Universal Health Coverage, Sustainable Development and the Pillar of Social Rights:

Implications and Opportunities for the European Public Health Alliance

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european public health alliance

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Executive summary

This report outlines the rationale for and primary considerations of a formal link between the health target of the Sustainable Development Goals (SDGs) and the health-related commitments contained within the proposed text of the European Pillar of Social Rights (EPSR). It does so in light of the two pressing policy agendas which face the European Union (EU) in the second half of 2016 – the commitment to a 'fairer and deeper' economic and monetary union (EMU) and the need to implement the United Nations' (UN) SDGs. Specifically, it focuses on the potential role of the EPSR in helping member states achieve their SDG targets on the provision of universal health coverage (UHC) and the reduction of premature mortality from non-communicable diseases (NCDs), and the relevance of these targets for the EU's existing goals under the Europe 2020 Strategy and the strengthened macroeconomic governance framework. It argues that, since both the SDGs and the macroeconomic governance framework require action on UHC and the reduction of NCDs, the EPSR is the most appropriate tool for ensuring effective and coherent implementation.

After reviewing the policy context and health-related objectives of the EPSR and the SDGs, the Report goes on to explore the role of UHC and action to tackle NCDs in reducing health inequalities, improving health outcomes and strengthening health system sustainability. It concludes with a series of policy recommendations.

Recommendation 1: Clarify the language of the EPSR

Though universal coverage, disease prevention and health promotion are all mentioned in domain 12 and its preamble, the EPSR must make an explicit commitment to achieving genuine UHC and tackling the rising prevalence of NCDs.

Recommendation 2: Define the EPSR within the context of the macroeconomic governance framework

Ensuring the relevance of the EPSR and facilitating its contribution to a 'deeper and fairer' EMU is best achieved by locating it within the context of the macroeconomic governance framework.

Recommendation 3: Frame UHC as a lever to tackle broader inequalities

UHC should not be considered a 'silver bullet' for health systems. Rather, it must be framed as a means to the end of improving health outcomes and reducing health inequalities, not as a narrowly-defined goal in itself.

Recommendation 4: Map and appraise existing indicators

Assigning appropriate benchmarks and monitoring frameworks is crucial to ensuring implementation of the EPSR (and through it, the SDGs) – this is most efficiently achieved by building on the variety of indicators and reporting mechanisms already in place.

Recommendation 5: Step up action on NCDs

Despite its scale and immediacy, the NCD burden is noticeably under-prioritised in EU policy frameworks. The EPSR provides a valuable opportunity to address this weakness and make progress towards reducing health inequalities across Europe.

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1. Introduction

In the second half of 2016, there are two prominent and pressing agendas which require European Union (EU) action. Firstly, the Union institutions must respond to the mid-term review of the Europe 2020 Strategy and make progress towards a 'deeper and fairer' economic and monetary union (EMU). Secondly, they must move to solidify the reputation that the EU has gained as a key player in the post-2015 global development agenda, and put forward a strategy for integrating its commitments under the Sustainable Development Goals (SDGs). This report makes the case for exploiting the synergies in these two agendas and formally linking the health targets within the SDGs and the health-related commitments contained in the proposed European Pillar of Social Rights (EPSR). More specifically, it focuses on the potential role of the EPSR in helping member states achieve their SDG targets on the provision of universal health coverage (UHC) and the reduction of premature mortality from non-communicable diseases (NCDs). It argues that, since both the SDGs and the economic governance framework require, either directly or indirectly, action on UHC and NCDs, the EPSR is the most appropriate tool for ensuring effective and coherent implementation.

Almost a year since they were adopted by the United Nations (UN) General Assembly, the EU has still not put forward a strategy for implementation of the SDGs. The Goals require both external and internal policy action across a wide range of sectors, as well as precise and detailed monitoring at national, regional and global level. For health, core public health targets around air pollution, tobacco control, alcohol abuse and access to medicines require integrated, 'whole government' approaches, whilst fundamental tools of disease prevention and health promotion, including the provision of UHC, need to be embedded as necessary precursors to healthy, wealthy and peaceful societies. The EU has at its disposable a range of policy frameworks within which such targets can be integrated, but has yet to agree on a comprehensive plan for implementation.

At the same time as addressing its global health role, the EU is seeking to revive progress towards the Europe 2020 targets, hampered to date by the legacy of the economic crisis. To ensure that the strengthening of EMU is not pursued at the expense of social objectives, the Commission has proposed, among other initiatives, a European Pillar of Social Rights, bringing together for the first time the social rights and objectives of the EU. These will inform action towards the Europe 2020 targets, providing a first glance overview of the social performance of individual member states, including the quality, accessibility, universality and cost-effectiveness of their health systems. The precise content of the EPSR and the most appropriate indicators by which to assess national performance are yet to be finalised but already there is significant overlap between existing objectives under Europe 2020, the Sustainable Development Strategy and the new targets contained in the SDGs.

This report explores these overlaps and argues for formal linkage between them. It first introduces and contextualises the central policy frameworks – the EPSR and SDGs – highlighting their health-related aims and objectives and the common relevance of UHC. Chapter four explores UHC in more detail, assessing the role of UHC and action to tackle NCDs as crucial levers for reducing health inequalities, improving health outcomes and contributing to the long-term sustainability of health systems. Chapter five brings the above elements together to make the case for targeting UHC as a link between the EPSR and the SDGs. A final section presents a series of tangible policy recommendations for making such a link operational.

2. The European Pillar of Social Rights

2.1 What is the European Pillar of Social Rights?

The European Pillar of Social Rights (EPSR) is a collection of the social objectives and rights which apply to citizens and third-country nationals residing within the European Union (EU). The rights within it are not new, nor are they modified versions of pre-existing ones; rather, the Pillar collects together the various relevant strands of the acquis communautaire and identifies the fundamental common principles of social and employment policy in EU member states[1]. The aim of the Pillar, by consolidating these principles in one comprehensive list, is to support action to foster a 'fair and truly pan-European labour market' and to provide a reference point for assessing the social and employment performance of member states[2].

Divided into three main sections – equal opportunities and access to the labour market, fair working conditions, and adequate and sustainable social protection – the Pillar lists 20 policy domains, each of which concern a specific element of labour markets and welfare systems (Figure 1). In each domain, the Pillar identifies the rights and objectives which currently exist in the founding treaties, the Charter of Fundamental Rights and the case law of the Court of Justice, as well as in international social policy instruments from the Council of Europe, the International Labour Organization (ILO) and others.

Figure 1: Policy domains of the proposed EPSR, by chapter

Chapter I: Equal opportunities and access to labour markets
1. Skills, education and lifelong learning
2. Flexible and secure labour contracts
3. Secure professional transitions
4. Active support to employment
5. Gender equality and work life balance
6. Equal opportunities

Chapter II: Fair working conditions
7. Conditions of employment
8. Wages
9. Health and safety at work
10. Social dialogue and involvement of workers

Chapter III: Adequate and sustainable social protection
11. Integrated social benefits and services
12. Healthcare and sickness benefits
13. Pensions
14. Unemployment benefits
15. Minimum income
16. Disability
17. Long-term care
18. Childcare
19. Housing
20. Access to essential services

The EPSR was first described by European Commission President, Jean-Claude Juncker, in his 2015 State of the Union speech. It forms a central part of the Commission's ambition

[1] Annex to the Communication launching a consultation on a European Pillar of Social Rights, COM (2016) 127 final 8.3.2016. Available here [accessed July 2016].
[2] Speech to the European Parliament by European Commission President Jean-Claude Juncker, 9 September 2015. Available here [accessed July 2016].

to earn a 'social triple A' – performing as well in areas of social protection as in economic and financial sustainability[3]. In March 2016, the Commission published its proposal for a Pillar of Social Rights and opened a public consultation on its contents, which remains available until the end of the year[4]. The purpose of the consultation is to assess the existing social acquis, reflect upon changes to the reality of working life and social conditions, and to gather views on the role, scope and content of the Pillar as a feature of a 'deeper and fairer' economic and monetary union (EMU). Once finalised, the Pillar will form the basis of further activity to modernise existing social legislation and encourage upward convergence of social and employment benchmarks in the euro area.[5]

2.2 Health in the proposed European Pillar of Social Rights

As seen in Figure 1, the EPSR contains a dedicated policy domain for health (domain 12), but also a number of tangential domains which concern health less directly (such as domains 9, 11 and 17). Though the rights enumerated in domain 9 (health and safety at work), 11 (integrated social benefits and services) and 17 (long-term care), for example, are important facets of healthcare policy, this report takes a health systems approach and, for clarity, focuses on the health-related rights included in domain 12 (parts (a) and (b)). The full text of these is presented in Fig 2.

The rights and principles enumerated in Figure 2 are collected from the Charter of

Figure 2: Domains 12(a) and 12(b) of the proposed EPSR

12. Healthcare and sickness benefits

a) Everyone shall have timely access to good quality preventive and curative health care, and the need for healthcare shall not lead to poverty or financial strain.
b) Healthcare systems shall encourage the cost-effective provision of care, while strengthening health promotion and disease prevention, in order to improve the resilience of healthcare systems and their financial sustainability.

Fundamental rights (Article 35 on the right to preventative healthcare, medical treatment, and ensuring a high level of human health protection, and Article 34 on the entitlement to social security benefits and services), and three main articles from the founding treaties – Article 151 TFEU (setting proper social protection as an objective), Article 153 TFEU (requiring the Union to support member states in social security and the modernisation of social protection systems) and Article 168 TFEU (the health article).

The Commission's 'preliminary outline' of the EPSR elaborates on the individual domains and the kind of measures anticipated under each. The preamble to domain 12 is focused on the financial sustainability of health systems and the collective pressures they face. It states that[6]:

[3] Speech to the European Parliament by European Commission President-elect Jean-Claude Juncker, 22 October 2014. Available here [accessed July 2016]; *Completing Europe's Economic and Monetary Union*, The Five Presidents' Report, June 2015. Available here [accessed July 2016].
[4] Communication launching a consultation on a European Pillar of Social Rights, COM(2016) 127 final 8.3.2016. Available here [accessed July 2016].
[5] The Pillar will initially be established within the euro area, but will also be open for other member states to join on a voluntary basis.
[6] Annex to the Communication launching a consultation on a European Pillar of Social Rights, Op Cit footnote 1, page 12.

> ***'Ensuring universal access to high quality care w***hile guaranteeing the financial sustainability of health systems, encouraging the cost-effective provision of care, and encouraging health promotion and disease prevention requires increased efforts in improving the resilience, efficiency and effectiveness of health systems, and can improve the ability of healthcare systems to cope with the challenges. Providing universal access to healthcare and addressing health inequalities will reinforce social cohesion and improve ***economic outcomes.'***

Read in conjunction with the proposed wording for the principles in domain 12, it encourages the strengthening of resilience, sustainability, quality and access in health systems, linking this to health promotion and disease prevention, universal access and the reduction of health inequalities.

2.3 The EPSR as a tool of macroeconomic governance

As noted above, the EPSR is one of a number of initiatives introduced by the Juncker Commission in pursuit of a 'social triple A' and as part of its commitment to strengthening the social dimension of EM. The key instrument identified for achieving this goal and putting social issues further up the EU agenda is the European Semester, the central mechanism of the post-crisis strengthened economic governance framework[7]. The Commission has already introduced a number of changes aimed at 'socialising' the Semester framework, including provisions for deeper employment and social analysis, and a strengthened role for the social partners. It has also added three new employment-based indicators to the scoreboard of the macroeconomic imbalance procedure (MIP) – the MIP is designed to spot weaknesses and instabilities within national economies before they cause problems, and now monitors domestic changes in the activity rate, the long-term unemployment rate and the youth unemployment rate, on top of its original 11 indicators.

In its conclusions of 7 December 2015, the Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council stated that a 'revamped European Semester' is needed in order to continue strengthening social governance and encouraging structural reforms which contribute to the improvement of social and employment outcomes[8]. The conclusions mention at several points the need to ensure that the tools of economic governance work towards the 'common employment and social objectives' and they include an invitation to the Commission to 'cooperate with the EMCO and the SPC on the elaboration of a Commission proposal to develop a European pillar of social rights.'

To date, no explicit link between the EPSR and the European Semester or the macroeconomic governance framework has been drawn by the European Commission. However, as the EU institutions continue to increase their surveillance, monitoring and collection of data at the national level, they will require indicators, benchmarks, and common objectives to guide their analysis. A coherent set of social rights, clarifying the overarching goals and responsibilities of the EU and its members, could provide a valuable point of reference. Moreover, if appropriately framed, it might contribute to the coherence

[7] See EPHA (2015) 2015 Country Specific Recommendations, available here [accessed August 2016].
[8] Council conclusions on social governance for an inclusive European Union, adopted 7 December 2015. Available here [accessed July 2016].

of the economic governance framework by feeding social considerations into the priorities outlined in the Annual Growth Survey (AGS) and pursued in the National Reform Programmes (NRPs) and Country Specific Recommendations (CSRs), as well as the further development of indicators and benchmarks for the Joint Assessment Framework (JAF), the Employment Performance Monitor (EPM), the Social Protection Performance Monitor (SPPM) and the overarching scoreboard of key employment and social indicators (see below). As such, establishing the EPSR as a supplementary part of the economic governance framework would ensure its relevance, aid its implementation and contribute to the strengthening of social priorities within the EMU.

2.4 The European Semester: in pursuit of sustainable health systems

The EU's macroeconomic governance framework, working primarily through the European Semester, seeks to increase the sustainability of health systems by improving their cost-effectiveness. In the early cycles of the Semester, this goal was pursued in narrow terms, with CSRs focusing on the reduction of health expenditure and the reform of service provision, to little or even damaging effect.[9] More recently, the Commission has acknowledged the need to ensure that social and health objectives are mainstreamed within the Semester process and that health be addressed not as an expenditure item, but as a prerequisite to the growth and jobs sought by the Europe 2020 Strategy. Integration of this viewpoint into the instruments of the Semester is progressing slowly but health-related CSRs now encourage structural reform of health systems to address inherent inefficiencies whilst maintaining access to high quality care, particularly for more vulnerable populations. Inconsistent requirements to 'rationalise' spending and reduce benefits packages whilst addressing health inequalities and combating poverty still prevail, but references to investing in health are on the rise[10]. Responding to concerning health expenditure projections in coming years, the CSR for Portugal states.[11]

> ***'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.'***

It goes on to recommend that Portugal 'Ensure the long-term sustainability of the health sector, without compromising access to primary healthcare'. Meanwhile, the Latvian CSR urges the government to continue with its reform of the health sector, including an increase in health expenditure and the introduction of UHC, so as to 'Improve the accessibility, quality and cost-effectiveness of the healthcare system'[12]. This is already a considerable improvement on the focus and language of the 2015 CSRs, which overlooked investment in health and instead focused on rationalisation and cost containment.[13] By contrast, the Portuguese and Latvian CSRs for 2016 make a clear connection between disease prevention and universal access to primary healthcare and the long term sustainability of health systems. The challenge for future cycles of the European Semester, supported by

[9] Azzopardi-Muscat et al. (2015) 'EU Country Specific Recommendations for health systems in the European Semester process: Trends, discourse and predictors' Health Policy Volume 119(3) pp. 375-383.
[10] EPHA (2016) Country specific recommendations 2016: What Is new?, available here [accessed August 2016].
[11] Council (2016) Recommendation for a Recommendation on the 2016 national reform programme for Portugal, available here [accessed August 2016].
[12] Council (2016) Recommendation for a Recommendation on the 2016 national reform programme for Latvia, available here [accessed August 2016].
[13] EPHA (2015) 2015 country specific recommendations: EPHA analysis, available here [accessed August 2016].

the EPSR, is to embed and build upon this link, ensuring that the macroeconomic governance framework contributes to both the protection and promotion of human health in the EU.

3. The Sustainable Development Goals

3.1 What are the Sustainable Development Goals?

In September 2015 the UN and its member countries adopted the 2030 Agenda for Sustainable Development, comprised of 17 Sustainable Development Goals.[14] The goals cover areas such as poverty, education, health and climate change, as well as peace, justice and access to strong governing institutions (Figure 3 3).

Figure 3: The Sustainable Development Goals

Goal 1. End poverty in all its forms everywhere

Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture

Goal 3. Ensure healthy lives and promote well-being for all at all ages

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5. Achieve gender equality and empower all women and girls

Goal 6. Ensure availability and sustainable management of water and sanitation for all

Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

Goal 10. Reduce inequality within and among countries

Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable

Goal 12. Ensure sustainable consumption and production patterns

Goal 13. Take urgent action to combat climate change and its impacts

Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development

Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Goal 17. Strengthen the means of implementation and revitalize the global partnership for sustainable development

[14] Transforming our world: The 2030 Agenda for Sustainable Development, United Nations, September 2015. Available here [accessed July 2016].

The 2030 Agenda builds on the Millennium Development Goals (MDGs), which were adopted by the UN in 2000 and expired in 2015. The 17 SDGs are accompanied by 169 specific targets and, though still under construction, some 230 indicators. The goals are to be implemented via a 'Global Partnership', carried over from the MDGs, comprised of governments, the private sector, civil society, UN agencies, academia, the scientific community and other stakeholders. Crucially, whilst the MDGs targeted only developing countries, the SDGs apply to all UN members. This means that, whilst the MDGs were mostly a matter of external policy – dealt with via foreign and development policy mechanisms – the SDGs require internal policy responses, both by the EU and its member states.

3.2 Health in the Sustainable Development Goals

When the MDGs were published, three of the eight goals were directly related to health, targeting maternal health, child mortality and diseases such as HIV/AIDS and malaria[15]. Though now contained in just one goal, the health objectives of Agenda 2030 are considerably broader in scope.

The founding Agenda report envisions '...a world with equitable and universal access to...healthcare and social protection, where physical, mental and social well-being are assured'.

SDG #3 Ensure healthy lives and promote well-being for all, at all ages

Moreover, the report states the following:[16]

'To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left ***behind...We are committed to the prevention and treatment of non***-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable ***development.'***

Accompanying the health goal are 13 specific targets, providing focal points for action. These cover a broad range of metrics upon which progress towards SDG #3 might be measured, including maternal health, prevalence of major communicable diseases, access to fundamental health services and medicines, and recruitment and retention of health workforce. Figure 4 presents the targets associated with SDG #3.

Though the SDGs apply to all countries and not only developing nations, some of the targets included are of less relevance to European states. In the case of the health goal, targets relating to communicable and neglected tropical diseases, maternal mortality and preventable death of new-borns, for example, are generally less applicable.

[15] The Millennium Development Goals, United Nations, September 2000. Available here [accessed July 2016].
[16] Transforming our world: The 2030 Agenda for Sustainable Development, Op Cit footnote 14, point 26.

Figure 4 highlights the health targets most relevant for EU health systems, national governments, the EU institutions and, by virtue of this, the EPHA. Those shaded orange relate to various areas of EPHA's work where reference to the SDGs might be of value in supporting ongoing advocacy and specific campaigns, such as access to medicines and the adoption of a new EU alcohol strategy. Whilst these may also be important, this report focuses on the two targets shaded in green, requiring action on non-communicable diseases and universal health coverage. Both are central EPHA priorities and areas of crucial relevance for the macroeconomic governance of health.

Figure 4: Targets associated with SDG #3

	Target
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
3.2	By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
3.4	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
3.b	Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

3.3 What is the EU's role in the SDGs?

The EU is committed to fully implement the SDGs across both its external and internal policie.[17] Agenda 2030 envisages a global partnership of actors to support implementation and realisation of the SDGs, mentioning specifically the importance of the national, regional and global levels. The EU is likely to play a central role as a regional-level platform for sharing of implementation experience and best practice. Moreover, work on the mechanisms for monitoring and follow-up of the SDG commitments, including indicators and relevant data sets, is still in progress, presenting further opportunity for EU leadership.

3.3.1 The SDGs in external EU policy: the EU as a global actor

The MDGs, being aimed at addressing poverty in developing nations, were primarily dealt with via the EU's external policy. The EU and its member states collectively provide more official development assistance (ODA) than all other donors combined, contributing €58.2 billion in 2014, and have committed to achieve the UN's goal of providing 0.7% ODA/GNI in the post-2015 period.[18] For the MDGs, funding from the external aid budget and the European Development Fund was supplemented by the European Commission and individual programmes were directed according to a 12-point action plan, the Agenda for Change and the EU MDG Initiative, which targeted support at the goals most off-track for achievement when reviewed in 2010.[19] Progress was overseen by DG DEVCO (International Cooperation and Development), with occasional thematic collaboration across other DGs.

By contrast, the SDGs apply to all signatory countries and thus require implementation via both the external and internal policies of the EU. Externally, two main initiatives have been launched. The first is a proposal for an EU Global Strategy on Foreign and Security Policy, introduced by the High Representative for Foreign Affairs and Security Policy. This is of greatest relevance to SDG #16 and the creation of peaceful and secure societies where development can be safely pursued. The second is a revision of the European Consensus on Development (ECD). Building on the existing 2005 Consensus and the 2011 Agenda for Change, the Commission's new proposal seeks to reformulate EU development policy in light of the links between the Agenda 2030, the Paris Climate Change Agreement, the migration crisis and other challenges of post-2015 development. A consultation on the content of the Consensus closed on 21 August 2016.[20]

As EU development policy has evolved, the Commission has adopted a series of communications and established a range of mechanisms to ensure policy coherence in development. This means ensuring that all EU policies likely to affect developing countries work to further the EU's development goals – for instance in trade, environment, agriculture and energy policy actions. Though this is again targeted within the consultation on the ECD, the Commission has yet to put forward plans to ensure similar coherence between its internal policies and its commitments under the SDGs, despite calls from the Council of the EU and the European Parliament to do so.[21]

[17] European Commission (2015) 'Fact sheet: Sustainable Development Goals and the Agenda 2030', 25 September 2015, available here [accessed August 2016].
[18] EU (2015) 'Financing global sustainable development after 2015: Illustrations of key EU contributions', available here [accessed August 2016].
[19] European Commission (2013) 'EU contribution to the Millennium Development Goals', available here [accessed August 2016].
[20] See Consultation webpage, available here [accessed August 2016].
[21] See European Commission webpage on 'Policy coherence for development', available here [accessed August 2016]; Council (2015) Conclusions on policy coherence for development, available here [accessed August 2016]; European Parliament (2016) Motion for a resolution on the report on policy coherence 2015, available here [accessed August 2016].

3.3.2 The SDGs in internal EU policy: the case for policy coherence

There are two main EU policy frameworks which have goals that relate to the SDGs and might be used to facilitate implementation and ensure policy coherence: The Sustainable Development Strategy and the Europe 2020 Strategy.[22]

The EU Sustainable Development Strategy

The EU's current Sustainable Development Strategy was adopted in 2001 and revised in 2006 and 2009. Implementation is overseen by DG ENV (Environment), though its objectives have been mainstreamed across other policy areas. It includes a public health objective – to promote good public health on equal conditions and improve protection against health threats – but a review conducted in 2009 concluded that 'overall development of health in the EU is rather mixed', citing increasing life expectancy but rising exposure to air pollution, toxic chemicals and other emerging challenges[23]. Moreover, the 2015 implementation report noted that there has been no improvement in the proportion of citizens reporting unmet medical need and that the number of people unable to afford care has risen sharply since the onset of the economic crisis[24]. These monitoring activities are supported by data from Eurostat, which uses 10 headline indicators to assess progress – in health, the specific metrics used are life expectancy and healthy life years, deaths due to chronic disease, unmet need for medical care, long-standing illness or health problem, and a variety of environmental health determinant indicators[25]. Research into member states' achievement of the goals finds that Luxembourg, Sweden and Finland made most progress, whilst Lithuania, Bulgaria and Romania performed poorly.[26]

In response to Agenda 2030 and the SDGs, the European Parliament adopted a Resolution in May 2016, noting that:[27]

> ***'...the new universal framework for sustainable development calls for*** more coherence between different policy areas and EU actors, requiring further coordination, dialogue and joint work at all levels within and between EU institutions to ensure the integration of the three pillars of sustainable development (environmental, economic, ***and social) in EU internal and external policies.'***

Mirroring calls from civil society, the Parliament called for the Commission to put forward a proposal for a new EU Sustainable Development Strategy, 'encompassing all relevant internal and external policy areas.'[28]

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[22] Pisano et al. (2015) 'The European context for monitoring and reviewing SDGs' European Sustainable Development Network, available here [accessed August 2016].
[23] European Commission (2009) Communication 'Review of the EU Strategy on Sustainable Development', available here [accessed August 2016].
[24] European Commission (2015) 2015 monitoring report of the EU Sustainable Development Strategy, available here [accessed August 2016].
[25] Eurostat webpage on 'sustainable development and public health', available here [accessed August 2016].
[26] Janković Šoja et al. (2016) 'Ranking EU countries according to their level of success in achieving the objectives of the Sustainable Development Strategy' Sustainability Volume 8(4) pp. 306.
[27] European Parliament (2016) Resolution on the follow-up and review of the 2030 Agenda, adopted 12 May 2016, available here [accessed August 2016].
[28] SDG Watch Europe (2016) Open letter to Commission President Junker calling for an overarching sustainable development strategy, 3 June 2016, available here [accessed August 2016].

Figure 5: Statements of the EU institutions on sustainable development and the SDGs

European Commission
- June 2014 'A decent life for all: from vision to collective action'
- February 2015 'A Global Partnership for poverty eradication and sustainable development after 2015'
- September 2015 'European Commission welcomes new 2030 United Nations Agenda for Sustainable Development'
- October 2015 'Commission work programme 2016'

Council of the EU
- December 2014 'Conclusions on a transformative post-2015 agenda'
- May 2015 'Conclusions on a new Global Partnership for poverty eradication and sustainable development after 2015'
- October 2015 'Conclusions on policy coherence for development'

European Parliament
- November 2014 'Resolution on the EU and the global development framework after 2015'
- November 2015 'Resolution on the role of the EU in the UN'
- May 2016 'Resolution on follow-up and state of play of the Agenda 2030'
- May 2016 'Motion for a resolution on the 2015 report on policy coherence for development'

The Europe 2020 Strategy

Adopted in 2010, the Europe 2020 Strategy is the EU's jobs and growth strategy, building on a replacing the previous Lisbon Strategy for growth. Through a series of targets and flagship initiatives, the Strategy seeks to promote smart, sustainable and inclusive growth across the continent. The sustainability principle refers to the creation of '...a more resource efficient, greener and more competitive economy', with an emphasis on the transition to a low-carbon economy.[29] Progress towards the Europe 2020 targets is measured by reference to a series of indicators on employment, research and development, climate change and energy, education, and poverty and social exclusion. As such, there are synergies with the targets of the SDGs – progress towards the Europe 2020 target of reducing the rate of early school leaving, for instance, complements the first target under SDG #4, which seeks to ensure all children complete primary and secondary education. Though there was no mention of the SDGs in the 2015 review of the Strategy, the latter provides the greatest potential for ensuring policy coherence between the SDGs and EU policy.

4. Universal Health Coverage: A European Priority

Universal Health Coverage, broadly understood as providing everyone with the health services they need without causing financial hardship, was described by Dr Margaret Chan in a 2012 address as 'the single most powerful concept that public health has to offer' and 'the ultimate expression of fairness'[30]. Its ability to improve health outcomes, relieve poverty and fuel economic prosperity, as well as its role in creating cost-effective and financially

[29] European Commission (2010) Communication launching the Europe 2020 Strategy, available here [accessed August 2016]; European Commission webpage on the priorities of the Europe 2020 Strategy, available here [accessed August 2016].
[30] Dr Margaret Chan, 'Best days for public health are ahead of us', address to the Sixty-fifth World Health Assembly in May 2012. Available here [accessed July 2016].

sustainable health systems, is well-documented.[31] At an international level, the spread of UHC over recent years is understood as the 'third great transition' of global health, following the introduction of proper sanitation in the 18th century and the eradication of many major communicable diseases in the 20th. .[32] Significant progress has been made across Latin America, India and many other countries, and this momentum is reflected in the inclusion of UHC in the SDGs.

4.1 What does it mean to have Universal Health Coverage?

The WHO understands three elements of UHC: [33]

- Equity in access to health services – everyone who needs services should get them, not only those who can pay for them;
- The quality of health services should be good enough to improve the health of those receiving services; and
- People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

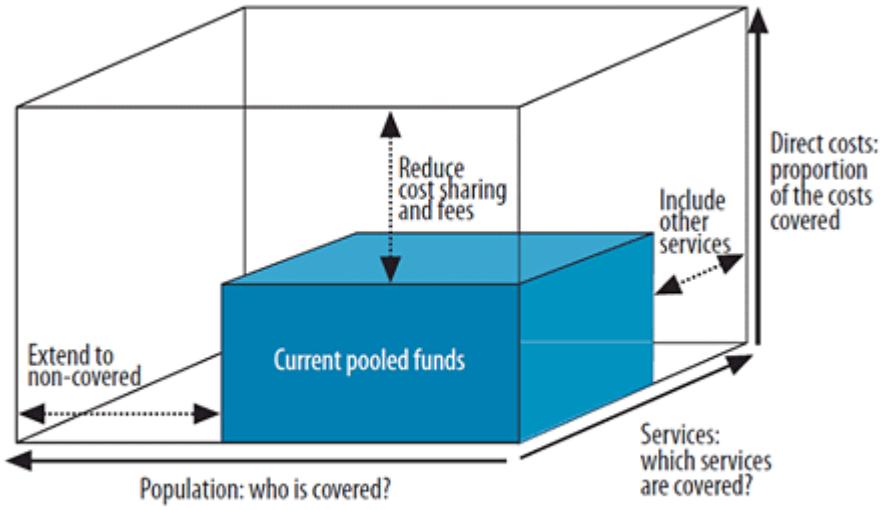
Different organisations (the EU, the ILO, the WHO, the OECD) value or prioritise the above three dimensions differently in their understandings of UHC, making identification of a single definition difficult. In turn, this means that there is no single agreed list of countries which have or do not have UHC – the United States, by way of a contested example, committed to extend coverage to 94% of its population under President Obama's Affordable Care Act, but explicitly excludes undocumented migrants and has yet to push coverage above the 90% threshold, meaning some studies consider it to remain an outlier[34]. However, most studies concur that there are three main dimensions to UHC – who is covered, what is covered and who pays what proportion of the cost (Figure 6).

Moreover, this means that the provision of UHC might be strengthened or weakened by changes in:

- The proportion of the population to whom coverage is offered (unemployed, undocumented migrants, children, pregnant women etc.)
- The basket of services included within coverage (medicines, tests & examinations, dental care etc.)
- The proportion of the cost which falls on the patient (co-payments, fees etc.

[31] Frenk and de Ferranti (2012) 'Universal health coverage: good health, good economics' The Lancet Vol 380 (9845) 8 September 2012; Dr Margaret Chan, address to conference on universal health coverage, Japan, December 2015, available here [accessed July 2016]; Summers (2015) 'Economists' Declaration on Universal Health Coverage' The Lancet Volume 386(10008) pp. 2112.
[32] Rodin and de Ferranti (2012) 'Universal health coverage: the third global health transition?' The Lancet Vol 380 (9845) 8 September 2012.
[33] World Health Organisation webpage on universal health coverage, available here [accessed August 2016].
[34] Stuckler et al. (2010) 'The political economy of universal health coverage' Background paper for the global symposium on health systems research, available here [accessed August 2016] page 8.

Figure 6: The dimensions of UHC



Three dimensions to consider when moving towards universal coverage

4.2 The provision of UHC and action against NCDs: a virtuous circle

The NCD epidemic poses unique challenges for the achievement of UHC, but also a focal point for the design of policies in pursuit of universal coverage. The cycle, if adequately established, is likely to be virtuous – populations able to access preventative care and high quality treatment will avoid or manage NCDs more efficiency, thus improving overall health outcomes, reducing burden upon the system and addressing inequalities. However, the design and implementation of UHC must take account of NCDs from the earliest possible stage and provide the right combination of services, coverage and cost mechanisms. To date, recognition of the specific challenges posed by NCDs within UHC discussions has been limited.[35]

The NCD Alliance published a briefing in 2014 which outlines the relationship between UHC and NCDs and highlights the particular considerations which UHC pathways must take into account[36]. It notes, for instance, that UHC requires health systems with the capacity to provide a comprehensive package of NCD services, spanning both prevention and treatment, across a range of diseases. The WHO Package of Essential NCD Interventions provides a good starting point here and can be scaled up in stages depending upon the 'starting position' of the country concerned. The briefing also stresses, however, that NCD services are not enough in and of themselves – they must be accompanied by measures to tackle to social determinants of chronic disease. Here, the role of UHC in tackling health inequalities becomes evident. Vulnerable groups (including those on low income or experiencing social exclusion) are not only more prone to ill health but less likely to be able to access or afford adequate care. In most countries, there is a strong socio-economic gradient for NCD outcomes, with poorer or less advantaged communities more likely to die

[35] Beaglehole, R. and Bonita, R. (2016) 'Economists, universal health coverage and non-communicable diseases' The Lancet Volume 387(10021).
[36] NCD Alliance (2014) Universal health coverage and non-communicable diseases: a mutually reinforcing agenda, available here [accessed September 2016].

prematurely from a NCD than those better off[37]. The NCD Alliance recommends designing UHC systems which target vulnerable communities, empower civil society and embrace 'progressive universalism.'

4.3 The status of UHC and NCD prevalence in the EU: a story of inequality

The OECD's 2014 Health at a Glance Report states that:[38]

> ***'Most EU countries have maintained universal (or near-universal) coverage for a core set of health services, with the exception of Bulgaria, Greece and Cyprus where a significant proportion of the population is uninsured. Still, even in these countries, measures have been taken to provide coverage for the uninsured'***

Europe is broadly considered to enjoy universal coverage across the continent, but previously strong UHC has been weakened and progress in lagging countries slowed in the aftermath of the economic crisis. Some conclude that the post-crisis climate 'opened a political window of opportunity for those who were hostile to the European post-war welfare states' and undid much of the progress made under the 'health is wealth' agenda, framing health systems once again as an expenditure item rather than an investment.[39]

In 2013 the countries of the WHO Region adopted a series indicators and targets within the framework of the Health 2020 agenda, one of which was to 'move towards universal health coverage'. However, the 2015 European Health Report concluded that 'moving towards universal health coverage still requires considerable action', largely as a result of falling public expenditure on health and high out-of-pocket payments.[40] Changes to the main health policy levers which affect UHC have taken place in many EU countries in the aftermath of the crisis. The ILO lists 10 EU member states (BG, CY, CZ, HU, EE, EL, LT, RO, SI, UK) which have announced fiscal consolidation policies with the potential to impact upon universal coverage.[41] Most involve cuts to health expenditure but the postponement of the new national health insurance system in Cyprus, volume limits and increased user charges in Hungary, removal of care provisions in Greece, reductions in some services in Slovenia and cancellation of the Health in Pregnancy grant in the UK are also highlighted. The Report concludes that:[42]

> ***'Overall, the impact of fiscal consolidation measures taken in response to the crisis has been to stall or even reverse progress towards universal health coverage by sharpening inequities in access to health care, increasing the financial burden on private households, reducing benefits and thus increasing exclusion.'***

[37] NCD Alliance (2014) Universal health coverage and non-communicable diseases: a mutually reinforcing agenda, available here [accessed September 2016]; page 5.
[38] OECD (2014) Health at a glance: Europe 2014, available here [accessed August 2016].
[39] McKee et al. (2013) 'Universal health coverage: a quest for all countries but under threat in some' Value in Health Vol 16(1).
[40] The European Health Report 2015, World Health Organization. Available here [accessed July 2016].
[41] International Labour Organisation (2015) 'World Social Protection Report 2014-15', available here [accessed August 2016] page 114.
[42] International Labour Organisation (2015) 'World Social Protection Report 2014-15', available here [accessed August 2016] page 113.

Research has found, however, that the impact of the economic crisis upon UHC is differentiated across European countries depending upon the policy response of national governments – the decision by the Danish government to offset increases in some user charges with reductions in or abolition of fees for other services, for instance – highlighting the reality that there are political choices to made on the part of national governments.[43] Figure 7 lists some of the threats to UHC in EU member states recorded in the literature.

Figure 7: Observed threats to UHC in Europe

Observed threats to UHC in Europe:

- Limits to publicly-funded benefits packages
- Introduction of co-payments
- Allowing waiting times to increase
- Closure of healthcare facilities
- Reduced opening hours of healthcare facilities
- Reduced number of healthcare professionals

The WHO's online platform for information on NCDs states that:

'Of the six WHO regions, the Europe**an Region is the most affected by non-communicable diseases (NCDs), and their growth is startling. The impact of the major NCDs (diabetes, cardiovascular diseases, cancer, chronic respiratory diseases and mental disorders) is equally alarming: taken together, these five conditions account for an estimated 86% of the deaths and 77% of the disease burden in the **Region.'

In 2013 the WHO and European Commission launched a joint project – Integrated Surveillance of Non-Communicable Diseases (iNCD) – to study NCD indicators, reflecting the varying quality, availability and comparability of existing data sources. As such, accurate comparison of progress across member states is difficult but, by way of broad illustration, Figure 8 presents one of the available indicator sets, taken from Eurostat, on the death rate due to chronic disease. It provides a stark demonstration of the relevance and impact of health inequalities in NCD prevalence in Europe. The nine member states with the high death rate are all countries which became members of the EU during or after 2004, predominantly Central and Eastern European states and those with lower GDPs. A full exploration of the complex interplay between health inequalities and NCD risk factors is beyond the scope of this report but, as is shown in the next section, this group includes the countries which most commonly perform badly in reporting of unmet medical need and, as noted above, have taken measures since the economic crisis which have threatened or damaged access to care and progress towards UHC.

[43] Burström (2015) 'The attack on universal health coverage in Europe: different effects in different parts of Europe' European Journal of Public Health Vol 25(3).

Figure 8: Death rate due to chronic diseases, per 100,000 persons, bottom 9 plus EU27 average

EU27 average	116.2	Slovenia	184.1
Estonia	159.1	Lithuania	215,1
Poland	159,1	Latvia	216,8
Croatia	163,6	Romania	225
Bulgaria	182	Hungary	257,3

A number of policy instruments targeting the main NCD risk factors – smoking, alcohol abuse, unhealthy diet and sedentary lifestyle – exist at EU level and in 2011 the UN adopted a Declaration on prevention and control of NCDs but, to date vast disparities and inequalities remain.

4.4 Measuring UHC: access to care and unmet medical need

Monitoring progress in the fight against NCDs is based on a relatively well-established selection of epidemiological indicators and criteria; judging progress towards UHC is more methodologically challenging. Measurement of the presence, effectiveness and changing nature of UHC is generally undertaken using two main indicators: access to care and financial protection.[44] Access is concerned with barriers to care, whether in the form of inability to travel due to poor transport services, lack of available facilities because there are not enough hospitals or healthcare staff, or inability to afford the costs associated with receiving care.

The most common and useful indicator for measuring access to care (and thus the achievement of UHC) is self-reported unmet need. Eurostat collects data to aid understanding of which population groups are worst affected and what barriers individuals perceive that they face when trying to access care. Of particular interest for analysis of UHC policies, it distinguishes between health system and non-health system related barriers – the former include care being too expensive, waiting times too long or care being too far away, whilst the latter includes fear of medical treatment, the decision to 'wait and see' and other such reasons for not seeking care.

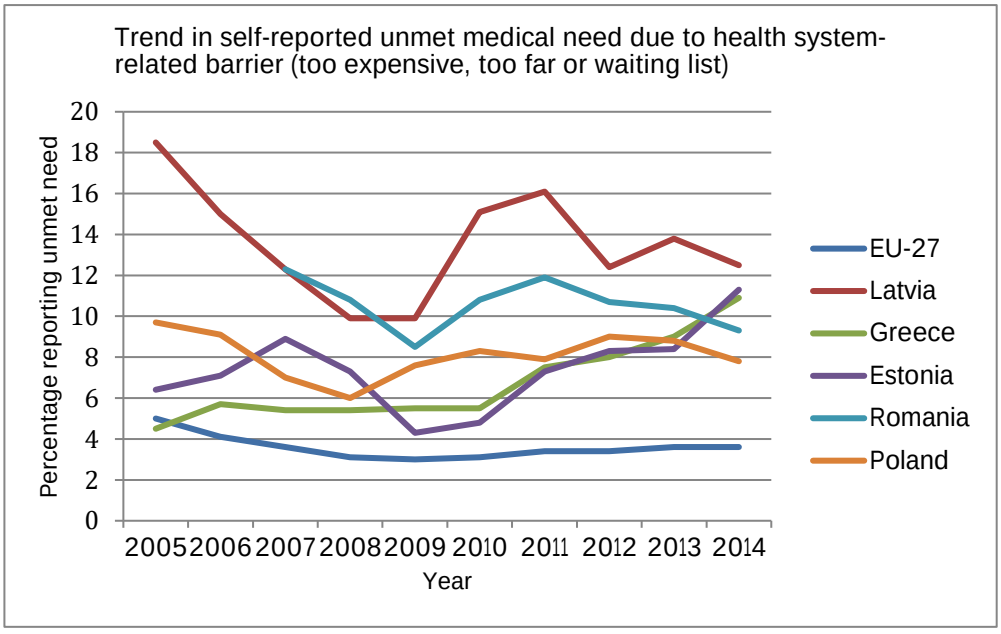
[44] Vega, J. (Rockefeller Foundation) 'Universal Health Coverage, Sustainable Development and the Post-2015 Agenda', available here [accessed August 2016].

Figure 9: Unmet medical need in selected EU countries, 2014

Total share of persons (%) reporting unmet medical need		All reasons	Health system-related reason given:		
			Too expensive	Too far	Waiting list
	EU-28	6.7	2.4	0.1	1.1
	Austria (lowest)	0.3	0.1	0	0
	Latvia (highest)	19.2	10.5	0.4	1.6
	Estonia	13.1	0.5	0.7	10.1
	Poland	12.9	3.1	0.3	4.4
	Greece	12.7	9.7	0.3	0.9
	Romania	11.3	8.3	0.5	0.5

Since the onset of the economic crisis, more than 1.5 million extra people have reported an unmet medical need in Europe.[45] Prior to the crisis, the proportion of the population reporting unmet need in the EU was declining, falling by 2.1% between 2005 and 2008. The increase has not affected all member states – Sweden, for example, has actually experienced a fall in unmet need since 2008 – or all populations equally. The volume of additional unmet need was six times higher in the lowest income groups than the highest, confirming broader evidence that the changes are hitting vulnerable and deprived groups hardest. Figures 10 and 11 illustrate the prevailing disparities.

Figure 10: Historical trends in unmet medical need in selected EU countries



[45] This and other data in this paragraph from Reeves et al. (2015) 'The attack on universal health coverage in Europe: recession, austerity and unmet needs' European Journal of Public Health Vol 25(3).

Figure 11: Selected statistics on unmet medical need in the EU

- More than 10% of the lowest income quartile reported unmet medical need in: Romania (12.0), Italy (13.3), Greece (16.4) and Latvia (23.6).
- More than 10% of those with the lowest level of educational attainment reported unmet medical need in: Poland (10.7), Greece (15.4), Latvia (17.0) and Romania (17.3).
- More than 10% of those in age brackets '45-64' and '65 and over' reported unmet medical need in: Poland (10.1; 11.5), Romania (10.9; 23.0), Greece (12.5; 15.4), Estonia (12.3; 16.1) and Latvia (15.5; 17.7).
- Proportion of lowest income quartile reporting care too expensive in 2007: 5.4 (EU-27), 4.2 (Estonia), 9.0 (Greece), 18.5 (Latvia), 7.5 (Poland), 19.3 (Romania), 33.4 (Bulgaria).

5.The EPSR: A Tool for Integration and Policy Coherence

5.1 Reviewing the case for formal linkage

This Report advocates the establishment of a formal link between the SDGs and the EPSR as a way of ensuring the coherence, relevance and implementation of the overlapping objectives of these policy frameworks. This linkage should be built upon a common pursuit of UHC and action to tackle NCDs.

Goals 3.4 and 3.8 of the SDGs make the achievement of UHC and the reduction of premature mortality from NCDs explicit targets, but the EU has yet to put forward a strategy for their implementation and integration into Union policy. Meanwhile, domain 12 of the proposed EPSR, though not yet finalised, indirectly embodies similar goals and presents an opportunity to embed these more explicitly and coherently within EU policy frameworks. It is also clear, from the brief overview of data presented above, that both UHC and the burden of NCDs require immediate action on the part of the EU and its member states. Whilst the prevalence of NCDs continues to grow, access to care has been damaged by the economic crisis and the austerity politics which have followed in its wake, threatening the provision of UHC. Such trends reflect and exacerbate inequalities in health systems and outcomes across the continent.

The creation of a EPSR presents an opportunity to address these challenges whilst taking action on two of the EU's most pressing agendas – the 'socialisation' of EMU and the implementation of the SDGs. What is required to achieve this is an extension of the EU's 'policy coherence' model and the integration of EPSR as a tool for implementation of the SDGs.

5.1.1 Policy coherence and the need for synergy

Drawing on the 'policy coherence for development' model discussed above, a new approach is needed to ensure that the pursuit of the SDGs is embodied in all EU policy instruments. A critical element of this will be the mainstreaming of the SDGs within the Europe 2020 Strategy.

Reviews of the EU's previous Sustainable Development Strategy emphasised its links to the Lisbon Strategy for growth and jobs.[46]

> ***'The EU SDS and the Lisbon Strategy for growth and jobs complement each other... These two strategies recognise that*** economic, social and environmental objectives can reinforce each other and they should therefore advance together. Both strategies aim at supporting the necessary structural changes which enable the Member States´ economies to cope with the challenges of globalisation by creating a level playing field in which dynamism, innovation and creative entrepreneurship can flourish whilst ***ensuring social equity and a healthy environment'***

A similar connection should be drawn when reviving the EU's Sustainable Development Strategy and implementing the SDGs, to ensure alignment with the goals and processes of the Europe 2020 Strategy. Moreover, since progress towards the Europe 2020 targets is promoted and monitored via the European Semester, integration across the macroeconomic governance instruments is also crucial. In addition to integrating Agenda 2030 into its external policy instruments – such as the new Global Strategy and the revived Consensus on Development – the EU needs to mainstream the SDG targets into its internal policy frameworks, including the Europe 2020 Strategy, its implementing instruments and any new Sustainable Development Strategy proposal. This mainstreaming should highlight and build upon the contribution of UHC and a reduction in the burden of NCDs to the tackling of health inequalities, the improvement of health outcomes, the creation of greater economic productivity and the strengthening of long term sustainability in health systems. Only by recognising the mutually supporting nature of these objectives can implementing mechanisms foster genuine policy coherence.

5.1.2 Integrating the EPSR as a tool for implementation

The mainstreaming of the SDGs within the EU's broader internal and external policy frameworks is crucial to the pursuit of the health-related goals, but achieving them will also require the establishment of a specific mechanism for monitoring and implementation. The creation of the EPSR provides the ideal context for this.

Figure 12 illustrates the current overlaps and interactions between the SDGs and the Europe 2020 Strategy, as pursued via the macroeconomic framework. The policy targets – provision of UHC and action to reduce the prevalence of NCDs – are mutually reinforcing, but also both contribute to the overarching goal of ensuring access, quality care and financial sustainability. Though this goal is not explicitly recognised in the SDGs, the various targets within the health SDG rely upon and contribute to the establishment of a strong,

[46] Council of the EU (2006) Revision of the EU Sustainable Development Strategy, available here [accessed August 2016].

cost-effective health system, reflecting the overarching goal of the macroeconomic governance framework. Similarly, though the macroeconomic governance instruments have only occasionally targeted UHC and reduction of NCD prevalence directly, the contribution of the latter to cost-efficiency and sustainability in the health system makes them increasingly relevant policy objectives in the context of the Europe 2020 Strategy.

Figure 12: The SDGs and Europe 2020 - current interaction

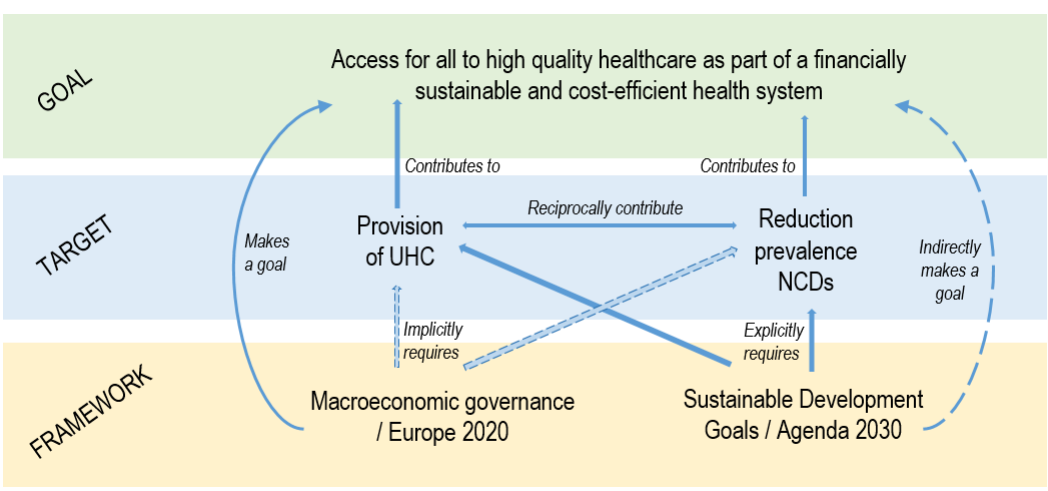
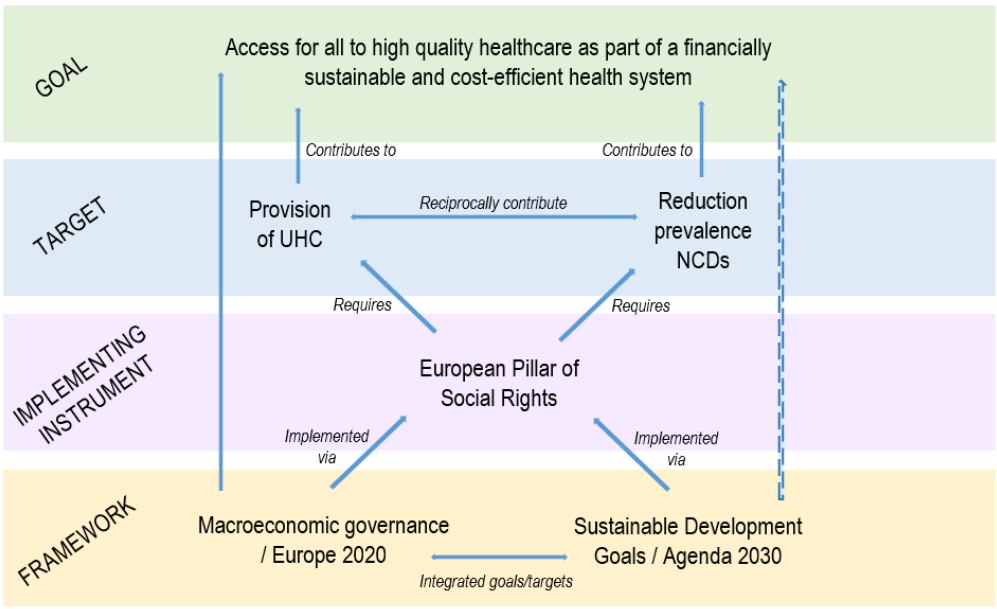


Figure 13 shows how the EPSR might be established as an implementing instrument, contributing to the overarching health systems goal by ensuring national action on the provision of UHC and the reduction of NCD prevalence. Here, member states' commitments under the SDGs and the macroeconomic governance framework are aligned and their implementation integrated. Essentially, Figure 13 represents the formal integration of the SDG targets and the Europe 2020 objectives, the adoption of a structured mechanism of implementation for the former, and the institutionalisation of the link between the provision of UHC and the pursuit of sustainability and cost-efficiency in the health system. The best tool to achieve these objectives, this report argues, is the EPSR.

Figure 13: The SDGs and Europe 2020 - potential integration via the EPSR



5.2 Making it operational: Indicators and monitoring

The establishment of clear, appropriate and feasible indicators and a coherent monitoring framework is critical to both the successful implementation of the SDGs and the relevance of the EPSR. Though none are perfect, there are now a variety of datasets and monitoring mechanisms for health at the EU and international levels; the adoption of indicators for the SDGs and EPSR must take these into account and exploit synergies wherever possible.

5.2.1 EU and international health indicators

There is not currently a health-related indicator in the MIP or the EPM, and the SPPM monitors only self-reported unmet need for medical care and healthy life years.[47] Meanwhile the JAF, which underpins both the EPM and the SPPM, previously made scant mention of health but, in 2013, the SPC and Council Working Party on Public Health at Senior Level (WPPHSL) began work on a dedicated JAF in the field of health (JAF-H). Though still under development, the JAF-H identifies indicators to measure progress in overall health outcomes, healthcare performance (including quality and access) and non-healthcare determinants (lifestyle choices, behaviours and environmental factors), as well as in 'context' dimensions such as health system resources and socio-economic situation[48]. Such indicators provide a basis for monitoring the provision of UHC but should be supplemented to ensure that service provision, service coverage and cost barriers are accounted for.

On NCDs, the WHO Global Monitoring Framework and the 2013-2020 NCD Action Plan provide good starting points for the adoption of indicators, to be supplemented by the joint project with the EU on new indicator sets (the iNCD project mentioned above) in the near future. Eurostat, the OECD and the European Core Health Indicators framework also provide some applicable data sets – the challenge for the EU is to map, assess and integrate an appropriate range of indicators to support implementation of the relevant SDG targets.

5.2.2 The Sustainable Development Goal indicators

To facilitate and monitor the implementation of the SDGs, the UN's Statistical Commission (UNSC) has established an Inter-Agency and Expert Group (IAEG) and tasked it with developing a series of indicators to accompany the goals and their targets. An initial list was proposed and agreed in March 2016, with the understanding that it forms 'a practical starting point' but that work on the methodologies and focus of the indicators is ongoing.[49]

The proposed indicators to accompany SDG #3 are listed in Figure 14 below. The UNSC has created a Global SDG Indicators Database, which will eventually hold data on all relevant indicators. For now, it only lists the indicators for which data are available – in the case of SDG #3, 13 indicators can currently be accessed (with at least some data available),

[47] 2015 SPPM dashboard results, Social Protection Committee, available here [accessed July 2016]; Foundations and structures for the JAF, COM/SPC/EMCO report to the Council of the EU, available here [accessed July 2016].
[48] DG EMPL, Towards a Joint Assessment Framework in Health, work in progress update 2015. Available here [accessed July 2016].
[49] Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators, UN Statistical Commission, available here [accessed July 2016]; Report of the Forty-Seventh Session of the UNSC, 8-16 March 2016. Available here [accessed July 2016].

whilst data is still being sought for the other 10 indicators proposed by the IAEG. These are highlighted in Figure 14.

The UNSC's 'conclusions' on the IAEG report contain two important points. Firstly, they note that the global indicators will not necessarily be applicable to all national contexts, and that *'indicators for regional, national and subnational levels of monit*oring will be developed at the regional and national levels'. Secondly, it states that 'national ownership is key to *achieving sustainable development and…national reviews are [to be] voluntary and* country-led'. Moreover, the Lithuanian delegation to the UNSC made an intervention in which it suggested that international comparability of the SDG indicators and development of methodologies could be coordinated by Eurostat[50]. As such, there is a clear role for the EU here in reviewing, refining and making the UN indicators applicable to member states and the specific challenges facing European governments.

[50] Statement by Statistikos Departamentas, Lithuania, at the Forty-Seventh Session of the UNSC, 8-16 March 2016. Available here [accessed July 2016].

Figure 14: Targets and indicators associated with SDG #3

	Target	Indicator
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1* Maternal deaths per 100,000 live births 3.1.2 Proportion of births attended by skilled health personnel
3.2	By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-5 mortality rate (deaths per 1,000 live births) 3.2.2 Neonatal mortality rate (deaths per 1,000 live births)
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population (by age group, sex and key populations) 3.3.2 Tuberculosis incidence per 1,000 persons per year 3.3.3 Malaria incident cases per 1,000 persons per year 3.3.4* Number of new hepatitis B infections per 100,000 population in a given year 3.3.5* Number of people requiring interventions against neglected tropical diseases
3.4	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality of cardiovascular disease, cancer, diabetes or chronic respiratory disease 3.4.2 Suicide mortality rate
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1* Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders 3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1** Number of road traffic fatal injury deaths within 30 days, per 100,000 population (age standardised)
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Percentage of women of reproductive age (aged 15-49) who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (aged 10-14; aged 15-19) per 1,000 women in that age group
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1* Coverage of tracer interventions (e.g. child full immunization, antiretroviral therapy, tuberculosis treatment, hypertension treatment, skilled attendant at birth, etc.) 3.8.2* Fraction of the population protected against catastrophic/impoverishing out-of-pocket health

3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to household and ambient air pollution 3.9.2*** Mortality rate attributed to hazardous chemicals, water and soil pollution and contamination
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1* Age-standardized prevalence of current tobacco use among persons aged 15 years and older
3.b	Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.b.1* Proportion of the population with access to affordable medicines and vaccines on a sustainable basis 3.b.2 Total net official development assistance to the medical research and basic health sectors
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1* Health worker density and distribution
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.d.1* Percentage of attributes of 13 core capacities that have been attained at a specific point in time

Source: Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators, UN Statistical Commission, available here [accessed July 2016]; UN Global SDG Indicators Database, available here [accessed July 2016].
* Indicator not currently available on the Global SDG Database
** Indicator appears on the Global SDG Database with different wording or formation
*** Indicator 3.9.2 is replaced on the Global SDG Database by '3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (WASH)' and '3.9.3 Mortality rate attributed to unintended poisoning'

6. Policy recommendations

This report has outlined the rationale for and primary considerations of a formal link between the health target of the SDGs and the health-related commitments contained within the proposed text of the EPSR. A final section makes five policy recommendations to lay the foundations for this link.

Recommendation 1: Clarify the language of the EPSR

As noted in its response to the Commission's consultation, EPHA welcomes the establishment of a EPSR and the commitment to base renewed convergence on common standards in key policy areas, such as healthcare. However, the final EPSR, in particular domain 12, must clearly outline the importance of a high level of health and well-being across all social groups as a foundation for resilient economies and social cohesion. The text proposed is a promising first step but retains the emphasis on cost-efficiency which has proven so damaging in the post-crisis period whilst overlooking the rise in health inequalities and the importance of mainstreaming health. Moreover, the commitment to UHC and action to tackle NCDs – via disease prevention, health promotion and adequate service provision – must be more clearly stated.

Recommendation 2: Define the EPSR within the context of the macroeconomic governance framework

As yet, no explicit link between the EPSR and the European Semester has been drawn but locating the Pillar within the broader macroeconomic governance context is important for both the relevance of the former and the proper functioning of the latter. EPHA encourages the Commission to utilise the final EPSR as a tool for feeding into the Semester and contributing to the rebalancing of its social and economic objectives. In addition to providing a clear context for the EPSR, by locating it clearly within the macroeconomic governance framework, this would provide an avenue through which the Pillar can achieve its aim of 'socialising' the structures of EMU and contributing to a 'social triple A.'

Recommendation 3: Frame UHC as a lever to tackle broader inequalities

When clarifying the commitment to UHC and designing mechanisms for its implementation, EU instruments must be careful to frame the concept broadly and inclusively. The achievement of genuine UHC has the potential to address some of the vast inequalities which exist between regions and social groups in the EU, but only if it is implemented in a holistic manner. Research indicates that treating UHC as a 'silver bullet' and framing it too narrowly has the potential to prompt an expansion of clinical services for individuals at the expense of more population-based public health interventions, resulting in more services and greater access, but worse overall health outcomes[51]. Most of the targets under SDG #3 require population-level public health interventions and its inclusion in the EPSR should serve to address inequalities in health across different population groups – it is thus important to advocate UHC as a means to the end goal of improving health, rather than as a goal in itself.

[51] Schmidt et al. (2015) 'Public health, universal health coverage, and Sustainable Development Goals: can they coexist?' The Lancet Vol 386 (9996) 29 August 2015.

Recommendation 4: Map and appraise existing indicators

The adoption of clear, appropriate and feasible indicators will be crucial to the achievement of the SDG health goal and will help ensure the relevance and practical contribution of the EPSR. However, given the variety of health indicators and monitoring frameworks already applied to health systems, the risk of duplication and additional reporting burden should be mitigated as far as possible. With this in mind, EPHA encourages an initial mapping exercise to give an overview of the indicators which already exist and the mechanisms by which data is already collected. Assessed alongside similar indicators used by the WHO and OECD, this list should then form the basis of an indicator and monitoring framework for the EPSR and, through this, the SDG targets on UHC and NCDs.

Recommendation 5: Step up action on NCDs

Despite clear evidence illustrating the scale of the problem, its social and economic costs, and the risk factors which contribute to it, as well as a wealth of policy recommendations from the WHO and the OECD, the NCD burden remains worryingly under-prioritised in EU policy frameworks. Many of the public policies which contribute to NCD prevalence lie outside of the health sector, and failure to implement the Health in All Policies principle and inappropriate reliance on models of self- and co-regulation exacerbate their damaging impact. Moreover, the burden of NCDs falls disproportionately on vulnerable social groups, rooted in deep-set inequalities between East and West, rich and poor, or 'new' and 'old' member states. The EPSR and the SDGs offer an opportunity to 'kick-start' EU action on NCDs by putting this at the centre of UHC. EPHA urges that the EPSR, as the implementing tool of the SDGs, be used to benchmark and monitor progress, and as a foundation for strong and coherent EU policies to tackle the growing prevalence of NCDs.

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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