member state for the coming semester period.

EuroHealthNet's interest in the EU semester is reinforced by the fact that CSRs also address questions related to the priorities and investments of member states in the field of social affairs and health. As such, CSRs represent an opportunity to ascertain the extent to which they may – or may not – contribute to health equity.

This document brings together two areas amenable to policy actions that can improve health and reduce health inequalities: children and families; and health systems from a health promotion perspective. For children and families, the analysis aims to ascertain the scope and inclusiveness of CSRs related to children and families and to find out whether the suggested measures are a step towards improving health and reducing health inequalities. For health systems we try to examine whether the 2016 CSRs are likely to stimulate reforms that reduce health inequalities and support investment in health promotion and disease prevention.

These topics were selected based on EuroHealthNet's previous work on health systems, child development and health promotion. This document aims to compare findings of 2016 with those of 2015 analysis and responds to the announcement of the Annual Growth Survey 2017 in November 2016, which marks the beginning of a new EU semester process.

This year analysis found that:

- There is an increased awareness of the need for policies related to children and families, especially in the light of labour market and social inclusion.
- The need for fiscally sustainable health care systems is recognised among most CSRs relating to health, yet the call for strengthening primary care, disease prevention and health promotion or looking at health in an integrated way is limited.
- Access to health is increasingly raised in CSRs related to health in comparison to the analysis of CSRs in 2015. However, vulnerable people, children or migrants are not directly mentioned.
- Children, vulnerable people and migrants are mentioned in connection with social inclusion and labour market integration.

Several steps have been identified as promoters of greater health equity:

- Ensure that children and families are on the agenda of all CSRs.
- More focus should be put on coverage and access to quality of health care.

- Improve health system governance and support inter-sectoral work and cooperation.
- A stronger focus and consideration should be given to the impacts of the economic crisis in terms of resources; investing in health promotion and disease prevention should be one of the measures to support health systems fiscal sustainability.

1. EU Semester: opportunities to improve health equity

Income and wealth inequality has been rising in Europe in recent decades. The number of people in the EU living at risk of poverty and social exclusion increased by 4.5 million between 2010-2014[1]. Although Europeans are living longer than ever, there are growing divides in life expectancy and health between socio-economic groups[2]. Many of the life-years that people are gaining are not being spent in good health, particularly amongst lower end of the social gradient.

Socio-economic gradients in health, or the systematic correlation between health status and socio-economic status, which exists in all EU Member States, may be becoming stronger in many EU countries[34].

The causes of these inequalities are complex. They cannot be reduced to a single group of risk factors, but develop through the conditions in which people are "born, grow, live, work, and age", the 'social determinants of health'. These determinants are shaped through prevailing macro-policies on social protection, taxation, health, education, the environment, and from living and working conditions[5]. They also result from lifestyle determinants, or susceptibility to specific risk factors, like alcohol, tobacco consumption, bad nutrition, and lack of physical activity, which are strongly linked to social and economic conditions[6].

As growing numbers of people suffer from one or more chronic conditions, the high costs of treatment are increasingly putting pressure on the financial sustainability of health and social systems. Currently, public spending on health care and long term care accounts for 8.5% of GDP in the EU. It is expected that this will increase with 1-2% in 2060. Investing in health promotion and disease prevention could delay the onset of age-related conditions as well as of non-communicable diseases with long life consequences. The health care system will improve its potential to deliver better health outcomes, while promoting efficiency and cost-containment[7].

Early childhood is a major driver of inequalities in health. Neighbourhood deprivation, lower parental income/wealth, educational attainment, occupational social class, higher parental job strain, parental unemployment, lack of housing tenure, and material deprivation in the household are key factors associated with a wide range of adverse child health and developmental outcomes. Providing access to universal but tailored comprehensive early years services based on social and economic need is important to reduce inequalities during the early development of children[8].

Our market economies are not delivering well-being in a fair and effective manner and this can be improved. Health is an enabler of social and economic participation in daily life, the 'engine' behind our economies, and a key determinant of a person's well-being, happiness and satisfaction. Moreover, people systematically value health above all other aspects of their lives[9].

EuroHealthNet is monitoring the EU semester process, working with its members and partners for a stronger focus on public health, health promotion and preventive services. The analysis performed this year focuses on (1) health promotion and disease prevention in relation with sustainable health systems and (2) children and families, as two key areas that can improve health and reduce inequalities and where inequities in health could challenge policy reform and sustainability in implementation.

Overall findings show that recommendations emphasize priorities on a yearly basis following the general trend towards short term budgeting of health systems. This conflict with longer-term planning needed to implement child development and health system reforms, and to achieve broader public health and health promotion objectives.

We also observe that many CSRs identify problems in the 'whereas' section but do not propose solutions. In addition, the focus of the recommendations could be enhanced by providing better targeted and specific solutions to specific issues. These could support the national process of prioritisation and resource allocation when different sectors and goals are competing in the public budget. However, we appreciate that not all EU member states wish to receive detailed CSRs and prefer broader recommendations for member state action.

Several steps could be taken to ensure that the 2016 CSRs result in greater health equity:

- **More focus should be put on coverage and access to quality of health care**; even if health insurance coverage is universal in almost all EU Member States, there are differences regarding access and quality of care linked with affordability, waiting times, and travelling distance, as well as socio-economic and cultural factors. A stronger focus should be on using measures that are universal and at the same time targeted to ensure access to vulnerable groups.

- **A stronger focus and consideration should be given to the impacts of a series of global financial, economic and social crises** in terms of resources, access and quality of health care.

- **Strengthen the focus on improved health system governance**, including '*strengthening the cooperation between fiscal and health policy government authorities'* and *'the need to improve health through health promotion and disease prevention policies and policies outside the health care sectors'.*

- **Ensure that children and families are on the agenda of the CSRs.** Although the elements recommended by DRIVERS[10] are largely available in 2016**,** children and families are on the

agenda in too few CSRs. Health is determined across the life course, and policies and interventions to improve child health help ensure the future sustainability of health and social systems, reducing early retirement and increasing well-being and healthy life years.

1.1. Economic, social and health inequality

EuroHealthNet seeks to ascertain that in discussions at EU and national levels about the EU 2020 strategy, the social determinants of health across the life course, equitable access to health services, as well as health promotion and disease prevention measures are considered. The EU semester is an important opportunity to address the link between economic, social and health inequalities.

In countries with bigger income inequalities, health and social problems are more common, as the graph below demonstrates. Considerable scientific evidence also points to a link between economic growth and economic inequality. Economic growth is affected indirectly by economic inequality. The main challenge is that the lowest 40 % of the population '*are not able to invest into their skills and education, which constitutes a considerable loss of human potential*'[11].

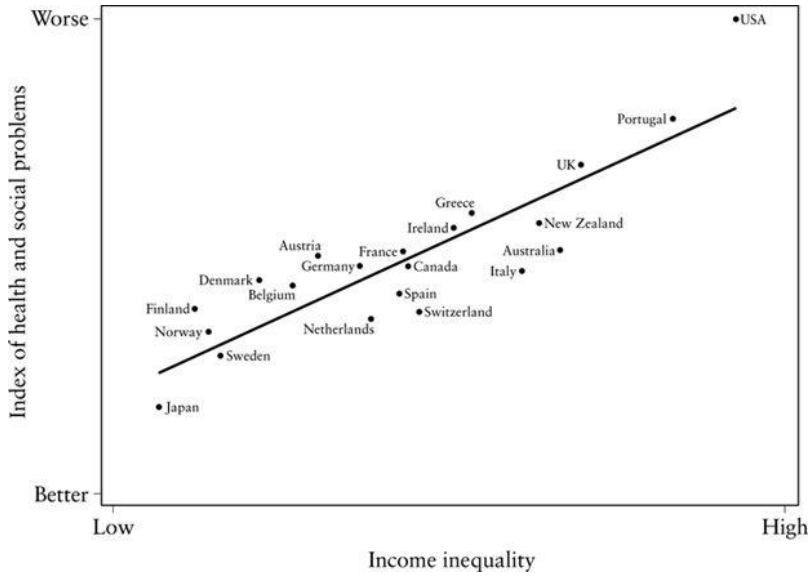


Figure 1. Health and social problems are closely related to inequality among rich countries [12] [13]

1.2. What is the EU Semester Process?

The EU semester is an annual cycle of macro-economic, budgetary and structural policy coordination and surveillance taking place at the EU level. Its cycle is focused on the first six-months of each year, time during which Member States can align their budgetary and economic policies with the objectives and rules agreed under the Stability and Growth Pact and the Europe 2020 Strategy.

The EU semester is designed to detect, prevent and correct problematic economic trends, such as excessive deficits and debts, and help prevent future imbalances and systemic risks from appearing within the European Union. Every year, the European Commission analyses the fiscal and structural reform policies of every member state, provides recommendations to member states and monitors their implementation. As the economic crisis grew into a social and health crisis from 2010 onwards, commentators started pointing to divergent social situations across the EU (e.g. in terms of poverty, unemployment). The EU semester process consequently expanded from concentrating mostly on macro-economic issues to including several social indicators within its scope[14].

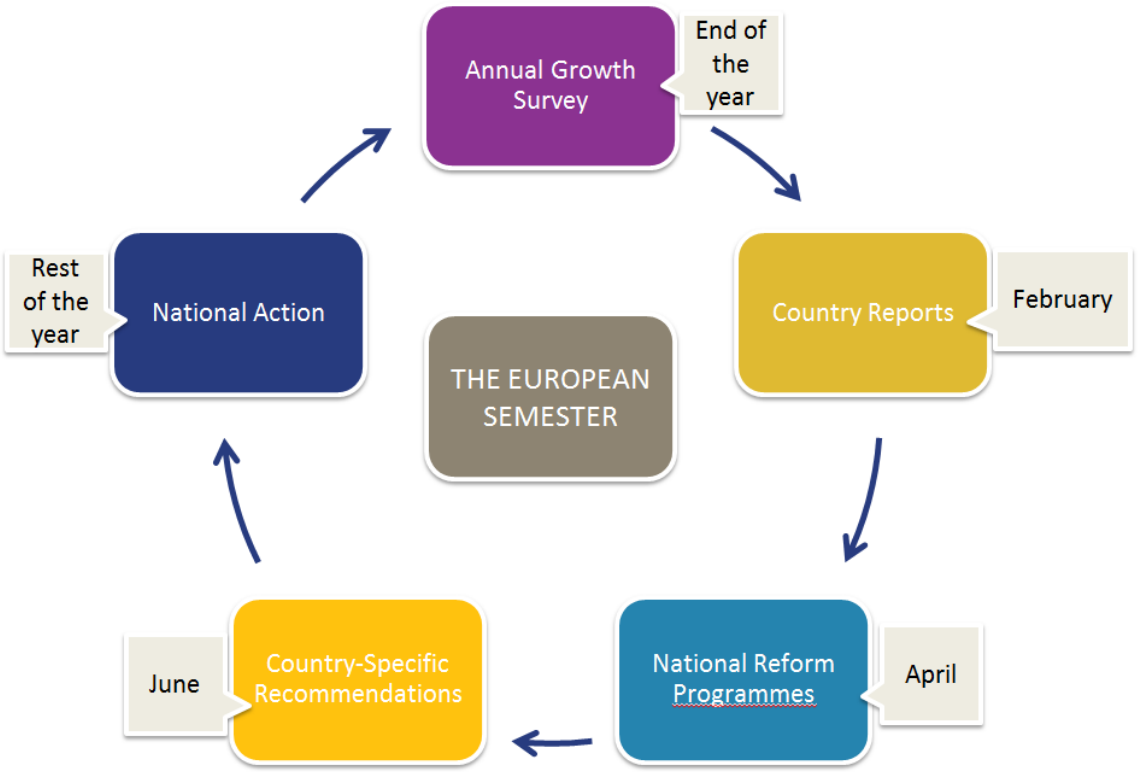


Figure 2. The EU semester process

The EU semester consists of difference phases: (1) The Annual Growth Survey (AGS) which launches the EU semester and – together with the draft Joint Employment Report – sets the priorities for action; (2) The Country Reports (based on EC analysis), which include in-depth reviews of macroeconomic imbalances for those member states where the risk of such imbalances was estimated to be high. (3) The National Reforms Programmes (prepared by countries) detail how the targets of the EU 2020 Strategy are being reached, which national policies will be implemented and how EU guidance has been taken into account; (4) The Country-Specific Recommendations (CSRs) recommends a set of actions for each member state to take, according to its economic and social performance during the previous year and to the delivery of priorities set out in the AGS.

The CSRs are politically binding being formally adopted by the Council[15]. The CSRs of 2016 include all EU Member States, except Greece, as it is instead covered by economic adjustment programmes.

1.3. What are the priorities?

The policy priorities included in the AGS 2016 highlight the importance of a broader social investment, including healthcare. While there is a strong focus on enhancing cost-effectiveness and financial sustainability, the AGS 2016 stresses the importance of adequate access to health care and the need for health promotion and disease prevention. Better population health is linked with improved labour market participation and labour productivity. Most of the actions can be identified in the CSRs, as the Annual Growth Survey stresses that '*responsible policies are now needed to ensure that … health care and long-term care systems are financially sustainable and can provide adequate protection for all.*'[16] . While reference is made to health, health care and long-term care, it is notable that childcare and family policies as well as inequalities, equity, social inclusion, and poverty receives limited attention.

In the Annual Growth Survey of 2017, health policies and their social impact are addressed in the light of labour market inclusion, which is welcomed by EuroHealthNet: '*Health policies should support and reinforce social safety nets and active inclusion strategies, through preventive, but also curative and rehabilitation policies.'* The AGS 2017 calls for continued reform of health systems in order to ensure *'universal access to cost effective public health and healthcare services [and thereby]. Protecting the population from falling into poverty or social exclusion due to ill-health and related expenditure is essential, both from a social and economic view-point*'[17]. This recognition is important for countering health inequalities across the EU. At the same time, it is suggested in the AGS 2017 that Member States that do not have the sufficient funds to invest in longer term sustainability should instead prioritise to '*deliver on the requirements given by the Stability and Growth Package*[18]'.

1.4. What is new?

In 2014-15, a review of the Europe 2020 Strategy was carried out by the Commission. The consultation demonstrated Member States do not embrace the Europe 2020 Strategy adequately and that deeper involvement on the ground is necessary. Accordingly, the Commission aims to improve '*its implementation and monitoring in the context of the European Semester*' and '*has adjusted the guidance to Member States on the preparation of their National Reform Programmes to make sure that the Europe 2020 strategy continues to play a prominent role.*' [19]

The EU semester 2016 has adopted some changes. Already in 2015, the EU semester was streamlined further as it was split into two stages: (1) the discussions and recommendations directed

at the euro area; (2) CSRs to be discussed and decided upon. In the period of 2011-2014, the CSRs were becoming longer, but in 2015 there was a great reduction.[20]

The 2016 changes include further engaging with stakeholders, focusing the guidance provided, and published Country Reports earlier, in February (and thereby leaving more time to prepare the Country-Specific Recommendations). The changes to the 2016 EU semester process were announced in the Commission Communication of 21 October 2015[21]. Among revamps are increased attention to upward convergence through benchmarking and best practices; '*more focused support to reforms through EU funds and technical assistance*', and more attention to a robust euro area economy, which involves that '*practical improvements to the Macroeconomic Imbalances Procedure and to the implementation of the Stability and Growth Pact*', and '*the establishment of an advisory European Fiscal Board and of a network of national Competitiveness Boards*' (AGS 2016, p. 16).

Changes are also reflected in three priorities listed in the 2016 Annual Growth Survey in relation with employment and social aspects:

1. '*A stronger focus on employment and social performance. Employment and social aspects are further emphasised in the Macroeconomic Imbalances Procedure'.*
2. *'Three headline indicators (activity rate, youth unemployment, long-term unemployment) are used in the 2016 Alert Mechanism Report accompanying this Annual Growth Survey'.*
3. *'Greater attention is given to social fairness in the context of the new macroeconomic adjustment programmes'.* This attention is taken with the view to '*ensure that the adjustment is spread equitably and to protect the most vulnerable in society*.'[22] In August 2015, a social impact assessment was included in the memorandum of understanding for Greece for the first time, a practice the Commission 'intends to continue' in future stability support programmes' (AGS 2016, p. 16)

1.5. Where is the opportunity?

The CSRs are an important point in the EU Semester because they represent (supposedly) extensive consultation with stakeholders at European and national levels, and a potential political programme for each member state for the coming semester period.

EuroHealthNet seeks to ensure that the social determinants of health across the life course, equitable access to health services, as well as health promotion and disease prevention measures are considered in discussions at EU and national levels about the EU 2020 Strategy, the Social Investment Package and in developing health promotion systems. Our interest in the EU semester is reinforced by the fact that CSRs increasingly address questions related to the priorities and investments of member states in the field of social affairs and health. As such, the CSRs represent an opportunity to ascertain the extent to which they may – or may not – contribute to health equity.

An important opportunity for improved health and social equity as part of the EU semester is provided by a potential **European Pillar of Social Rights**[23]. The aim of the European Pillar is to build

on and complement the EU social acquis[1], and to guide social and employment policies; it will serve as a reference framework to screen the performance of employment and social policies in member states and help drive reforms at national level. If linked with the EU semester process, it could effectively support policies addressing health inequalities and monitor their implementation. The preliminary outline includes the need for accessible, affordable, and quality childcare as well as early attention and preventative measures in relation to child poverty and disadvantages. It should also mainstream children's rights in all policy domains, strengthening investment and the voice of children, ensuring equity and a social rights pillar for all children.[24]

In relation with healthcare the preliminary outline of the European Pillar of Social Rights addresses universal access to high quality of healthcare, and encouraging health promotion and disease prevention as well as addressing health inequalities. Improved effectiveness and fiscal sustainability requires a well-developed and prepared workforce, and resources for multi-sectorial and multi-stakeholder initiatives. Modern principles of public health policies address the socio-economic determinants of health and health behaviour, with a focus on health inequalities. They should be used in both the European Pillar and the EU semester process to ensure the greatest potential in effectiveness and impact[25].

Another important opportunity which should be taken up by the EU semester is provided by the **United Nations Sustainable Agenda 2030 and the Sustainable Development Goals (SDGs)**[26]. Several SDGs are making explicit reference to health and well-being, equity and inequalities, poverty and education. It is recognised that at global level income inequality between countries has been reduced, but inequality within countries has risen. To reduce inequality it is recommended to use the principle of proportionate universalism, 'policies should be universal in principle paying attention to the needs of disadvantaged and marginalised populations'[27]. The SDGs consider that poverty can be reduced only by inclusive economic growth and involvement of the three dimensions of sustainable development: economic, social and environmental. An important goal is to achieve universal health coverage including financial risk protection and access to quality essential health care services and medicines and vaccines for all. Ensuring healthy lives and promoting well-being for all at all ages is essential for sustainable development[28].

The European Commission defines the details on the implementation of the SDGs in the communication on the *Next Steps for a Sustainable European Future*[29]. It mainstreams the Sustainable Development Goals in the European policy framework and current Commission priorities and launches reflection on further developing our longer term vision and the focus of sectoral policies after 2020. The strategic developments in relation with the SDGs and the Agenda for Sustainable Development 2030 could be integrated in the CSRs and the EU semester process to support unity and upward convergence in implementation.

[1] The social acquis is the part of the acquis communautaire that includes the body of laws (Treaty provisions, regulations, directives, decisions, European Court of Justice (ECJ) case-law and other Union legal measures, binding and non-binding), principles, policy objectives, declarations, resolutions and international agreements defining the social policy of the EU. http://www.eurofound.europa.eu/printpdf/observatories/eurwork/industrial-relations-dictionary/social-acquis

2. Do the 2016 CSRs enable moves towards sustainable health systems?

In October 2016, DG Economic and Financial Affairs and The Economic Policy Committee (Ageing Working Group, consisting of Member State representatives) released a Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability[30] (hereinafter called 'the Joint Report') that sets out challenges and policy options for healthcare and long-term care towards fiscally sustainable access to good quality services for all.

The demographic changes, technological advances and increased debt in most countries are putting strong and growing fiscal pressures on curative healthcare and long-term care services and systems in all EU Member States. The Joint Report states that '*with healthcare spending still centred around curative care sustainability is threatened, especially with an ageing population'* and acknowledges healthcare as *'only one contributor to good health, next to wider socio-economic determinants of health, such as education, income and environmental factors'.*

The Joint Report raises a call to '*increase the efforts in public policy, with strong emphasis on health promotion and disease prevention to delay the onset of age-related conditions, as well as, more broadly, of non-communicable diseases with life-long consequences, to maximise the system's potential to deliver better health outcomes while promoting efficiency and cost containment'.*

Countries still give relatively little importance to health promotion and disease prevention compared with curative care. The Joint Report highlights that *'more focus on health promotion does not need to come with higher costs'*, and interventions for non-communicable diseases can deliver 'significantly public health impacts' in an easily implementable and cost-effective way with high effectiveness. Examples include tax increases, bans on advertising and promotion, restricting access to risk factors and public awareness campaigns, counselling and screening.

Already in 2013, WHO Europe, OECD, and The European Observatory on Health Policies and Systems published a policy summary which brings together evidence that proves the extent to which investments in health promotion and preventive policies addressing some of the social determinants of health, represent an efficient option to help promote and protect population health. They refer to policies that address some of the health risk factors such as: tobacco and alcohol consumption, impacts of dietary behaviour and patterns of physical activity, exposure to environmental harm, and risks to mental health and well-being. While some of the interventions will be cost-effective in the short term (i.e. protection of mental health in the workplace) other interventions may take several decades before demonstrating cost effectiveness. Most policies in this area could generate cost benefits for the health system, including by reducing or delaying the demand for future health care resources. They are also able to generate additional benefits by limiting wider costs of poor health in

society, such as absenteeism from work, poorer levels in school attainment, higher rates of violence and crime, and early retirement from labour due to sickness and disability[31].

It is, then, relevant and necessary to find out whether Country-Specific Recommendations (CSRs), issued by the European Commission in response to member states' National Reform Programmes (NRPs), take health promotion and disease prevention into consideration. This analysis therefore aims to find out whether the suggested measures are a step in the right direction in terms of improving health system reforms that reduce health inequalities and support investment in health promotion and disease prevention.

Recommendations on health systems have been included in the Semester process since it began, and the number of CSRs where the topics of health and long term care is addressed has increased from 11 in 2015 to 14 in 2016. However, overall the main priority areas and issues presented has remained largely unchanged.

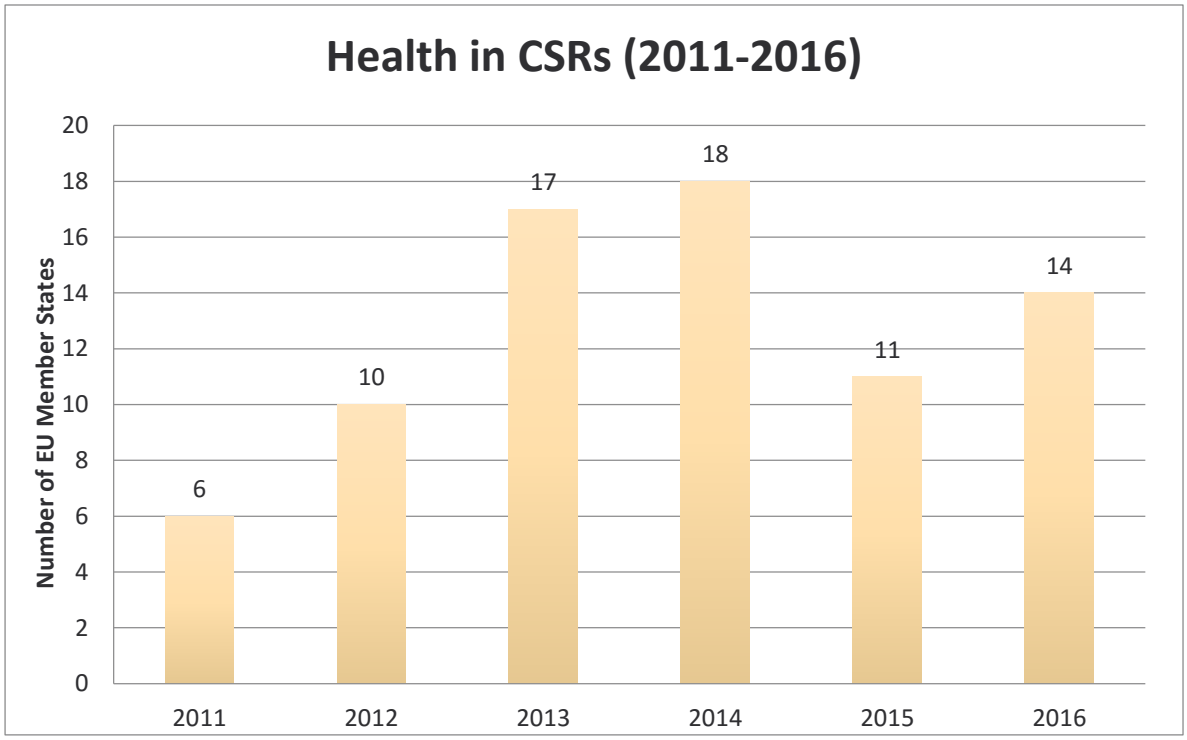


Figure 3. Health in CSRs, 2011-2016

2.1. Methods

We used the outcomes of two research projects coordinated by EuroHealthNet (DRIVERS[32] and GRADIENT[33]). The following questions were considered:

- Is the policy action a downstream measure, e.g. seeking to alter adverse health behaviours such as smoking or increasing breastfeeding rates through the health sector alone?
- Is the policy action a midstream measure, e.g. focusing on psychosocial factors, behavioural risk factors and risk conditions?
- Is the policy action an upstream measure, e.g. focusing on the wider circumstances that produce 'adverse' health behaviours (such as social conditions, employment, macro-environmental policies, and social justice policies)?
- Does the recommendation take into consideration the quality of services and does provision include coverage?

Questions were taken from the GRADIENT Evaluation Framework (GEF)[34] to evaluate if the policy actions address health inequities.

Furthermore, we have selected three policy options from the Joint Report on Health Care and Long-term Care Systems & Fiscal Sustainability and try to ascertain to what extend the CSRs support investment in health promotion and disease prevention, embrace principles of modern public health and acknowledge wider socio-economic determinants of health as well as multi-sectorial and multi-stakeholder involvement. The following questions were used:

- Do the CSRs provide recommendations or highlight the need to move away from the traditional hospital-centric model, by *'giving a stronger role to primary care and … by fostering health promotion and disease prevention…'*?

- Do the CSRs embrace the principles of modern public health/health promotion, e.g. '*Public health policies should account for the wider socio-economic determinants of health and health behaviour, including health inequalities'?*

- Do the CSRs include public health policies developed as integrated multi-sectorial and multi stakeholder initiatives?

We try to examine whether the 2016 CSRs are likely to produce health system reforms that reduce health inequalities and support investment in health promotion and disease prevention. We also included a comparison with the findings in EuroHealthNet's 2015 analysis.
Each country's CSR was read and a keyword search for the term 'health' was conducted.

2.2. Main findings

The keyword search for 'health' found results for 18 member states (BG, CZ, DE, IE, ES, FR, IT, CY, LV, LT, MT, AT, PL, PT, RO, SI, SK, FI). Of these, for 5 the reference to health systems was only in the 'Whereas' section. This resulted in 13 countries (BG, CZ, IE, IT, CY, LV, LT, AT, PT, RO, SI, SK, FI) that had CSRs relating to the health system in both the 'Whereas' and 'Recommendations' sections. These CSRs were considered in the analysis.

As in the CSRs in 2015, reducing health inequalities are not explicitly referred to in any CSRs in 2016. Additionally, principles of modern public health or policies developed as integrated multi-sectorial

and multi-stakeholder initiatives are not explicitly addressed. However, in 2016 one CSR includes explicit recommendations for strengthening diseases prevention and health promotion as a way to improve the performance of the health care system (LT).

Member state	Q1. None-hospital-centric approach	Q2 Attention to socio-economic determinants to health	Q3. Multi-sector and stakeholder
BG	N	N	N
CZ	Y	N	N
IE	N	N	N
IT	N	N	N
CY	N	N	N
LV	N	N	N
LT	Y	N	N
AT	N	N	N
PT	Y	N	N
RO	Y	N	N
SL	N	N	N
SK	N	N	N
FI	N	N	N
Total	**4**	**0**	**0**

Table 1. Overview of questions and CSRs relating to sustainable health systems

Although most of the CSRs highlight the burden of hospital care for the fiscal sustainability of health care systems and the need to improve cost-effectiveness and efficiency of hospital care, only 3 CSRs make an explicit reference to strengthen primary care (CZ, LT, RO), while 3 CSRs (RO, LT, PT) refer to disease prevention and 1 CSR to health promotion (LT).

The majority of CSRs are classified as meeting the downstream measure because they focus on the financing of health systems (BG, IE, LV, LT, AU, RO, SL, SK, FI). Portugal, Czech Republic, Ireland, Romania, Slovenia and Portugal were classified as having midstream measures because primary care can focus on psychosocial an behavioural risks. Similar to the situation in 2015, Finland was classified as upstream for dealing with health and social services in an integrated way. Also an integrated way of addressing health has been considered for Romania, for which a 'law on community services has been proposed'.

Year	Q1. Downsteam measure	Q2. Midstream measure?	Q3. Upstream measure?	Q4. Access, quality and coverage of services?
2015	81 % BG, CZ, HR, LV LT, RO, SL, SK, ES (9/11)	18 % BU, SK (2/11)	9 % FI (1/11)	27 % FI, LV, RO (3/11)
2016	62 % AU, BG, FI, IE, LV, SK, SL, RO (8/13)	46 % PT, CZ, IE, RO, SL, PT (6/13)	15 % FI, RO (2/13)	77 % LV, SL, CY, BG, IE, CY, PT, RO, SL, SK (10/13)

Table 2. Comparative analysis between 2015 and 2016 on CSRs in health systems

All health related CSRs (for the 13 countries which include them both in 'whereas' or 'recommendations' sections), address cost-effectiveness (CZ, IE, CY, LV, SI, SK, FI), health systems performance (BG, CY, LT, RO), hospitals (CZ, ES, CY, RO, SI, SK), or financial sustainability. Fiscal sustainability risks are referred in correlation with demographic changes and health care spending in 8 CSRs (IE, LV, CZ, MT, PL, PT, SI, SK). The CSRs for IE, ES and RO mention pharmaceutical spending, mainly in relation with measures to limit growth and rationalise spending. Low levels of public funding are mentioned in the CSRs for BG, CY and RO.

Compared with 2015 CSRs there is a stronger focus on access to health care with eight CSRs referring to it either in the 'whereas' section or in the 'recommendations' section (BG, IE, CY, LV, PT, RO, SI, SK). The quality of services is addressed only in two CSRs (LV, SI) and coverage is explicitly referred to only in one CSR (CY). Measures to improve access to health care for vulnerable people (i.e. low income pensioners and people in remote and isolated communities) are mentioned only in one CSR (RO). There is no specific reference to access to health care for migrants or other vulnerable people such as: children and families from disadvantaged backgrounds, the long-term unemployed, the 'in-work poor', older people, victims of domestic violence and intimate partner violence, people with unstable housing situations (the homeless), those with physical, mental and learning disabilities or poor mental health, and prisoners.

When compared with the 2015 analysis, we can see an increase in the overall focus on health systems performance, hospitals, and cost-effectiveness. Moreover, there is a substantial increase in the reference to access to health care services and the financial sustainability is linked directly with demographic changes and cost for the health care system, including hospital costs and pharmaceuticals. Similar with the 2015 analysis, there is a little focus on community services and integrated services as well as on quality of health care or coverage.

The health outcomes are mentioned in three CSRs (LT, RO, SK), however, as in the CSRs 2015, there is no link with the social concerns addressed in the CSRs or assessment of the underlying causes of ill health. Health status is determined by many factors outside the health systems, with broad indicators like life expectancy and healthy life years being influenced by many factors besides the provision of health care services.

In order to improve health, public policies should focus on health promotion and disease prevention as well as policies outside the health sector, such as transport, environment, food, education, etc. A more holistic 'Health in All Policies' approach to improving health is a way of improving fiscal sustainability and effectiveness of public spending.

However, the CSRs have a strong focus on cost-effectiveness, performance and efficient use of resources and insufficient reference to health promotion and diseases prevention. There is no reference to integrated multi-sectorial and multi multi-stakeholder approaches.

2.3. Discussion

Non-communicable diseases are the leading cause of mortality and morbidity in Europe and are a challenge for the sustainability of health care systems. Unhealthy lifestyles and behaviours are well documented drivers for non-communicable diseases. Obesity, unhealthy diets, alcohol consumption, smoking and lack of physical activity are associated with the main causes of mortality and morbidity in the EU, i.e. cardiovascular disease, cancer, and dementia. Stronger public health programmes could ensure a comprehensive set of coordinated actions that respond to current and future public health threats. Changes in lifestyles could significantly increase life expectancy at birth in all EU countries without high increase of the current costs and in the healthcare budgets. Although investment in health promotion would bring high returns in long term, currently the public expenditure on prevention and public health services constitutes a low share of total public health expenditure. Across the EU, public health expenditure on prevention and public health services ranges from 4.3% in Finland to only 1% in Portugal[35], with 2.8% out of total public expenditure and for 0.2% as a percentage of GDP in 2013[36]. The CSRs should take into consideration these aspects in relation with health systems fiscal sustainability. They should promote health system reforms that invest in health promotion and diseases prevention and address the social determinants of health and inequalities through integrated action across sectors.

More emphasis should be also put on access to quality health care services for all. Ensuring access to quality healthcare services can reduce health inequalities and help people break the circle of disadvantage. Certain population groups are well known to have difficulties in access to healthcare, i.e. people living in countries with poor overall access or in geographically remote areas, people with low health literacy, people with poor education and low incomes, people with disabilities, elderly people, chronic illnesses or those from a disadvantaged ethnic minority. Moreover, the economic

crisis has resulted in the emergence of new groups that were not considered vulnerable previously due to increased unemployment (especially among young men) and increased household debts particularly for young families which face housing and job insecurity. For these groups of young people and families, the difficulties in access to health care is due to reduced disposable income, loss of a job or benefit that came with insurance, being marginally beyond the threshold for which social support measures apply, need for a service which coverage has been reduced or for which demand has increased, and discrimination due to xenophobia[37].

The EU semester can have a potentially important role in addressing the effectiveness of health systems and their ability to translate inputs into better health outcomes. While looking at performance of health systems, the EU semester should have a greater focus on public health policies, including health promotion and disease prevention. Moreover, the European Pillar of Social Rights represents an important opportunity for increased uptake and a structured process in support of improved investment in health promotion and diseases prevention and ensured access to quality health care services for all.

The 2017 Annual Growth Survey and the implementation of the CSRs could support greater health equity, increased sustainability of health systems and improved health outcomes for all.

More focus should be put on public health, health promotion and disease prevention, on primary and community care. It is important to increase the level of investment in public health and health promotion and transform hospital based services into preventive services; low levels of funding at national level could partly be addressed through appropriate use of structural funds, which remain an insufficiently used resource for public health and health promotion.

A stronger focus should be on investing in capacity building and how to address challenges related to financial and human resources (the lack of public service capacity is mentioned briefly as impeding in policy implementation in the CSR for RO).

The CSRs recommendations should be further disseminated and discussed with regional authorities in those countries where competencies for public health and health promotion are set at regional level.

More in-depth analysis of the underlying causes of ill health in countries' with poor performing health systems and low health outcomes as well as inter-sectoral policies and multi-stakeholder approaches would strengthen public health policies results and impact.

The CSRs should continue to emphasise the importance of equitable access to healthcare and conduct further analysis on coverage rates, especially as regards vulnerable people. Universal measures and policies must be accompanied by interventions targeting the most deprived and vulnerable people. Policies towards reduction of health inequalities and promotion of health and well-being for all in the EU semester should integrate strategic developments in relation with the SDGs and the global agenda for sustainable development.

3. Do the 2016 CSRs have the potential to improve health equity for all children and families?

Action to tackle health inequalities should start in early childhood. The foundations for emotional, intellectual and physical development are laid early in life. The environment a child experiences, from the prenatal period through early childhood, can have a profound influence on later life changes and outcomes.[38] Families are important in providing a loving and supportive environment for children, which is conducive to child well-being[39]. Considerable evidence from studies in child development also emphasise that children crucially need '*stable, secure and stimulating relationships with caregivers*' in order to thrive and remain healthy in later life, '*such relationships are universally desirable, but not equally available*.'[40]

Research findings have shown that children who have low cognitive scores at 22 months but grow up in families of high socioeconomic conditions improve their relative scores as they approach the age of 10; however children with high scores at 22 months who grow up in families of low socioeconomic position worsen as they approach age 10[41].

It is important to increase the investment in early years to support good quality early years education and childcare provided in a proportionate way across the social gradient[42]. Support for families should be improved not only by investing in pre and post-natal interventions, and ensuring parental leave and guarantee the income for a decent life, but through parenting programmes and children's centres including outreach interventions to identify the most vulnerable and provide targeted support.

Despite some promising or effective actions, social and health inequalities persist and grow within and between the Member states of the European Union[43]. Increasing health inequalities require a better targeted response and flexibility of the policy actions to ensure that a proportionate universalism[44] approach is applied. Policies should include universal measures and at the same time targeted provisions to reach all people across the social gradient.

Eurostat's latest data from 2015 shows that more than one fourth (26.9 %) of children in Europe were at risk of poverty and social exclusion.[45] Recent data shows that children at the bottom end have fallen further behind in income, education, health, and life satisfaction.[46]

It is relevant and necessary to find out whether Country-Specific Recommendations (CSRs), issued by the European Commission in response to member states' National Reform Programmes (NRPs), take children and their families into consideration. This analysis therefore aims to ascertain the scope and inclusiveness of CSRs related to children and families, and to find out whether the suggested measures are a step in the right direction in following the 2014 Communication on Investing in Children and in terms of improving health and reducing health inequalities.

3.1. Methods

We use the outcomes of two FP7 research initiatives, DRIVERS and GRADIENT, co-ordinated by EuroHealthNet to examine whether the 2016 CSRs are likely to improve health and reduce health inequalities in children and families. The CSR analysis will be conducted according to a similar methodological framework as the previous year in order to ensure an adequate base for comparison.

Using the findings of the DRIVERS research – in particular the systematic review of interventions which aim to improve child health[47] and the project's four principles by which policy makers can design policies to reduce health inequalities, we selected questions from the GRADIENT research: Gradient Evaluation Framework (GEF) (Table 6). The GEF is a tool to help policy makers design and implement policies to level the gradient in health in children and families[48]. We then use these questions to analyse the CSRs.

Question	Type	GEF source	DRIVERS source
1. Are children or their families on the agenda?	Filtering question	3. Whole systems approach	DRIVERS ECD
2. Does it involve increases in investment?	Qualitative	3. Whole systems approach / 4. Scale and intensity	n/a
3. Does it encourage intersectoral action?	Qualitative	2. Intersectoral tools for all	DRIVERS
4. Are measures universal?	Qualitative	1. Universalism	Principle 1
5. Does it respond to disadvantage?	Qualitative	1. Universalism	Principle 2
6. Does it encourage early intervention (from an early age)?	Qualitative	3. Whole systems approach	DRIVERS ECD

Table 3. Sources of questions used in children & families analysis

A keyword search was used to answer the first question. If a CSR included 'child*', 'famil*', 'single' or 'breadw*' anywhere in the text (including both the 'whereas' section and the 'hereby' section) these CSRs reports are analysed further in this chapter. This was the case for 14 EU member states. It should be noted that there were areas mentioned in tandem with children (such as education and poverty) which could have a knock-on effect on family and child policies, but cannot be properly evaluated here (Groups 2-5, Table 4). Both GEF gradient and the DRIVERS evidence highlighted the importance of policies and interventions aimed at children and their families.

Group	Area of CSR recommendation	Member states (#)
1	Children and families	CZ, IE, ES, SK, UK (5)
2	Low-income earners	LV, LT, HU (3)
3	Education	AU, BE, BU, DE, ES, FR, LV, LT, HU, PL, SK, RO (12)
4	Employment	BE, BU, DE, IE, ES, FR, IT, CY, LT, HU, NL, PL, RO, SK (14)
5	Poverty	IE, IT (2)
N/A	None	DK, EE, FI, HR, LU, MT, PO, SE, SL (9)

Table 4. Areas of the recommendations

We continued analysis only for the 14 countries where children and their families were mentioned, either in the 'whereas' section, which contextualises the present state of each country, as well as the recommendations, i.e. the 'hereby' section. For these, we qualitatively assessed responses to Questions 1-6, with responses categorised as 'yes' (Y) or 'no' (N).

In comparison, in 2015 CSRs analysis 13 countries were included using the same methodology with the exception of excluding the search word 'household*' as an indicator to pinpoint children and family policies. This elimination concerns the words more regular use in relation to macroeconomic debt situations in EU Member States and not pertaining to the situation in individual households.

3.2. Main findings

Question 1: Are children or their families on the agenda?

In the case of 14 Member States, children and/or their families were mentioned (AT, BE, BG, CZ, EE, IE, ES, HU, IT, PL, PT, RO, SK, UK). Children and/or their families were not mentioned in a total of 13 countries (DK, DE, FR, HR, CY, LV, LT, LU, MT, NL, SI, FI, SE); these are excluded from further analysis. Greece did not receive any CSRs.

Out of the 14 countries with mentions in both texts 9 countries mentioned children and families in the contextual 'whereas' section but not in 'hereby' section, i.e. the Recommendations section (AT, BE, BG, EE, HU, IT, PL, PT, RO); these were excluded from further analysis. This left 5 countries which had CSRs with children and families mentioned in both 'whereas' and 'Recommendations' sections (CZ, IE, ES, SK, UK). However, only in the case of Spain were both children and their families mentioned explicitly together.

In 2015, CSRs concerning children and families were given to 9 countries (compared to 5 in 2016), 2 countries (compared to 1 in 2016) of which children and their families were on the agenda in that they were mentioned explicitly together.

Question 2: Does it involve increases in investment?

Investment in early child development, family support, or early education as such was not explicitly mentioned for any country. However, many recommendations could conceivably entail a need for increased investment, e.g. when urging to expand, accelerate, strengthen, take further measures, facilitate, address, or tampering a withdrawal of unemployment benefits. These actions will nonetheless require increasing investment to the administrative or governance capacity. Accordingly, all countries with CSRs relating to children and families were classified as involving increases in investment.

In the case of 4 out of 5 countries with CSRs, access to childcare and the quality of services was addressed explicitly raised (IE, ES, SK, UK). Disadvantaged groups, herein under unemployed, women, children, and Roma children, were also mentioned in 4 out of 5 CSRs (CZ, IE, ES, SK). In the analysis performed in 2015 by EuroHealthNet, all CSRs with mention of children and families involved investment, i.e. 9 CSRs.

Question 3: Does it encourage an intersectoral approach?

By an intersectoral approach we refer to policies and actions requiring the involvement of, and collaboration between, more than one policy sectors. 3 countries out of 5 (CZ, ES, SK) received a CSR encouraging a clear intersectoral approach. These recommendations concerned education policies with collaborations between academia and enterprises (CZ), employment policies with cooperation between employment services and social services (ES) as well as employment with education measures (SK).

In particular the recommendation for Spain to increase the collaboration between regional employment services and social services conformed well with the challenge set out in the contextual 'whereas'-section that points to the limited effectiveness of family and housing benefits singlehandedly reducing poverty: The lack of adequate and affordable childcare and long term care consequently discourages women from employment. In 2015, 4 out of the 9 CSRs in the field encouraged an intersectoral approach (compared to 3 out of 5 in 2016).

Question 4: Are measures universal?

With this question, we sought to find out whether CSRs are aimed at children and families across the social gradient or if, on the other hand, they target specific groups. The majority of recommendations were universal as they did not target specific groups, namely 4 out 5 (CZ, IE, ES, UK). Only the recommendation for Slovakia is not interpreted as universal despite its broad scope; the recommendation is specifically directed long-term unemployed, disadvantaged groups, women, and Roma children. In this analysis this recommendation is determined to be non-universal in that it does not direct attention across the social gradient. In 2015, 6 out of 9 countries included in the analysis received CSRs that are universal (compared to 4 out of 5 in 2016).

Question 5: Does it respond to needs of disadvantaged people?

All of the 5 CSRs respond to needs of disadvantaged people. The recommendations for the Czech Republic and Slovakia concerned Roma children, whereas those of Ireland and Spain rather addressed children and families at risk of poverty. That of the United Kingdom raised the need to address the skills mismatches of the workers confined to low-wage and low-hours of work. In 2015, 5 out of 9 countries included in the analysis received CSRs which responded to needs of disadvantaged people (compared to 5 out of 5).

Question 6: Does it encourage early intervention (from an early age)?

Recommendations for all 5 countries explicitly encourage intervention from an early age in education or care. Recommendation for Ireland, Spain, Slovakia, and the United Kingdom explicitly refers to childcare, while that of the Czech Republic addresses pre-school inclusion. In 2015, 3 out of the 9 CSRs in the policy field encouraged early intervention (compared to 5 out of 5 in 2016).

Member state	Q1. Children and parents?	Q2. Investment?	Q3. Intersectoral?	Q4. Universal?	Q5. Disadvantage?	Q6. Early intervention?
CZ	N	Y	Y	Y	Y	Y
IE	N	Y	N	Y	Y	Y
ES	Y	Y	Y	Y	Y	Y
SK	N	Y	Y	N	Y	Y
UK	N	Y	N	Y	Y	Y
Total	**1**	**5**	**3**	**4**	**5**	**5**

Table 5. Overview of questions and CSRs relating to children

Mention should also be made about the number of CSRs which refer to children and families in the 'whereas' sections, but do not provide corresponding 'recommendations', as his is the case of 9 countries AT, BE, BG, EE, HU, IT, PL, PT, RO. In comparison to EuroHealthNet's CSR analysis from 2015 there are some notable changes. In 2015, there were 13 countries with references to children and family policies in the 'whereas' section, of which 9 countries received recommendations. In 2016, 14 countries had references, but this year only 5 countries received recommendations. It appears that the contextual part of the CSRs continue to emphasise the sector in that the 'whereas' section both elaborates on actions taken and on challenges faced by the EU member states. Meanwhile, fewer recommendations are made on the topic.

EU Member State	Are children or their families in the agenda?	"Whereas" section only	"Whereas" and "Recommendations" sections
AT	Y	✓	
BE	Y	✓	
BG	Y		
CZ	Y		✓
DE	N		
DK	N		
EE	Y	✓	
ES	Y		✓
FI	N		
FR	N		
HR	N		
HU	Y	✓	
IE	Y		✓
IT	Y	✓	
LT	N		
LU	N		
LV	N		
MT	N		
NL	N		
PL	Y	✓	
PT	Y	✓	
RO	Y	✓	
SE	N		
SI	N		
SK	Y		✓
UK	Y		✓
TOTAL	Y = 14 N = 12	✓ =8	✓ =5

Table 6. Children and families in 2016 CSRs

DRIVERS evidence suggested that positive health outcomes result from interventions that augment parental capacities (such as maternal or paternal self-esteem, non-abusive parenting styles including nurturing and management, and parental involvement in school). Parenting programmes that promote healthy environments and healthy behaviours appear to be particularly effective in improving child health and well-being. The earlier these programmes are offered, the better the outcomes are. Such interventions are, however, not presented in the CSR in this field of analysis.

The DRIVERS evidence show that most policy interventions focus on the most vulnerable families, but lack sufficient scale across the population to level up the social gradient in health. When they are universal, they are usually not delivered with the intensity required to improve the health and development of children with higher levels of need. The favoured situation would be equal attention to both universalism and disadvantaged groups. The Review of Health Inequalities and Social Determinants in England 'Fair Society, Healthy Lives' explains that in order to minimise '*the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage*'[49]. Proportionate universalism is therefore what is required. As demonstrated in table 4, this principle has not been widely applied as both universalism and specified attention is not present in all 5 CSRs analysed here, only in 4 out of 5 cases.

Looking into the analysis from the view of the findings of the DRIVERS project, which aimed at improving child health, positive results are detected (cf. table 7 below). It is generally the case that that the CSRs of 2016 are to a higher extent in line with the DRIVERS recommendations than in 2015. This should be seen in context- there were almost double the amount of CSRs in 2015 compared to 2016, i.e. 9 CSRs in 2015 and 5 CSRs in 2016.

CSR results	Q1. Children and parents?	Q2. Investment?	Q3. Intersectoral?	Q4. Universal?	Q5. Disadvantage?	Q6. Early intervention ?
CSR 2015 (9)	2/9 22 %	9/9 100 %	4/9 44 %	6/9 66 %	5/9 55 %	3/9 33 %
CSR 2016 (5)	1/5 20 %	5/5 100 %	3/5 60 %	4/5 80 %	5/5 100 %	5/5 100 %

Table 7. CSRs 2015-2016 that received Y (Yes) in Drivers recommendation indicators compared

Percentagewise, these statistics look optimistic, however, looking at a broader timeline and at the nominal data the development is drastically deteriorating (cf. table 8). The CSRs in inclusive education and early child school leaving in the time period of 2014-2016 fell from 11 to 2 CSRs. In terms of childcare access the attention has been limited, reaching a high of 4 CSRs in 2014 and 2016 and with 0 CSRs at the lowest in 2015.

	2014	2015	2016
Childcare (access, affordability, quality)	4/10 (AT, DE, IT, PL)	0/9	4/5 (IE, ES, SK, UK)
Inclusive education and early school leaving	11/18 (BE, DE, DK, ES, FR, HR, IT, MT, PL, PT, SE)	5/9 (BG, HU, PL, RO, SK)	2/5 (CZ, SK)

Table 8. Categorisation of child development and poverty compared 2014-2016

Additionally, there is an inconsistency which pertains to the fact that not one country receives CSRs in the same field analysed in this chapter in all of the three years. Only one country received a recommendation on child development and child poverty two years in a row, namely Slovakia. It appears that the old CSRs from 2015 still stand.

3.3. Discussion

It is positive that childcare takes an important role in the 2016 CSRs relating to improving labour market integration of vulnerable groups and women, and bringing down the at-risk-of-poverty rate for children.

The implementation and the assessment of results of public health policies require a longer term approach than the fiscal yearly based recommendations can easily address. Achieving results in early child development reforms require relatively long timeframes. It is therefore important to give proper time to implement these reforms. Labour market and social inclusion issues have been one of the main factors addressed in the CSRs in relation to children and families. However, there is less emphasis on families, parents' involvement and support, as well as socio-economic levels which have a big impact in child development. The CSRs could support measures towards adequate parental leave, good quality parenting programmes and interventions that are both universal and responsive to needs, i.e. implementing a proportionate universalism approach across the social gradient.

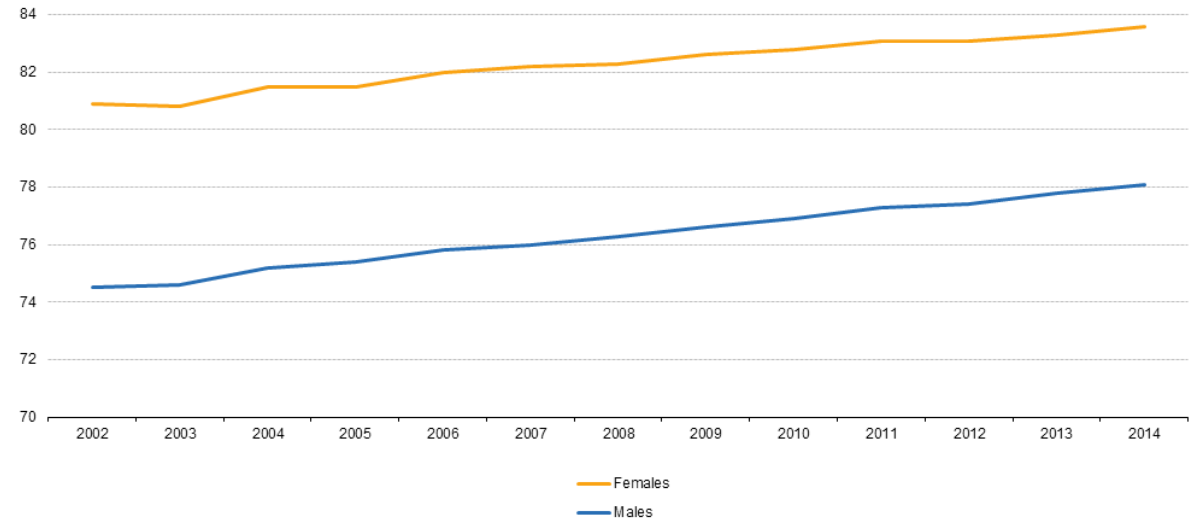
With the view of putting child poverty at the centre of policy, the European Parliament has provided an opportunity for the European Commission to respond to this challenge. In autumn 2015 the Parliament **Written Declaration on Investing in Children** called upon the European Commission to introduce specific indicators on children at risk of poverty in the social dimension of the Economic and Monetary Union; it also urged EU Member States to use EU funding to implement the Commission Recommendation 'Investing in Children: Breaking the cycle of disadvantage'.

The EU Semester therefore should more extensively address children and families.

Annexes

A. Life expectancy at birth, EU-28, 2002–14 (1) (years)

There are considerably differences between EU Member States in terms of the quality of life (health wise) that their respective populations may expect to live, when compared with the overall differences in the length of their lives. According to Eurostat, life expectancy at birth for men in 2014 ranged between 69.1 years in Latvia and 80.9 years in Cyprus; a difference of 11.8 years. A similar comparison for women shows that the lowest level of life expectancy in 2014 was recorded in Bulgaria (78.0 years) and the highest in Spain (86.2 years); a range of 8.2 years. The corresponding range for healthy life years at birth for men was between 51.5 years in Latvia and 73.6 years in Sweden (22.1 years difference), while that for women was from 54.6 years in Slovakia to 74.3 years in Malta (19.7 years).



(*) 2009, 2011, 2012 and 2014: breaks in series. Note: the y-axis is broken. 2013 and 2014: estimate and provisional.
Source: Eurostat (online data code: demo_mlexpec)

B. EU Member States addressing "health" in CSRs

EU Member States addressing "health" in CSRs	
BG	**Whereas**
	Healthcare spending more efficient, particularly by producing a national health map that will enable medical expenditure to be planned in accordance with territorial criteria and the needs of the population. The Bulgarian health system faces major challenges, including limited access, low funding and poor health outcomes.
	Recommendations
	Improve the efficiency of the health system by improving access and funding, and health outcomes.
CZ	**Whereas**
	On healthcare, the projected increase in long-term spending is also a matter of concern. The Czech Republic faces challenges in improving the governance and cost-effectiveness of its healthcare system, although a number of measures are currently at various stages of implementation. Indicators point to a high consumption of goods and services and to a comparatively high reliance on hospital-based care, which is more expensive than outpatient services. Available medical data do not appear to be used effectively for the planning and rationalisation of inpatient care capacities. The reimbursement system for hospital care is being reviewed due to various drawbacks, such as the small sample of hospitals used to calculate the reference rates. Options for strengthening outpatient care coordination, improving the gate-keeping role of practitioners and limiting unnecessary consumption of outpatient services have still not been sufficiently explored.
	Recommendation
	Take measures to ensure the long-term sustainability of public finances, in light of future risks in the area of healthcare.
DE	**Whereas**
	Specific characteristics of the tax system and health insurance discourage second earners from taking up a job or increasing the number of hours worked.
	Recommendations
	No recommendations
IE	**Whereas**
	Cost-effectiveness, equal access and sustainability remain critical challenges to the healthcare system. Specific strands of reforms are progressing, but spending on pharmaceuticals, in particular owing to the high cost of single-supplier medicines, continues to weigh on cost effectiveness. Financial management and information

	systems remain weak and unequal access to primary care is still an issue. Approximately 40 % of the population has free access to general practitioners, while the rest bear the full cost. Significant uncertainty surrounds the broad reform of the healthcare system as the universal health insurance model is in a quandary.
	Recommendations
	Enhance the quality of expenditure, particularly by increasing cost-effectiveness of healthcare and by prioritising government capital expenditure in R&D and in public infrastructure, in particular transport, water services and housing.
ES	**Whereas**
	In addition, a rule for application (on a voluntary basis) at regional level was approved in mid-2015 to limit growth in expenditure on healthcare and pharmaceutical products, and an agreement between the Government and the pharmaceutical industry was signed in November 2015 to help rationalise spending on pharmaceuticals. Despite this, in 2015, most regions as well as the social security sector fell significantly short of meeting their domestic fiscal targets. The stability law's expenditure rule was not observed by the central, regional and local government subsectors and growth in expenditure of pharmaceutical products, namely in hospitals, strengthened further, even excluding the impact of new anti-hepatitis C treatments.
	Recommendations
	No recommendations
FR	**Whereas**
	France has set ambitious targets for 2016 and 2017 to limit the growth of health expenditure. These targets could be complemented by further efforts to identify efficiency gains in the medium- to long-term.
	Recommendations
	No recommendations
IT	**Whereas**
	A number of areas are still over-protected or regulated, in particular the regulated professions, the health sector, local public transport and taxis, ports and airports.
	Recommendations
	Take further action to increase competition in regulated professions, the transport, health and retail sectors and the system of concessions
CY	**Whereas**
	Cyprus lacks universal healthcare coverage and its healthcare system fails to provide adequate and effective access to care. With low public funding for healthcare, unmet needs – due to cost as well as out-of-pocket payments – are significantly higher than in other EU member states. There is scope for improving efficiency in the use of resources. More autonomy for public hospitals and the creation of a national health system are among the measures that have been considered relevant, but not yet adopted, to improve the adequacy and cost-

	effectiveness of the Cypriot health system.
	Recommendations
	Adopt legislation for a hospital reform and advance with the planned implementation of universal health care coverage.
LV	**Whereas**
	Latvia in 2017 to take account of major structural reforms with a positive impact on the long-term sustainability of public finances, in particular for the ongoing health sector reform based on the Health Strategy for 2014-2020. The details of the reform are summarised in the Stability Programme. The objective is to increase public financing for the health sector to 4 % of GDP by 2020 relative to 3 % of GDP in 2015. The low public financing of healthcare, inherent structural weaknesses, high out-of-pocket payments and suboptimal cost-effectiveness leave much of the population with unmet healthcare needs. While access to healthcare for critical medical cases has been given priority, financial constraints limit the supply of services in general.
	Recommendations
	Ensure that the deviation from the adjustment path towards the medium-term budgetary objective in 2016 and 2017 is limited to the allowance linked to the systemic pension reform and the major structural reform in the healthcare sector. Improve the accessibility, quality and cost-effectiveness of the healthcare system
LT	**Whereas**
	In Lithuania, health outcomes are among the poorest in the European Union. In particular, the mortality rate of the population aged between 20 to 64 years of age is the highest in the Union, having an important impact on the potential available workforce and labour productivity. Weaknesses in the health system include too much reliance on in-patient care and low expenditure on prevention and public health. There is a need to address the negative demographic trend.
	Recommendations
	Improve the performance of the healthcare system by strengthening outpatient care, disease prevention and health promotion.
MT	**Whereas**
	The long-term sustainability of public finances in Malta remains a challenge. This is mainly due to the budgetary impact of ageing-related costs, such as healthcare and long-term care and pensions. In addition to pensions, public expenditure on healthcare and long-term care is projected to increase faster than the EU average, at 2,1 % and 1,2 % of GDP. The authorities have adopted a national health systems strategy and are conducting a healthcare spending review with a view to improving the efficiency of expenditure.
	Recommendations
	No recommendations
AT	**Whereas**

	The fiscal arrangements across the various layers of government (federal, state and local levels) are complex and revenue and expenditure responsibilities are not aligned in many policy areas, such as health care.
	Recommendations
	Ensure the sustainability of the healthcare system.
PL	**Whereas**
	There are significant fiscal sustainability risks in the longer term due to an unfavourable initial budgetary position and the projected increase in the costs of population ageing, mainly in relation to healthcare spending
	Recommendations
	No recommendations
PT	**Whereas**
	Portugal faces the double challenge of achieving the long-term fiscal sustainability of the healthcare system while at the same time maintaining the level of access to healthcare by improving efficiency in the system. Although Portugal currently has one of the lowest shares of public expenditure in total health spending in the Union, the projected increase in public healthcare expenditure by 2,5 % of GDP by 2060 is the highest. In view of addressing the long-term sustainability challenges in the health sector, comprehensive measures aimed at promoting disease prevention and public health policies as well as ensuring primary healthcare provision at an early and less costly stage have not yet been taken. In the short term, accurate budget planning and implementation in hospitals to ensure clearance of arrears remains an important challenge. While the long-term sustainability of the pension system was addressed in the recent reforms, its short to medium sustainability challenges remain unaddressed.
	Recommendations
	Ensure the long-term sustainability of the health sector, without compromising access to primary healthcare.
RO	**Whereas**
	Health outcomes in Romania are poor. Life expectancy at birth is well below the EU average for both men and women. Access to healthcare and over-reliance on hospital care remain major concerns. Widespread informal payments reduce access to healthcare for people with low incomes. Romania has adopted measures to improve access to healthcare for low-income pensioners and people in remote and isolated communities. A network of social and health mediators is being developed and a draft law on community services has been proposed. The deinstitutionalisation of people with disabilities remains a challenge. Romania has taken action to address the low funding of the healthcare system and its inefficient use of public resources. These reforms included clearing arrears in the health sector, increasing the sustainability of pharmaceutical spending, implementing e-health solutions, improving the funding of the health system,

	devising a strategy to shift resources from hospital-based care towards preventive and primary care, and centralised procurement procedures. However, the lack of administrative capacity is delaying implementation of the 2014-2020 national health strategy. In particular, the efficiency of the health system is constrained by delays in streamlining the hospital sector and switching from inpatient to more cost-effective outpatient healthcare. Employment, social, health-care and educational outcomes are lower in rural areas and people face much lower access to education, medical services, basic utilities, and public services due to low and fragmented local administrative capacity.
	Recommendations
	Curb informal payments in the healthcare system and increase the availability of outpatient care.
SI	**Whereas**
	It is essential that Slovenia tackles risks to fiscal sustainability stemming from increasing pressures on its health care and pension systems and reduces the increased public debt. Further reduction of obstacles to investment is required, particularly in the area of public administration. There is a need to strengthen the involvement of social partners in policy design and implementation of structural reforms in particular on pensions, health, long-term care and labour market policies. There is significant scope for increasing the cost-effectiveness of the healthcare system by strengthening the measures for improving primary care as a gate keeper, shifting from in-patient to outpatient care, improving the efficiency and governance of hospitals, improving contracting and payment processes for health services, developing better cost information for the adjustment of the imported diagnosis-related groups, and further development of a quality monitoring framework. The proportion of joint procurement is low and there is a strong focus on the 'lowest price' award criterion. A comprehensive review of the health care system has been completed and the Resolution on the National Healthcare Plan 2016-2025 was adopted by the Government at the end of 2015 and by the Parliament in March 2016. The Resolution represents a strategic plan for the development of the healthcare system. Some of its measures are being implemented, while proposals for other key binding implementing measures are in preparation and are yet to be presented. It also remains unclear whether the reform will address key issues such as in-built automatic stabiliser schemes, which would cushion revenue fluctuations over the business cycle or the access and quality of service provision. The adoption of the Long-term Care Act and the Healthcare and Health Insurance Act has been repeatedly delayed and the current roadmap for their adoption appears to be optimistic for the second half of 2016.
	Recommendations
	Complete and implement the reform of the long-term care and healthcare systems,

	making them more cost-efficient to ensure long-term sustainability of accessible and quality care.
SK	**Whereas**
	The long-term sustainability of public finance in Slovakia remains a challenge. This is mainly due to the projected growth of ageing-related costs on healthcare and pensions. Healthcare expenditure is the main driver of ageing-related costs. Public healthcare expenditure is projected to grow substantially in the long term, albeit from a comparatively low level. Despite some improvement, health indicators remain very low in Slovakia. To raise the cost-effectiveness of the healthcare sector, the Government has been taking measures in both inpatient and outpatient care. Efforts to introduce an integrated model of care continue. The success of this reform is likely to depend on ownership by the key stakeholders, the integration of healthcare centres and hospitals, and appropriate staffing. Despite measures adopted to limit a further build-up of debt in public hospitals, several are still in a poor financial situation. Challenges remain in fully reversing the negative expenditure trends, such as restructuring hospital capacity, introducing a prospective reimbursement system and increasing competition in public procurement in the area of healthcare. Regarding outpatient care, the weak gatekeeping role of general practitioners is partly due to a suboptimal division of competences between general practitioners and specialists and favours recourse to more costly specialised care.
	Recommendations
	Improve the cost-effectiveness of the healthcare system.
FI	**Whereas**
	Due to ageing of the population and a declining workforce, expenditure on pensions, health and long-term care is set to increase from 23,1 % in 2013 to 26,9 % of GDP by 2030. In January 2016, Finland enacted a pension reform that will link the statutory retirement age to changes in life expectancy as of 2027. Social and healthcare services, provided by the municipalities, amount to 10 % of GDP. Without reform of the system, that expenditure is forecast to grow by 2,4 % annually in nominal terms and increase as a share of GDP. The main outline of a far-reaching administrative reform and restructuring of healthcare and social services has been agreed.
	Recommendations
	Ensure timely adoption and implementation of the administrative reform with a view to better cost-effectiveness of social and healthcare services.

Notes and References

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