

2015 Country Specific Recommendations:

Misplaced Focus and the Omission
of Health Investment in the
European Semester

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Introduction

On 13 May 2015 the European Commission published the fifth edition of its country specific recommendations (CSRs), the centrepiece of the European Semester framework. The CSRs are a set of recommendations made to each member state (with the exception of those which are subject to an economic adjustment programme – namely Cyprus and Greece) and to the euro area as a whole. The recommendations lay out the measures which national governments should take in order to reach the goals of the Europe 2020 Strategy and to maintain the broader stability and growth of the EU.

In contrast to the recommendations issued in previous cycles and to the Country Reports, which inform the CSRs and were published in February, the 2015 CSRs have relatively little to say about health. Too vague to facilitate concrete implementation they fall short in promoting investment in health, in recognising the economic case for prevention and promotion, and in mainstreaming health into the top levels of EU governance. In seeking to reduce the scope of the recommendations, the Commission has undone the progress made to date in improving the relevance, applicability and value of the health-related CSRs.

EPHA calls upon the Commission, the legislature and relevant stakeholders to ensure that the 2016 Semester cycle works for the promotion of health as a vital component of sustainable societies. This analysis takes a closer look at the health in the 2015 CSRs, its implications in the broader context and some points of concern, before offering a series of policy recommendations to inform Council and European Parliament discussion, member state implementation and Commission preparation of the 2016 Semester cycle.

What is the European Semester?

The European Semester is an annual program of interventions which coordinate economic policy and structural reform in member states¹. First trialled in 2011, it integrates a range of existing measures, such as the economic-priority setting mechanisms of the [EuroPlus Pact](#), as well as absorbing several elements of the ‘Six Pack’ legislation, in pursuit of the goals set by the [Europe 2020 agenda](#). The Semester frames EMU processes so that the first half of the year is dedicated to coordination at the EU level, whilst the second half is reserved for the incorporation of EU objectives and requirements into national budgets. It was introduced in response to failings in the implementation of the ‘3% and 60% criteria’ contained in the [Stability and Growth Pact \(SGP\)](#). The SGP required that national governments keep deficits within 3% of GDP and public debt within 60% of GDP but, when exceeding these limits, governments commonly blamed a lack of country-specific context and consideration in these ‘one size fits all’ parameters. As a solution, the Commission introduced the [European Semester](#) to facilitate a tailored and holistic approach to maintaining fiscal stability.

The cycle begins with the release of the [Annual Growth Survey \(AGS\)](#), which highlights the economic policy priorities of the EU and advises national governments as to how best

¹ For a more detailed account of the European Semester and its various components, see the EPHA Call to Action, April 2013.



to achieve the goals of Europe 2020 and the [Alert Mechanisms Report \(AMR\)](#), which uses a scoreboard of indicators to identify countries with fiscal situations which require more in-depth assessment. For national governments, the AGS defines the parameters of what must be addressed in the [National Reform Programmes \(NRPs\)](#) and the [Stability and Convergence Programmes \(SCPs\)](#), which are drafted in the next phase of the Semester.

The NRPs, which outline planned structural reforms, and the SCPs, which address fiscal strategies, are drafted by member states and submitted to the Commission at the same time (around the end of April). The SCPs form the preventative arm of the SGP and are concerned with the situation of member states' public finances. The NRPs outline national governments' progress towards the headline targets of the Europe 2020 Strategy and are based upon the priorities identified in the AGS and the Integrated Guidelines.

The [Country Specific Recommendations \(CSRs\)](#) are the final stage of the 'European' element of the Semester – national governments must now use them to inform their domestic policy debates. They build upon the AGS, NRPs, SCPs and are also informed by analyses conducted by the [Social Protection Committee \(SPC\)](#), the [Economic Policy Committee \(EPC\)](#), the [Economic and Financial Committee \(EFC\)](#) and the [Employment Committee \(EMCO\)](#), as well as the various reports, statements and conclusions issued by the European Parliament and the Council of the EU.

After the adoption of the CSRs by the Council, national governments take the summer months to incorporate the recommendations, along with the AGS, NRPs, SCPs and other Semester documents, into their national budgets. For euro area countries, these are presented in draft form to the Commission by 15 October each year. The Commission then assesses the content of the proposals in light of each state's implementation of the previous year's CSRs and its progress towards its [medium term objective \(MTO\)](#) under the preventative arm of the SGP, publishing its own opinions in November.

In the 2015 AGS, published in November 2014 for the coming year, the new Commission, led by Jean-Claude Juncker, stated its intention to revise the way in which the Semester operates. Following four cycles of low-level implementation and significantly expanding scope for the recommendations, the new approach aims to focus on just the key priority areas with measurable targets and to increase national ownership by ensuring better involvement of national governments and other stakeholders in the drafting process. In practice, this has meant that the [staff working documents \(SWDs\)](#), normally published as a supplement to the CSRs in May, have been reformulated as [Country Reports](#) and are now published in February. They present the analysis upon which the CSRs will be based, giving time for stakeholders to read, critique and engage with the ongoing drafting process. The new approach has also resulted in fewer recommendations and less detail than seen in previous years. Though the level of depth covered by the Country Reports has remained significant, this has not been carried through to the recommendations themselves.



Who is involved in the process?

There is very little formal involvement of stakeholders in the European Semester process. The framework has undergone a recurrent revision during its five cycles to date, offering a small increase in the role of the Parliament, better involvement of other DGs in the Commission and, in the latest cycle, providing a timeframe more amenable to stakeholder engagement. However, the majority of input and drafting is the responsibility of [DG ECFIN \(Economic and Financial Affairs\)](#) and the various committees of the Council. The [European Policy Committee \(EPC\)](#), set up to advise the [ECOFIN \(economic and financial affairs\) Council](#) and the [Social Protection Committee \(SPC\)](#), set up to advise the [EPSCO \(employment and social affairs\) Council](#) provide analyses of the quality and sustainability of public finances and the implementation of social protection and social inclusion elements of the CSRs. Similarly, the [Economic and Financial Committee \(EFC\)](#) prepares analyses of economic and fiscal policies whilst the [Employment Committee \(EMCO\)](#) contributes to the [Employment Guidelines](#), multilateral surveillance and reporting, the Joint Employment Report and a host of other processes tied to the Semester. All four committees were established to advise the Council and the Commission upon request.

Within the Commission, DG ECFIN takes the lead on drafting the recommendations and various supporting reports, but is increasingly supported by [DG Santé \(health and food safety\)](#), [DG Empl \(employment and social affairs\)](#) and other DGs with relevant expertise. This is informally structured as part of an ongoing consultation and feedback process. In the case of the CSRs, the main output of the Semester, once the Commission has agreed and published its proposals, the Council organises debates and adopts conclusions within its various configurations, whilst the Parliament commonly produces reports and statements on the Commission text. Crucially, the Council's 'consulting' activities are accounted for in the formal process and it has the power to amend the Commission's proposals; the Parliament does not enjoy the same influence. Its formal role is restricted to a 'dialogue on economic priorities' – widely understood to be of little significance – and ex post facto debates and resolutions.

For other stakeholders, such as civil society, industry associations, social partners and non-governmental organisations (NGOs), formal participation is similarly unstructured. Whilst they are not excluded from the process explicitly, such stakeholders often lack the resources and expertise necessary to engage effectively. Perhaps even more concerning is the reality that, since there is no barrier to the involvement of interest groups, those who do succeed in influencing the process tend to be those with greater resources – in the case of health, this has predominantly been the pharmaceutical industry. EPHA issued a call for greater health actor involvement in the European Semester in 2013 but to date, capacity for participation had proven low².

A final procedural issue, exacerbated by the poor framework for stakeholder involvement, concerns the quality of analysis being used by DG ECFIN to construct the draft recommendations. This is characterised by inconsistent data from national settings, indicators which focus on outcomes rather than experience and simplistic definitions of complex terms such as 'sustainability'. Whilst some of these factors are beyond the control of ECFIN and its limited resources make more rigorous analysis difficult, some of the methodological weaknesses could be addressed through collaboration and sustained dialogue with other stakeholders. In particular, ECFIN fails to recognise, because it is not

² See EPHA Call to Action, April 2013.



represented in the dominant fiscal paradigm within which it operates, the economic argument for investing in health. The Belgian CSR notes the need for investment in road and rail infrastructure to support growth, yet the same argument is ignored in the case of health. Closer collaboration with DG Santé and the wider health community could strengthen the analysis and resulting recommendations in this area.

How is the Semester relevant for health?

When seeking to assess the financial sustainability of a country's finances the logical focus will fall upon those areas where expenditure is highest and increasing. In Europe, this inevitably suggests pensions, health and long-term care. Eurostat data from 2011 finds that healthcare expenditure exceeds 10% of GDP in six EU member states, whilst the latest OECD figures find that average health spending in OECD countries totals 9.3% of GDP³. Furthermore, the Commission's recent Ageing Report anticipates that the ageing of European populations will result in a further spending increase of 2% of GDP by 2060⁴. In light of these pressing challenges facing the sustainability of health and long-term care systems, the Council has urged national governments to fully implement the relevant CSRs, confirming the Semester's role in controlling these areas of expenditure growth⁵.

The Semester also fits in to the broader context of EU health policy-making. It is the implementing mechanism of the [Europe 2020 Strategy](#) – though the poor linkages between the CSRs and the goals of Europe 2020 have been criticised in previous cycles – and forms part of the renewed focus upon [Health System Performance assessment \(HSPA\)](#). The data and analyses used in the Semester will likely inform HSPA activities and vice versa, and work continues to improve the collection of comparable data for these purposes (the SPC subgroup on indicators, for example, is building upon work done in the open method of coordination to improve the range and quality of social indicators available for analysis). Since these strands of activity are at different stages of development, there is as yet limited linkage between them – ensuring coordination will be crucial to the success of these instruments in facilitating effective health system reform.

Establishing the impact of health-related CSRs upon national policy is inherently difficult. Policy interventions in any sector take time to conceive, design and implement, and often experience a long delay before producing an impact upon the targeted indicator. Moreover, the CSRs in health are commonly used by individual ministries to support policy actions already underway or to put pressure on national governments to implement an existing policy decision, so assigning causation is problematic. In the current climate of conservatism towards Europe, governments are unwilling to be pressured into specific policy measures by mechanisms such as the Semester.

Surface-level evaluations of the measures taken by governments to implement the CSRs are made each year by the Commission and generally indicate a low level of compliance, but the non-binding nature of the CSRs should not be mistaken for an indication that they are ignored or irrelevant. Firstly, for those countries subject to economic adjustment programmes, the CSRs are binding conditions of bailout funding, whilst for euro area countries, draft budgets must now be approved by the Commission and are inherently

³ See [Eurostat Healthcare Statistics 2014](#) and [OECD Health Statistics 2014](#).

⁴ [2015 Ageing Report](#), European Commission.

⁵ [Conclusions on the 2015 Ageing Report](#), Council of the EU.



based on Semester analyses. For countries which don't fall into these categories the CSRs remain non-binding, but there is growing evidence of their 'soft' power in changing behaviour. Accepting that criticisms can be made of the methodologies used and conclusions reached, the Semester recommendations remain the 'best available guess' at how to ensure that the economic and financial crisis is not repeated.

It is important to note that the legal mandate upon which the Semester, and to some extent the EU as a supranational body, is based does not permit the Commission to involve itself in the quality or accessibility of national healthcare systems. This is the primary reason that the CSRs fail to address these elements with the depth that is necessary to affect positive health outcomes. However, where 'mandated' interventions impact negatively upon health outcomes it is imperative that a 'governance for health' approach be adopted and health be understood beyond the context of its short-term financial cost.

Health in the 2015 Country Specific Recommendations

The 2015 CSRs reverse the trend seen in previous cycles of the Semester and offer not only fewer health-related recommendations, but also less detailed guidance for national governments. This year just 11 states received a recommendation relating to health. By comparison 19 received recommendations relating to health in 2014, 15 in 2013, six in 2012 and four in 2011, when the Semester process was first introduced⁶.

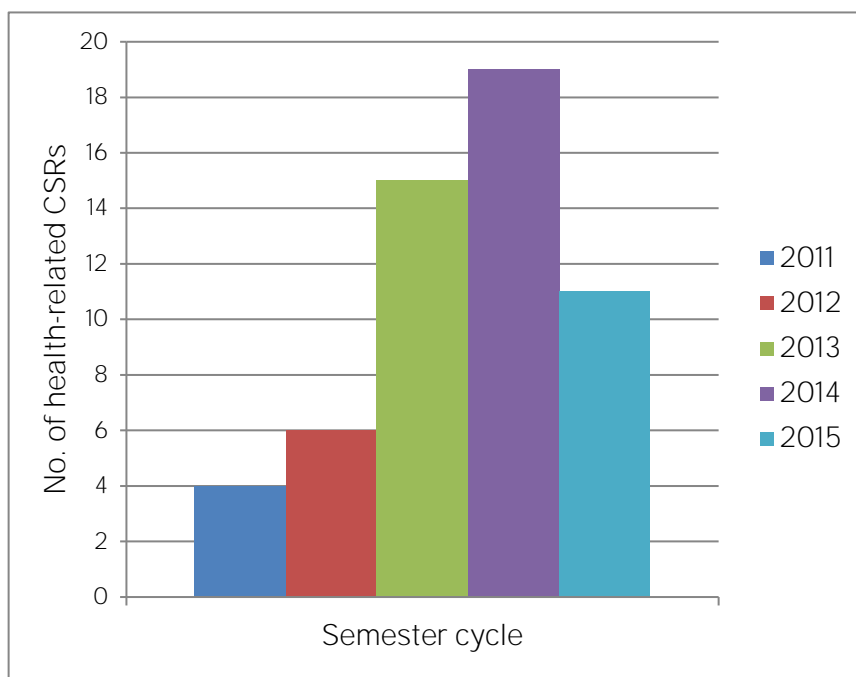


Figure 1: Number of health-related CSRs issued from 2011-2014

(Adapted by author from source, see footnote 1).

⁶ Azzopardi-Muscat, N., Clemens, T., Stoner, D. and Brand, H. (2015) 'EU Country Specific Recommendations for health systems in the European Semester process: Trends, discourse and predictors' Health Policy Volume 119 pp. 375-383. Excluding countries subject to an Economic Adjustment Programme (EAP) or a Memorandum of Understanding (MOU).



As regards level of detail, the 2015 Country Reports contained the most in-depth assessment of national health systems seen to date, analysing the balance between primary and secondary care, trends in health workforce and professional migration, gains to be made from implementing eHealth solutions and quality of care, among other topics. Of the vast range of issues covered in the Country Reports, however, only a scarce few have made it in to the CSRs. Two countries received recommendations relating to the level of pharmaceutical spending (IE, ES) and a further three received guidance aimed specifically at hospitals or the in/outpatient sectors (BG, LV, SK). Only two countries received a recommendation relating to long-term care or ageing (AT, SI), compared to 15 references in the Country Reports, whilst mention of growth-friendly taxation and shifting the tax burden towards bases such as consumption was made in just seven cases (BE, FR, DE, IE, LV, LT, LU), compared to 18 in the Country Reports. Reference to Roma populations remains stable, but pertains to education, poverty and employment, rather than health.

Category	No. of 2015 CSRs which contain mention	No. of 2015 CSR preambles which contain mention	No. of 2015 Country Reports which contain mention ⁷
Health cost-effectiveness or spending	11	12	20 (health addressed as one category)
Pharmaceutical market policies	2	3	N/A
Specific inpatient/outpatient care or hospital services	3	8	N/A
Long-term care or ageing	2	8	15
Roma inclusion	5	5	6
Growth-friendly tax	7	6	18

Figure 2: Content analysis, 2015 Country Specific Recommendations.

Discrepancy is also seen between the mentions of health made in the preamble of the recommendation documents and the final guidance issued. In some cases, the preamble provides detailed examination of the hospital sector or the system for long-term care but suggestions as to how the given problem might be addressed are not picked up in the final recommendations.

Specific health references

The language in the recommendations is narrow and repetitive. Reference is made in most CSRs to expenditure, reform, sustainability, cost-efficiency, structural challenges, rationalisation and cost-containment. Less commonly, the preambles discuss corruption, governance, outcomes and access in health. Long-term care provision, ageing populations and age-related expenditure feature in a few CSR documents, doubtlessly influenced by the Commission's recent report on the cost implications of ageing in the

⁷ See EPHA Analysis of the 2015 Country Reports, available at www.eph.org/a/6316.



EU⁸. Concerning the Roma population, language focuses on education, employment, poverty and social exclusion whilst reference to growth-friendly taxes and shifting of the tax burden, though not often reflected in the recommendations, can be seen in the preambles.

Conspicuously absent are references to investing in health, disease prevention and health promotion, improving health outcomes, healthy tax systems and the impact for health of other recommendations. This reflects the narrow paradigm within which the recommendations are drafted, whereby health is treated purely as an expenditure item and not as a sector contributing to wealth in its own right.

The Belgian CSR does not mention health specifically but puts emphasis on the need to shift the tax burden to **'less growth-distorting tax bases'**. The preamble notes that 'consumption tax is one such base which could be broadened and recognises that it could '...support employment, competitiveness and social and environmental objectives'. The French and Luxembourgish recommendations encourage similar action to **broaden the tax base** on consumption whilst the German, Irish and Hungarian preambles all note scope for more growth-friendly revenue structures.

Detailed analysis, though reduced from last year, is included in the preamble of some CSRs. For example, the Austrian text states that 'more patients should be treated in **multidisciplinary outpatient care settings** and the average length of stay for inpatient treatment should be lowered further'. The Bulgarian text, which contains a lengthy preamble section devoted to the healthcare system, identifies the **'oversized hospital sector'** as a core problem and describes the contractual obligation upon the healthcare fund to reimburse hospitals at predefined prices as 'incentivising...inadequately targeted medical care'. The final recommendation encourages Bulgaria to **'review the pricing of healthcare.'** Another specific reference is made in the Czech preamble, which notes that 'general practitioners are not adequately fulfilling their role as gate-keepers'. Meanwhile, the French CSR makes reference to the **'numerus clausus'** principle for access to health professions', which it says is hampering access to services and should be reviewed.

Other detailed provisions are made in the Irish preamble. It advises **'effectively rolling out e-health tools, activity-based funding and improved prescription practices'** as areas where cost-effectiveness might be increased. The latter point is also picked up in the final recommendation, which urges the gradual implementation of 'adequate prescription practices'. The Lithuanian text identifies the 'poor performance of the healthcare system', specifically highlighting the high number of hospital beds per capita, **high frequency of informal payments and corruption** in public procurement. It also states that investment in the health sector remains low. Conflict of interest and corruption in the health sector are noted in both the Latvian and the Lithuanian texts, though these are not specifically drawn upon in the recommendations. In Romania, a high reliance on in-patient services, an **'extensive inefficient hospital network'** and 'weak and fragmented referral networks' are identified as threats to the long-term sustainability of public finances. Meanwhile, concerns raised previously about informal payments and **low accessibility**, efficiency and quality are reiterated. The Slovakian recommendation calls for better management of hospital care and the strengthening of primary care.

As might be expected, frequent reference is made to health expenditure. The Croatian preamble encourages the government to **'rationalise hospital funding'**, whilst the Czech

⁸ See EPHA reaction to 2015 Ageing Report [here](#).



text identifies a need to improve both the cost-efficiency and governance of healthcare. In France, [cost-containment](#) in pharmaceutical prices is identified as a key area for improvement, though this is not carried through into the final recommendation. Similarly, the Irish CSR recommends a reduction in spending on patented medicines and the Spanish CSR notes a draft law currently in front of the Parliament to introduce a [spending rule on pharmaceuticals](#), which the recommendation states should serve to ‘rationalise’ pharmaceutical expenditure.

In the Latvian case, the government requested a temporary deviation from the adjustment to its medium-term objective on account of the [major structural reform](#) of the healthcare sector which it has undertaken. Whilst recognising the positive impact that the reform is likely to have on growth and long-term sustainability, the Council concluded that Latvia does not fulfil the requirements for a deviation. In the preamble, the analysis highlights a ‘high out-of-pocket payments, inadequate focus on performance incentives and efficiency’ and ‘lack of care coordination’ leading to ‘reduced access of large proportion of the population’.

[Reform of health systems](#) is a recurring theme in other countries’ recommendations too. The Finnish preamble notes the recent reform bill, which lapsed in the Parliament, and the recommendation urges the government to ensure effective design and implementation of reforms in social and health services. The Irish text notes recent efforts but states that the country needs ‘[deeper structural reforms](#)’ in order to contain costs in the face of an ageing population. Pursuit of ongoing reforms is also encouraged in the recommendations for Romania and Slovenia.

Long-term care is listed as a concern in the Luxembourgish preamble, which notes that the insurance fund is projected to run a deficit in 2015. In the Maltese case, the preamble states that ‘the increased demand for [informal long-term care](#)...may be preventing older women from seeking work in the labour market’, whilst in the Netherlands, it notes that ‘[the quality and accessibility of long-term care needs to be monitored.](#)’ The Slovenian preamble encourages ‘refocusing care provision from [institutional to home care](#)’ and encourages long-term care reform.

These common themes reflect the shift back to the vague and financially-centred recommendations seen in the early cycles of the Semester. Reference to quality, access and outcomes is minimal, with emphasis instead falling on structural reform, cost-containment and expenditure.

The broader context and points of concern

The goals of the Commission’s new approach to the Semester are laudable. The euro area CSR for 2015 notes that implementation of reforms set out in previous recommendations has not been sufficient – this is logically exacerbated by minimal involvement in drafting and the setting of vague recommendations without practical application. Many of the recommendations made in health have been well-directed but have lacked the logistical details necessary for implementation. Addressing this issue is a core element of making the Semester function better.

However, the 2015 CSRs, in their bid to be more focused and fewer in number, have returned to [the vague and impractical style of recommendation](#) seen in the past.



Croatia, for example, has been issued a recommendation to 'tackle fiscal risks in healthcare'. Similarly, Lithuania is to 'improve [...] the performance of the healthcare system' whilst Spain is to 'improve the cost-effectiveness of the healthcare sector.' In some of these cases the preamble outlines some specific concerns – for instance in Lithuania, an imbalance in the provision of care is identified – but most countries are left with a broad statement of an often well-acknowledged problem and little in the way of guidance on solutions. In addition to reducing the value and legitimacy attached to the Semester process, this approach does nothing to serve the stated goal of improving the focus and measurability of the CSRs.

A key topic missing from the 2015 CSRs is [investment](#). No mention is made either of the contribution of health towards the goals of the Europe 2020 Strategy, nor of the need to invest in health in order to achieve the objectives listed in the CSRs. Bulgaria, Latvia, Lithuania and Romania all receive CSRs this year which note low levels of funding or, in the case of Lithuania, low public investment in the health sector, but none of them encourage government investment to address this issue. Furthermore, within the recommendations made to those four countries, governments are advised to strengthen outpatient and primary care, reduce out-of-pocket payments and remedy poor accessibility – all of which require investment in the health sector and the infrastructure supporting it. This omission reflects the dominant paradigm within which DG ECFIN operates and the political bias which results from drafting health-related recommendations within such a paradigm. Though CSRs urging investment in transport infrastructure for growth are common, the corresponding case for investment in health is undervalued. This approach runs contrary to the schools of economic thought which prevail in many European countries and results in an unbalanced taxing-spending model.

A final issue concerns the [inefficient linkage](#) between different parts of the recommendations. As noted above, calls for budget neutrality and reductions in public spending are often incompatible with recommendations to improve the performance of the healthcare system. Similarly, calls to increase labour market participation, both in the general population and in specific social groups, are not complimented by the necessary health system measures to facilitate this increase in productivity or by reference to the health sector as an employer. This is particularly the case in recommendations pertaining to Roma communities, which focus upon employment and education, but not the health measures needed to enable individuals to participate in the labour market and education system. The governance for health principle, requiring the mainstreaming of health at the top levels of EU and national governance, is vital to ensure that such policy contradictions are avoided and health is promoted using the full range of available policy levers.



Looking ahead: Policy recommendations

In light of the 2015 CSRs, EPHA offers the following policy recommendations ahead of consideration of the draft CSRs by the legislature, implementation by member states and preparation of the 2016 Semester by the Commission.

For Council of the EU and European Parliament discussions:

- Emphasise and strengthen the link between the recommendations and the goals of the Europe 2020 Strategy, ensuring that the latter are the focus of the CSRs and that employment and social objectives are pursued equally.
- Support and strengthen the health-related aspects of the CSRs by adding concrete measurement tools and feasible targets which supplement the Commission's overarching goals.
- Foster a balanced combination of social and economic priorities in the CSRs by assessing the potential indirect implications of economic measures and ensuring the necessary social mechanisms are also highlighted.

For national implementation:

- Carefully integrate health-related and other CSRs whilst being mindful of the impact upon health and well-being from their interaction with one another and with domestic policy mechanisms.
- Identify ways to measure and monitor implementation of the CSRs to better inform comprehensive assessment of key indicators and progress over time.
- When designing implementing measures, focus on the potential of the health sector for jobs and long-term economic sustainability, and not solely as an expenditure item. Invest in health to promote productivity and growth.

For European Commission preparation of the 2016 European Semester:

- Ensure that the next cycle of the Semester embraces a governance for health approach, so as to avoid damaging policy contradictions and to utilise the full range of tools available to improve health outcomes.
- Give greater primacy to disease prevention and health promotion, particularly among groups at risk of vulnerability, with the goal of moving towards long-term sustainability in health systems and societies.
- Use the 2016 Semester to encourage investment in health, targeting human and physical resources, as well as the infrastructure which supports health and long-term care systems.
- Continue to develop and improve the framework for dialogue with stakeholders, including the European Parliament, national parliaments, social partners and civil society.



Further information

The full list of Country Specific Recommendations submitted by the Commission can be found on the European Commission [website](#), along with the accompanying [Communication](#).

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

- [Health in the **2013 country specific recommendations**](#)
- [Health in the **2014 country specific recommendations**](#)
- [Health in the **Europe 2020 Strategy**](#)
- [Health in the **2014 annual growth survey**](#)
- [Health in the **2015 annual growth survey**](#)
- [Health in the **European Semester**](#)



Annex

European Semester Timeline

November	European Commission	Publishes annual growth survey (AGS) Publishes alert mechanism report (AMR) Publishes opinion on draft budgetary plans (DBPs)
December	European Commission and national governments	Bilateral meetings with member states
	National governments	Adopt national budgets
January	European Commission	Fact-finding missions to member states
	Council Eurogroup	Adopts conclusions on AGS and AMR
February	Commission	Publishes Country Reports
March	European Council	Adopts economic priorities based on AGS
	European Parliament	Dialogue on economic priorities
April	National governments	Publish national reforms programmes (NRPs) and stability and convergence programmes (SCPs)
May	European Commission	Proposes country specific recommendations (CSRs)
June	Eurogroup Council	Discusses CSRs
	European Council	Endorses CSRs
July	European Council	Adopts final CSRs
August and September	‘The National Semester’	
October	National governments	Present draft budgetary plans
	European Parliament	Debate and resolution on Semester and CSRs

About EPHA

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

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european **public health** alliance

www.eph.org

Rue de Trèves 49-51
1040 Brussels
BELGIUM

TEL: +32 (0) 2 230 30 56

FAX: +32 (0) 2 233 38 80

MAIL: epha@eph.org