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EU Country Specific Recommendations for health systems in the European Semester process: Trends, discourse and predictors[☆]



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ABSTRACT

In the framework of “Europe 2020”, European Union Member States are subject to a new system of economic monitoring and governance known as the European Semester. This paper seeks to analyse the way in which national health systems are being influenced by EU institutions through the European Semester. A content analysis of the Country Specific Recommendations (CSRs) for the years 2011, 2012, 2013 and 2014 was carried out. This confirmed an increasing trend for health systems to feature in CSRs which tend to be framed in the discourse on sustainability of public finances rather than that of social inclusion with a predominant focus on the policy objective of sustainability. The likelihood of obtaining a health CSR was tested against a series of financial health system performance indicators and general government finance indicators. The odds ratio of obtaining a health CSR increased slightly with the increase in level of general Government debt, with an OR 1.02 (CI: 1.01, 1.03; $p = 0.007$) and decreased with an increased public health expenditure/total health expenditure ratio, with an OR 0.89 (CI: 0.84, 0.96; $p = 0.001$). The European Semester process is a relatively new process that is influencing health systems in the European Union. The effect of this process on health systems merits further attention. Health stakeholders should seek to engage more closely with this process which if steered appropriately could also present opportunities for health system reform.

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1. Introduction

The role of the European Union in relation to health systems and policies has been described in terms of three ‘faces’ [1]. First, Article 168 of the Treaty [2] gives a basis for the EU to promote public health policies which is the longest established strand of health policy activity [3] and can be traced back to the initial vertical programmes on AIDs [4] and cancer [5] as well as activity in the realm of health information [6]. The second face refers to the role of the internal market in European health care policy. Initially mainly driven by the European Courts of Justice [7,8], national concerns about the effect of these rulings resulted in the High Level Reflection process on patient mobility [9–11]. Member States rejected the inclusion of health in the Services (Bolkenstein) Directive but the adoption of the Directive on the application of patients’ rights in cross border care in 2011 marked a new era in European Union competence for health systems [12]. Whilst the concept of health systems monitoring and assessment was introduced in 2004 as part of the open method of coordination [13], Directive 2011/24 promotes coordination between Member States from a broader health system perspective [14]. The subject of this paper deals with the third face of EU policy that is impacting on health systems which is the new system of fiscal and economic governance. [15] The European Commission has advocated a stronger degree of ex ante policy coordination in important economic sectors [16]. The Economic Adjustment Programmes adopted in Ireland, Greece, Portugal and Cyprus have resulted in prescriptive guidance influencing policy developments in Member States’ health systems [17–21].

In the framework of the “Europe 2020” strategy [22] all Member States are subject to a new system of economic monitoring and governance known as the European Semester [23]. This process of preventive and corrective action has emerged in the wake of the financial crisis as an attempt to reform and strengthen the Stability and Growth Pact. It enables the Commission and Council to carry out surveillance of economic indicators as well as big budgetary programmes. In November of each year the Commission sets out its priorities in the Annual Growth Survey [18–21]. On the basis of these priorities the EU Heads of State issue policy guidance to Member States in March. This policy guidance is then meant to be reflected in the drawing up of National Reform Programmes and Stability/Convergence Programmes by each Member State. These programmes are assessed by the Commission which then draws up a number of Country Specific Recommendations (CSRs) which are considered and finally adopted by the European Council in June¹ (see Box 1).

In the aftermath of the financial and economic crisis, the locus of decision making on health systems has perceptibly shifted in a way that decisions are being taken now along

Box 1: Description of the ‘European Semester’
Europe 2020 is the European Union’s ten-year growth and jobs strategy that was launched in 2010. It is intended to overcome the crisis and create the conditions for a smart, sustainable and inclusive growth. Five targets have been set for the EU to achieve by the end of 2020. These cover employment; research and development; climate/energy; education; social inclusion and poverty reduction.

The Europe 2020 strategy is implemented and monitored in the context of the **European Semester** which is the yearly cycle of coordination of economic and budgetary policies. The European Semester is an EU-level policy co-ordination tool contributing towards the broader EU aims of strengthening economic governance and greater policy co-ordination. It provides a more integrated surveillance framework for the implementation of fiscal policies under the Stability and Growth Pact as well as the implementation of structural reforms through national reform programmes.

The **Annual Growth Survey** launches the European Semester by setting out the broad EU economic priorities for the year to come. It is the first step in the annual cycle each November.

The Council endorses the **Country-Specific Recommendations** for each Member State on the basis of Commission’s proposal. The recommendations are based on a thorough assessment of every Member State’s plans for sound public finances (Stability or Convergence Programmes, or SCPs) and policy measures to boost growth and jobs (National Reform Programmes, or NRPs).

Countries that request financial aid from, the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF) also commonly referred to as the Troika, agree to an **Economic Adjustment Programme** (EAP) package. The Economic Adjustment Programme seeks to address short- and medium-term financial, fiscal and structural challenges facing the specific country. Member States with an EAP are expected to adhere to the conditions set out in the programme as part of the conditional financial support. Countries in receipt of an Economic Adjustment Programme do not receive additional Country Specific Recommendations for that particular year.

Adapted from <http://ec.europa.eu/europe2020/europe-2020-in-a-nutshell/eu-tools-for-growth-and-jobs/index-en.htm> [accessed 25.11.14].

the interface between European institutions and Member States [24–26].

1.1. Purpose

The purpose of this study was to examine the manner in which health systems are being addressed in the European Semester process through an analysis of the CSRs. Specifically the following research questions were addressed.

1. What are the trends in CSRs addressing health systems?
2. How is the discourse on health systems being framed in the CSRs?
3. Can any predictors for CSRs on health systems be identified?

¹ For a comprehensive user friendly introduction to the European Semester process, the reader is referred to Chapter 5 in ‘Everything you always wanted to know about European Union health policies but were afraid to ask’ Greer et al. [26].

The study therefore sought to assess the way in which health systems are being targeted for reform through documentary analysis of the CSRs and statistical analysis for potential predictor variables.

1.2. Analytical framework

A theoretical framework was formulated to develop a rationale for a scientific analysis of the CSRs. The framework draws upon key developments in health policy at European level as well as the contextual issues leading to the development of the European Semester process itself.

1.2.1. Trends in health CSRs in the European Semester

Given the relative lack of visibility of health policy in the Europe 2020 strategy, it may be argued that health would not feature as a key consideration in the CSRs. There is also no legal or sanctioning power over health systems within the EU institutions. However the fact that health systems accounted on average for 9.0% of GDP in 2010 [27] and that DGECFIN and the Economic Policy Committee have made projections for future sustainability of health and long term care in Europe, indicate a growing interest in this policy sector [28,29].

The document “Investing in Health” [30], the expert panel on Investing for Health [31] and the Commission Communication on “Effective, accessible and resilient health systems” [32] are instances of a more comprehensive interest in health systems at EU level. Council Conclusions adopted during the Hungarian (2011) and Lithuanian (2013) Presidencies (2011) have both called for senior health decision makers to engage with the European Semester process.

1.2.2. Framing of the policy discourse

The European Semester mechanism of monitoring and surveillance was developed, against the backdrop of ensuring that Member States essentially keep a healthy financial and economic profile [26]. Equally social exclusion has become an issue of concern particularly in countries mostly affected by the financial crisis [33,34]. Therefore sustainability of public finances and the need to strengthen social inclusion can both provide a rationale for the emergence of CSRs on health systems and act as plausible framing mechanisms [35].

1.2.3. Potential predictors of CSRs

Given the motive for the establishment of the European Semester process, lack of sustainability in health systems should intuitively be a strong driver triggering the development of health related CSRs and recommendations on health system reforms. Therefore it is reasonable to assume that countries manifesting trends of a growth in the proportion of public health sector expenditure relative to economic growth should be associated with a higher chance of obtaining a health CSR. Rapid growth in public health expenditure relative to denominators such as Gross Domestic Product (GDP), Total Health Expenditure (THE) and General Government Health Expenditure (GGHE) may increase the chances of obtaining a health CSR due to their impact on sustainability of public finances. The state of the

general public finances could also well be a driver for health related CSRs given the economic significance of the health sector.

Future projections of the ratio of PHE growth may also theoretically drive the issuance of health CSRs in relation to future sustainability of public finances. The Ageing Report 2012 provides a useful starting point for this analysis as different scenarios (e.g. reference [constant] scenario, risk scenario)² can be examined. In these scenarios projected increase in public health care expenditure until 2060 as a proportion of GDP can be considered as a predictor variable. Assuming that the process is driven practically entirely by the financial and economic stability agenda then health system performance in terms of health outcomes would not be expected to have any effect on the likelihood of receiving a health CSR and these domains are not examined in this study.

2. Methods

The rationale explained in Section 1.2 was used to elaborate a mixed-method approach to the analysis of the CSRs. The English versions of the final CSR texts (or Economic Adjustment Programmes (EAP), or Memoranda of Understanding (MOU)) were retrieved from the official website of the EU in October 2014 [36]. The analysis involved all 27 Member States excluding Croatia (which was not eligible during the entire period under examination). A total of 108 documents were analysed.

2.1. Trends analysis

A descriptive content analysis with a search for the key words and phrases “health”, OR “health care”, OR “long term care” was performed. A summative content approach was adopted. A number of countries did not receive CSRs for certain years since they were already in receipt of specific guidance through their EAPs. For these countries the EAP itself or the review of the EAP published nearest to the date of the Council Recommendations with CSRs for other Member States was taken as the documentary source of analysis.

2.2. Detailed content analysis

2.2.1. Framing of the CSRs

The second step involved the analysis of the context in which the CSRs regarding health systems were embedded. The CSRs containing the identified key words were categorised according to whether the health system recommendation was a “stand alone” subject or whether it formed part of a recommendation addressing another policy sector. This method has been used elsewhere [37] and was deemed important in order to understand the context in which health systems are being framed in the CSR language. Proponents of discourse analysis as a technique for understanding Europeanisation of policy, emphasise the

² For a detailed explanation of the reference scenario and risk scenario see Ageing Report 2012.

need to complement a simple deductive approach with a broader analysis that seeks to attach meaning to the context and circumstances of the language being used in the policy documents [38].

2.2.2. Classification of actual CSR content

Further detailed content analysis of the extracted paragraphs was then carried out in order to examine the specific health system functions/goals featuring in the health CSRs. Components addressing “health”, “health care” and “long term care” were classified using two distinct analytic processes. The thematic analyses were conducted separately by two of the authors. Differences in the classification were highlighted and the final classification was decided upon during a consensus meeting.

2.2.2.1. Framework 1 (access, quality, sustainability). CSRs were classified according to whether they were targeting access, quality or sustainability in line with the framework used by the Social Protection Committee since 2001 [39]. Where an objective was aimed at addressing more than one of these themes, it was listed separately, repeatedly, under each of the themes being addressed.

2.2.2.2. Framework 2 (hit report template). CSRs were reanalysed using a different framework to triangulate the findings and increase the validity of the results. For this analysis, the template elaborated for describing health care systems in the HiT reports by the European Observatory on Health Systems and Policies [40] was used namely; organisation and governance, financing, physical and human resources, and provision of services.

Since EAPs were produced in a particular set of economic circumstances and since the text is not comparable in form, style or content to that of the CSRs, the EAPs were not included in this detailed qualitative analysis. In the case of Romania and Latvia, for specific years where CSRs were not published, reference was made to the Council Decisions and accompanying Memoranda of Understanding. The structure of these documents was deemed sufficiently similar to the CSRs in format to be included in the analysis.

2.3. Statistical analysis for variables associated with health CSRs

2.3.1. Potential predictor variables

The objective of this analysis was to identify any variables associated with the likelihood of health CSRs being issued to a MS. Predictor variables selected included typical health systems performance expenditure indicators as well as general economic and fiscal indicators. Each of the 27 MS was assigned a binary outcome for 2011, 2012, 2013 and 2014 respectively depending on whether they had a health CSR (1) or not (0). The data for the predictor variables was extracted from the WHO European Health for all Database and EUROSTAT database in October 2014. The following variables were tested using binary logistic regression;

- GDP per capita in PPS

- Public sector expenditure on health as a % of GDP (PHE % of GDP)
- Public sector expenditure on health as a % of total health expenditure (PHE as a % of THE)
- Public sector expenditure on health as % of total government expenditure (PHE as a % of TGE)
- Total health expenditure as % of gross domestic product (GDP) (THE % of GDP)
- Total health expenditure in PPP\$ per capita (THE in PPP\$ per capita)
- Government deficit/surplus % of GDP
- Total general government expenditure as a % of GDP
- General government gross debt

2.3.2. Past trends in public health expenditure

Past trends in public health care expenditure were analysed against the likelihood of obtaining a health CSR since it was thought that the rate of change of expenditure could be a potential predictor variable. As a result of the small sample size, the non-parametric test, Spearman’s Rho correlation, was performed to analyse the correlation between the total number of CSRs issued over three years for each MS (0, 1, 2, 3 or 4) with the average annual percentage growth rate for the following three proportions (PHE/GDP, PHE/THE, PHE/GGHE, PHE growth rate and GDP per capita growth rate) for the period 2008–2012. Separate models were carried out to test each association.

2.3.3. Future forecasts in public health expenditure

For an analysis of the effect of future projections on the likelihood of getting a health CSR, use was made of the reference and risk scenarios for public health expenditure as a % of GDP in 2060 elaborated in the 2012 Ageing Report. Here associations were also tested using the non-parametric test Spearman’s Rho as outlined in Section 2.3.2.

3. Results

3.1. Prevalence of health CSRs

The results of the analysis for the presence of the terms “health”, OR “health care”, OR “long term care” within CSRs, EAPs or MoU are shown in Table 1. There is a clear trend for health recommendations increasingly to feature in CSRs. Six countries have not had a health related CSR to date.

3.1.1. Framing of CSRs on health and long-term care

In 2013, for the first time, four countries had a CSR which was specific to health or long-term care. The results are shown in Table 2. For this analysis, the EAP and MoU countries were excluded since the format of the recommendations is not comparable.

3.2. Classification of CSRs by content

Results shown in Table 3 demonstrate that sustainability is the most frequent theme using the access, quality, sustainability classification (see Section 2.2.2.1) whilst financing is the most frequent theme using the Hit report classification (see Section 2.2.2.2). A single CSR may have been assigned to more than one category depending on

Table 1
Member States issued with health system recommendations through CSRs in the European Semester Process.^a

Year	2014	2013	2012	2011
Austria	Y	Y	Y	Y
Belgium	Y	Y	Y	N
Bulgaria	Y	Y	Y	N
Cyprus	Y (EAP)	Y (EAP)	Y	Y
Czech Republic	Y	Y	N	N
Denmark	N	N	N	N
Estonia	N	N	N	N
Finland	Y	Y	N	N
France	Y	Y	N	N
Germany	Y	Y	Y	Y
Greece	Y (EAP)	Y (EAP)	Y (EAP)	Y (EAP)
Hungary	N	N	N	N
Ireland	Y	Y (EAP)	Y (EAP)	N
Italy	N	N	N	N
Latvia	Y	N	N	Y (MOU)
Lithuania	Y	N	N	N
Luxembourg	Y	Y	N	N
Malta	Y	Y	N	N
The Netherlands	Y	Y	Y	Y
Poland	Y	Y	N	N
Portugal	Y	Y (EAP)	Y (EAP)	Y (EAP)
Romania	Y	Y	Y (MOU)	Y (MOU)
Slovakia	Y	Y	N	N
Slovenia	Y	Y	N	N
Spain	Y	Y	N	N
Sweden	N	N	N	N
United Kingdom	N	N	N	N
Total	21	19	10	8

EAP, Economic Adjustment Programme; MOU, Memorandum of Understanding.

^a This includes reference to the health or long-term care as part of a CSR addressing another policy sector.

Table 2
Framing of CSRs.

Main theme	2014	2013	2012	2011
Health or long-term care	3	4	1	0
Pensions and social security	7	4	1	1
Education	0	1	0	0
Sustainability of public finances	6	6	4	3

the language used and target of the health system reform. The actual language being used is depicted in the verbatim excerpts of the CSR text available in the online appendix. Increasing cost-effectiveness and curbing age related expenditure are two of the most prevalent themes encountered. A consistency in the CSR wording from one year to the next appears.

Table 3
Classification of CSR content by policy objective and health system domain.^a

Policy objective	Health system domain	Number of CSRs
Access Quality Sustainability		12
		11
		42
	Organisation and governance	18
	Financing	40
	Physical and human resources	0
	Provision of services	15

^a A single CSR has sometimes been classified into multiple objectives or domains.

3.3. Potential predictors of health CSRs

General economic and fiscal indicators were tested against the association with CSRs. Although not health specific, it was deemed possible that these indicators may play a role in the issuance of health CSRs since these are mainly linked to sustainability of public finances. The odds ratio of obtaining a health related CSR increased slightly with the increase in level of general Government debt, with an OR 1.02 (CI: 1.01, 1.03; $p=0.007$) per 1% increase in General Government gross debt.

The only association observed between variables of health system financial performance and health CSRs was for the share of public health expenditure as a proportion of total health expenditure where the odds ratio of obtaining a CSR decreased with an increased public health expenditure/total health expenditure ratio, with an OR 0.89 (CI: 0.84, 0.96; $p=0.001$) per 1% increase in Public Health Expenditure as a % of Total Health Expenditure. This relationship remained present when both variables (General Government gross debt and Public health expenditure/total health expenditure) were put into one model. These results are presented in Table 4.

As a result of this unexpected result, to further understand the relationship between Public Health Expenditure as a % of Total Health Expenditure and the issuance of a CSR, the ratio PHE as a % of THE was subdivided into four quartiles with the lowest ratio of PHE/THE being represented as Q1 and the highest ratio being represented as Q4. Whilst no significant differences were observed between countries falling into the first three quartiles of public health expenditure as a % of THE in terms of obtaining a CSR, the likelihood of obtaining a CSR when a country's PHE/THE ratio was within the 4th (highest) quartile decreased to 9.5%. Countries falling into this category were significantly less likely to obtain a CSR when compared to each of the other quartiles. It was further noted that out of the six countries that never received a CSR, four have their PHE/THE ratio in the highest quartile. Further material is provided in the online appendix.

There was no relationship between the past annual rate of growth of public health expenditure or that of GDP and obtaining a health CSR. Given the importance attributed to the impact of ageing, the association between projected future public health expenditure for the reference and risk ageing working group scenarios modelled until 2060 and the number of CSRs was tested. Here again no significant associations were observed. The results are reported in Table 5.

4. Discussion

Previous work has noted an increased involvement of the EU in the financial governance of health systems albeit without more specifically analysing the policy tools used [41]. Using CSRs as a data source we analysed the way health systems are being addressed through the European Semester process. An increasing 'socialisation' [35] of the Semester has been noted although the ubiquitous emphasis appears to be on sustainability.

Table 4
Results from binary logistic regression with presence of CSR as outcome variable.

Parameter	Odds ratio	CI	p-Value
GDP per capita in PPS	1.00	(0.99–1.01)	0.966
Public sector expenditure on health as a % of GDP	0.97	(0.78–1.20)	0.752
Public sector expenditure on health as a % of total health expenditure	0.89	(0.84–0.96)	0.001*
Public sector expenditure on health as a % of total government expenditure	1.00	(0.87–1.15)	0.983
Total health expenditure as a % of gross domestic product (GDP)	1.09	(0.88–1.34)	0.438
Total health expenditure in PPP\$ per capita	1.00	(1.00–1.00)	0.340
Government deficit/surplus as a % of GDP	0.98	(0.90–1.08)	0.738
Total general government expenditure as a % of GDP	0.97	(0.92–1.03)	0.352
General government gross debt	1.02	(1.01–1.03)	0.007*
Joint analysis of general government gross debt and public health expenditure as a % of total health expenditure	1.03	(1.01–1.04)	0.004*
	0.92	(0.86–0.98)	0.011*

*signifies a statistically significant relationship $p < 0.05$.

Aside from the specific situations in countries relying on financial assistance and bail outs, this analysis has shown that health systems in general are coming under increasing scrutiny by the European institutions. Health and long-term care are gaining visibility as policy issues in the European semester as they are also attracting CSRs in their own right. A hierarchy of health policy objectives is emerging with sustainability becoming supreme to access and quality, departing from the balanced triad of policy objectives promulgated through the Open Method of Coordination [39,42] or the focus on key values for European health systems [43]. Health system CSRs are framed as a means to the objective of ensuring sustainability of public finances and not as part of the pillar on combating poverty and social exclusion. The analysis also indicates a shift away

from concentrating only on the financing of health systems as a lever for policy reform but shows how health care organisation and delivery is also recently being targeted as an area for policy reform. The study has confirmed that to date it was not possible to discern an association between health performance indicators related to public expenditure and sustainability of health systems and the issuance of health CSRs. However an association was observed between the level of general country debt and health CSRs indicating that the performance of the health system is a secondary consideration to the overall country financial situation.

Financing and sustainability are dominating the discourse on health systems. This possibility had been alluded to in an analysis outlining how health systems will be influenced by the EU's policy agenda post financial crisis [14]. The hierarchy and subordination of policies within the European institutions is not something new and has been reported elsewhere [17,35] confirming the observed tendency of linking health goals more closely to the EU's economic growth narrative rather than valuing the health policy objectives in their own right [44]. Despite the existence of official documents supporting the need to invest in health [30], investments in health infrastructure and human resources as a pre-requisite for economic growth do not feature as a priority. Whilst the narrative of the European Semester promotes investment in education and research, health and long term care systems are referred to in terms of a policy challenge [36].

The CSRs recommending controls in health care spending are also likely to affect the prospects of job creation in the health sector running counter to the observation that the health sector is one of the important growth sectors for employment in Europe [45]. Zealous implementation of CSRs aimed to secure sustainability of public finances may well have spill over effects into fields such as employment.

The process of CSR formulation does not appear to be one driven by traditional metrics of health system performance but seems to be influenced by several factors which may include lobbying and negotiation by the Member States themselves but equally between the different Commission DGs, each with its own specific mission, objectives and line of expertise [46]. Given the importance attributed to the Ageing Report projections, it was surprising that

Table 5
Association between trends in public health expenditure growth and number of CSRs.

Parameter	Spearman's rho	p value
% Annual average growth rate GDP per capita 2008–2012 vs total number of health CSRs (2011–2014)	–0.11	0.60
% Annual average growth rate Public health expenditure 2008–2012 vs total number of health CSRs (2011–2014)	0.03	0.88
% Annual average growth rate Public health expenditure/GDP 2008–2012 vs total number of health CSRs (2011–2014)	–0.04	0.86
% Annual average growth rate of Public Health Expenditure as a % of Total Health Expenditure 2008–2012 vs total number of health CSRs (2011–2014)	0.11	0.60
Projected increase in Public health expenditure/GDP 2010–2060 (AWG Reference Scenario) vs total number of health CSRs (2011–2014)	0.02	0.93
Projected increase in Public health expenditure/GDP 2010–2060 (AWG Risk Scenario) vs total number of health CSRs (2011–2014)	–0.11	0.58

the health care spending projections were not associated with the odds ratio of obtaining a health CSR. The evolving situation where countries are increasingly under pressure to implement their CSRs to be viewed as coming in line with the advocated norms for financial and economic policy objectives makes it even more imperative that the CSRs are informed by appropriate evidence both in their genesis as well as for their potential health impacts. Increased transparency in the process leading up to the formulation of CSRs for health systems should be considered by the EU institutions involved in the process which has been acknowledged to be a relatively new process which is still being fine-tuned.³ Health experts and decision-makers would do well to engage more actively in shaping the processes of the European Semester. The explicit call for work on health systems performance to inform the European Semester [47] appears to acknowledge the need to continue to refine and develop the process of CSR elaboration. The expert group on Health Systems Performance Assessment [42] has an important role to play such that the input into metrics for CSRs does not remain the quasi exclusive domain of the Economic and Social Policy Committees. The Commission Staff Working documents drawn up to inform the CSRs are important policy statements but do not in themselves lead directly and certainly into CSRs. Indeed it has become quite pertinent to question why certain countries not attracting health CSRs. Examination of the actual text of the CSRs shows a certain consistency from one year to the next. It has become increasingly difficult to disentangle the extent to which the EU is pushing national health systems reforms through the Semester or whether Member States are riding on the back of the Semester to gain the additional Brussels based support for unpopular policy reforms at national level [48].

The European Semester appears to have irreversibly shifted the locus of decision making for health system reform from a purely national competence to one which is shared with the European institutions. The effect of this top down approach on the existing mechanisms of health systems stewardship at national and regional level remain to be seen. On the one hand the excessive focus on fiscal sustainability may have a negative impact whilst on the other hand the top down pressure for reform may result in an opportunity to tackle long-standing issues for which there was insufficient political will or technical resource in the past [49].

4.1. Strengths and limitations

This study has the following strengths. The content analysis made use of two separate policy frameworks to triangulate the evidence and the complete set of CSRs was examined over a four year period. Earlier versions of this paper were presented at a meeting on The International Dimension of Collaborative Health Systems Research in

May 2014 and at the European Public Health Conference in November 2014 where discussion between key stakeholders served to provide information on the evolving nature of the European Semester process and indications for future research. The study is only a preliminary attempt to describe a process that due to intrinsic complexity and the presence of several confounding factors can be only partially undergo objective analysis. It is possible that trends will emerge over the next couple of years as the power of the sample under investigation increases. On the other hand methods such as qualitative comparative analysis could form an alternative approach to the analysis and will be considered in future work. The assumption that the presence of a CSR is linked to recommendations on health system sustainability is also a limitation given that a few CSRs do focus on aspects of access and quality. This confounding factor may have also served to dilute the real effects. Health and long-term care recommendations were analysed together as health system reforms. A separate analysis of these two policy areas would be important as the number of CSRs available for analysis increases.

4.2. Further research

The production and subsequent evaluation of the National Reform Programmes and the Convergence and Stability Programmes are tangible products of the policy making interface between national and EU level decisions. The manner and direction in which European health systems are being steered and the extent to which the European Semester is shaping health system reform in practice is an important area for further research.

5. Conclusions

Health systems policy and reform no longer takes place entirely at national level. Whilst interdependence has become unavoidable for public health to progress [50], it is important to ensure that the manner in which health systems are steered through the European Semester process focuses on improving health system performance as a means to improve the health of European citizens. The setting up of an expert panel to provide advice on Investing in Health is a step in the right direction [31]. Getting this expertise into the heart of the decision making processes in the European Semester to bring about a better informed health-informed approach to evaluating health issues within the European Semester is the next challenge. There is a need to rebalance the discourse at European level so as to duly recognise that health systems are not merely a burden on public finances for Europe. The Annual Growth Survey 2014 [51] mentions health together with pensions as being areas requiring attention to efficiency and sustainability whilst ensuring access to high quality services. Whilst this statement augurs well for retaining the balance between the policy objectives of access, quality and sustainability, the fact that all the CSRs for pensions and health are captured under the heading of *sustainability of public finances* and not that of employment and social policies leads to the conclusion that the debate at European level remains skewed. More

³ Emphasis was made on the fact that the process should be viewed as a learning exercise still needing refinement during a round table discussion that took place during a workshop on the European Semester organised at the European Public Health Conference, Glasgow, 21/11/2014.

active engagement of health decision-makers is required. Further coordination by European Union institutions should be geared towards supporting Member States to take the best decisions possible, decisions which will lead to the maximisation of health gain and improvements in health status for Europe's citizens. This spotlight on health systems may be turned into an opportunity for a new paradigm [3] in the process of health policy development at European level since it appears unlikely that health systems scrutiny by the EU institutions will be reversed even with a return to economic growth. The possible impact of this development on Europe's health systems and their common values [43] remains to be seen and a full impact assessment of the European Semester process on health systems reform in Europe may be a timely consideration.

Conflict of interest statement

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.healthpol.2015.01.007>.

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