

# **Choosing paths in European Union health policy: A political analysis of a critical juncture**

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The treaties that constitute the European Union and allocate the competencies of its institutions are explicit about the limited extent of its health powers, which are largely confined to public health issues such as blood regulation (art. 152) (Hatzopoulos 2005; Hervey and McHale 2004; McKee and Mossialos 2006; McKee et al. 2002; Mossialos and McKee 2002; Steffen 2005). Health services- the organization and finance of medical care- are not mentioned in the treaties. This presumptively denies the EU a competency. The European Court of Justice has repeatedly confirmed that the organization and finance of health services are the responsibility of member states<sup>1</sup>.

But health services policy, like other policy areas before it, is demonstrating that European Union competencies can expand according to rules other than those contained in the treaties (Lamping 2005; Pierson and Leibfried 1995). The basic logic is easy to explain: while health services might not be part of the explicit domain of the EU, internal market law can shape the environment of health services (Hassenteufel and Hennion-Moreau 2006).

Extension of internal market law into health has given rise to a constitutive politics of health policy in the EU- a “critical juncture” that will shape future constraints and actors. The EU health policy arena is a rapidly changing system in which the borders defining policy, the institutions making policy, and the structural balance of powers between states and interest groups are still to be determined (Steffen 2005). This article makes four points. The first section argues that contemporary EU health policy is at a “critical juncture.” A critical juncture is characterized by a high degree of contingency, multiple possible trajectories, and a high likelihood that the results will prove self-perpetuating. The second section explains that this critical juncture was created by the reaction of member states and the Commission to challenges created by ECJ decisions. The third section discusses the indeterminacy and inertia of EU health policy. Decisions are difficult to predict now, because there are no established ways of making health services policy, but will be difficult to change once made because of the high barriers to major policy change in the EU. The fourth and longest section considers the options- the various possible paths on which EU policy might embark.

## **Data**

The primary source of data is 70 semi-structured interviews conducted with EU member state and regional government officials from the UK, France, Germany, and Spain, and lobbyists between July 2003 and July 2007, with the main waves in October-December 2005 and March-July 2006. Table 1 gives some summary descriptive statistics. Interviews with officials were primarily with desk officers, who were in most cases the highest rank charged with understanding the specific policy and political issues (i.e. the health ministry officials responsible for EU affairs, the Commission heads of Unit, who typically brought along policy experts, and the regional government officials, typically delegated from the health departments and located in either their regional capital or Brussels). Lobbyists were from either EU groups or from member-state level organizations that had invested in EU policy experts. Most such groups have only one

lobbyist charged with EU health services issues. Their organizations all participated in at least the EU Health Policy Forum or the 2007 consultation on EU health services law, and snowball questions to all interviewees confirmed their importance. The interviews, conducted with the promise of anonymity, lasted about 45 minutes and were transcribed from notes. Other evidence and contextual information comes from EU documents, and participation in practitioner events such as the annual European Health Forum Gastein and 2005-6 meetings held by professional organizations in London and Brussels to prepare responses to the consultation on a health services directive.

Table 1:  
Interviewees

	Health department (international or EU unit) / DG Sanco	Permanent representation/ officials of DG Empl. and Markt	Regional government	Lobbyist	Academic	Total
France	1	1	n/a	0	3	5
Germany	2 (1 ret.)	1	3	1	3	10
Spain	0	1	3	0	5	9
UK	5	2	8	7	1	23
EU	4	6	n/a	11	2	23
	12	11	14	19	14	70

## Why decisions taken now will matter later

For a long time, there was nothing that could be described as an “EU health services policy,” and very little by way of EU health services politics. This meant that there were no ground rules- and no established actors, legal devices, policy instruments or academic debates. Now, however, there are legal debates, policy debates, specialized publications (such as *Eurohealth*), interest groups, and all the other activities that come with a recognized policy issue. But what will the ground rules be? Which policies are likely to be adopted, and which are likely to be ruled out?

This article focuses on the effects of decisions taken now, in the early days of EU health services policy. The logic of the argument comes from historical institutionalism, an approach to the study of political institutions. This literature points out that small decisions about institutions and policy tools taken at one time can have a major influence over what is possible and realistic in the future (it is a voluminous literature. See Pierson 2004; Streeck and Thelen 2005; Thelen 1999; Thelen and Steinmo 1992). The key concept is path dependency. Path dependency is used to explain why inefficient or suboptimal outcomes persist. They persist, it runs, because the transition costs of shifting to a better path are too high. At some time in the past, those involved

made decisions and investments that set them along one trajectory. Now, even if they wish they were on a different trajectory, their existing investments bind them to it. This is path dependence because even if the path turns out to be less than optimal, it would be too hard and time-consuming to go back to the fork and take the other path.

The initial choice of direction is crucial, because while it is easy to change directions at a fork in the road, every step forward makes it harder to go back and change. The forks are known as “critical junctures”. Critical junctures are times at which the ordinary incrementalism of politics is temporarily replaced by uncertainty and the possibility of significant change, which will later stabilize and return to incrementalism (Krasner 1984). Thus, for example, health systems tend to evolve according to their own incremental logic- except when a mobilization of considerable outside force changes the basic structures within which they evolve (Tuohy 1999). Paul Pierson, in his synthesis of historical institutionalism, attempts to capture the conditions under which a critical juncture exists and matters. He identifies four conditions for a critical juncture (Pierson 2004:45). They are:

- (1) *Multiple equilibria*; “under a set of initial conditions conducive to positive feedback, a range of outcomes is generally possible”
- (2) *Contingency*; “Relatively small events, if occurring at the right moment can have large and enduring consequences;”
- (3) “a critical role for *timing and sequencing*. In these path-dependent processes, when an event occurs may be crucial. Because early [steps in] a sequence matter much more than later [steps], an event that happens ‘too late’ may have no effect, although it might have been of great consequence if the timing had been different.”
- (4) *Inertia*- “once such a process has been established, positive feedback will generally lead to a single equilibrium. This equilibrium will in turn be resistant to change”.

If these four criteria are fulfilled, then the system is at a critical juncture. Pierson is not clear about how long a critical juncture lasts; the concept connotes speed, but there is no necessary reason for that. Path dependency is a process in which the cost of changing equilibrium increases (as the two paths part). This can be slow or fast; principally, it should depend on the magnitude of individual decisions and the way the political system functions (it takes longer to legislate in the EU and Germany, for example, than in the UK or New Zealand).

EU health services policy currently fulfills Pierson’s four characteristics. There are multiple possible equilibria, with at least four different possible models of policy, and highly contingent politics. The structural characteristics of the EU create a high likelihood that the sequence of policy decisions and their self-reinforcing nature will make decisions taken now more important. The debate is therefore not just about policies; it is about the kinds of policies that will be made and who will make them. EU health services policy is at a crossroads; decisions now will shape possible policies for a long time to come.

## **Issues in the Europeanization of health services**

An EU health services policy debate came about because the ECJ gradually expanded the scope of EU law to incorporate health services. From 1998 onward, the ECJ issued a stream of

decisions sufficient to force member states and the Commission to react with more attention and more policy ideas.

## The issues

The European Court of Justice (ECJ), the Luxembourg-based court that has become responsible for interpreting and enforcing EU Treaties and legislation, initiated the entry into health services. The “most effective supranational body in the history of the world” (Stone Sweet 2005:108), the ECJ has driven European integration, first by establishing that EU legislation and its decisions overruled states’ decisions, then through a large jurisprudence that is critical of measures that discriminate on the basis of citizenship within the EU (Alter 2001; Burley and Mattli 1993; Rasmussen 1986; Stein 1981). It has certainly played that leading role in extending European integration in the case of health services policy (Greer 2005; Greer 2006b). There is by now an extensive literature on the law and policy implications of the ECJ’s decisions, with some excellent overviews (Hatzopoulos 2005; Hervey and McHale 2004; McKee and Mossialos 2006; McKee et al. 2002; Mossialos and McKee 2004).

The Court made extended its authority via decisions on three issues.. The first major issue was patient mobility. This burst on to the European health policy scene with two dramatic 1998 decisions, *Kohll* and *Decker*.<sup>ii</sup> In both cases a Luxembourg citizen used a service outside the country, requested reimbursement from a Luxembourg health insurance scheme, had the request denied, and sued. The Court ruled in both cases that the Luxembourg insurance funds’ denials were unjustified discrimination on the basis of the member state of the provider. The crucial issue is that the Court in these cases defined the issue as one of the internal market (Art. 49) rather than social security. Practical costs are limited so far (Ackers and Dwyer 2002; Rosenmöller et al. 2006). The problem is that there is a large *acquis* of internal market law with which health systems often do not seem to comply; closure has been both an administrative and philosophical characteristic of member state welfare states (Ferrera 2005). Insofar as the Court (and member state courts) apply Article 49 law or principles to health services, they could oblige major changes in health services organization (by, for example, reducing member state payers’ ability to discriminate in favour of providers that they control, or their ability to make purely member-state decisions about what kinds of treatment are justified)<sup>iii</sup>. The current pattern- case by case decisionmaking- does not make it clear how radical the principles truly are or what the effects will be.

The second major issue arose with judicial interpretation of the Working Time Directive (WTD, 93/104/EEC). The WTD regulates working times across Europe, limiting the total number of hours that can be worked and ensuring rest periods for employees between shifts. Applied to health services, it was always going to have controversial consequences, raising labor costs by demanding more hires to cover the same hours (Sheldon 2004). The ECJ, however, did a great deal to make it more controversial with two decisions that meant member states would incur more costs and more changes than they had expected by expanding the scope of “working time” in the *SiMAP* and *Jaeger* decisions<sup>iv</sup>. When the Directive came to be implemented, those two decisions increased the costs substantially.

The third issue is still more difficult to work out, but potentially more serious. It is the extent to which the economic activities of health services are folded into competition, public

procurement, and other internal market law. A number of private providers and operators in health have brought cases, arguing that public systems enjoy unjust exemptions from competition law.<sup>v</sup> The threat is that courts or (since the decentralization of EU competition law enforcement in 2004) competition authorities in member states could invoke competition or internal law against “solidarity” mechanisms (Dawson et al. 2005; Jost et al. 2006). Even if that does not happen, there is a potential “ratchet” effect, since it could be difficult to expel private firms from areas where the public sector has opened itself to competition<sup>vi</sup>.

## Triggering activity

It is not obvious that decisions taken in 1998 should produce a reaction in 2007. The explanation for the time between the first ECJ actions and the present political activity lies in two established characteristics of EU politics. One is “contained compliance”, in which member states try to restrict the effects of ECJ rulings, and the other is an EU institutional structure whose bottlenecks slow legislative responses.

Member states initially reacted to ECJ decisions (i.e. *Kohll* and *Decker*) with “contained compliance”, interpreting them narrowly and substantively and avoiding policy changes for as long as possible (also Ferrera 2005 chapter 4). As Lisa Conant argues, this is the standard reaction of member states to adverse decisions (Conant 2002). Most states argued that the two decisions applied only to Luxembourg, and that if they had any further applicability it was to social insurance systems similar to Luxembourg (their official stances are summarised by Gobrecht 1999). Germany held the EU presidency at the time, and the German federal health minister, Horst Seehofer, instructed his officials to “destroy those decisions” (interview, retired German health ministry official, Bonn, May 2007). Their chosen technique, one picked up by subsequent presidencies, was to commission research, hold conferences, and develop a Reflection Process that would try to delimit the powers of the EU and reassert member state control of the issue.

The problem, as German (June 2007), Spanish (June 2006), British (October 2006), and French (March 2007) officials said, is that the decisions continued to come. The ECJ, ruling along logically consistent lines, expanded the scope of its influence over health services and social insurance systems. The rulings came to include most aspects of health services, and in the May 2007 *Watts* decision the Court ruled that they also covered tax-financed models such as the British NHS systems. Contained compliance had the drawback that it was allowing the Court to develop a jurisprudence of health, while the stream of cases created legal instability.

Meanwhile, broader health policy communities in European member states were absorbed with other issues. It was not until the eventual implementation of the Working Time Directive in 2004-5, and shortly afterwards the Services Directive, that attention to EU health issues increased. In other words, the legal history of our critical juncture begins in 1998 but it is a history of contained compliance, and simple nonresponse, until late 2005.

After 2005, the decisionmaking stage dragged out because of the slowness of much EU policy activity. The EU, with its often complex procedure, extensive consultation processes, diverse institutions, and preplanned agendas, does not make policy especially quickly. Legislative proposals made in 2004 (such as the Services Directive) did not have their fate decided until 2006. Softer law programs often evolve by annual or quarterly meetings. This

means that a critical juncture, by the standards of the EU, can last a long time- until legislation, or a decision not to legislate, closes it.

## **The indeterminacy and inertia of EU health services policy**

At this stage it is very difficult... The Commission is not able to propose and Member States are not very clear about what they want to do.

-French official, Brussels, July 2006

The EU health services policy arena is an arena with no well-established health players, principles, or legal basis. That means contingency matters more in EU health policy than even in most other arenas of EU policy. The outcomes of these decisions will be important because the EU's institutional structures make it difficult to change legislation or many ECJ decisions.

### **Indeterminacy**

The scope of health services policy, the policy tools, and the legal bases for EU intervention are still poorly defined. There are four reasons why is difficult to predict the EU health services policy at this stage.

First, the “treaty base game” is very important at the moment (Rhodes 1995:99). The treaty base game is the effort to determine which parts of the treaties justify policies. The EU institutions can do nothing significant without a competency from the treaties, so finding a treaty justification for even a policy that member states support is crucial. It is documented that the Commission, and sometimes member states, will routinely try to base policies on sections of the treaties that increase the likelihood of passage (i.e. that minimize the role of the European Parliament or allow qualified majority, rather than unanimity, passage in the states' Council of Ministers), afford the best defenses against legal challenge, and create the greatest likelihood that discontented groups will have standing to sue member states for noncompliance (Héritier 1999:20-21; Jupille 2004:104). This matters because the treaty base for a policy, once selected and established, shapes the legal and regulatory tools available, the part of the Commission which will handle the policy area, the departments of member states engaged, and the habitual policy interlocutors they bring. A health policy using the health treaty bases, which are mostly about public health, is much more circumscribed by treaty bases than would be a policy based on assimilation of health to internal market treaty bases such as Art. 49. A health services policy built on social security law would require that states make decisions by unanimity, while one built on Art. 49 would allow decisions by qualified majority vote (Hervey and McHale 2004:69-108).

Second, the treaty base game is entangled with the internal bureaucratic politics of the European Commission. The Commission has a well-documented propensity to act as a “purposeful opportunist”: to expand EU competencies by opportunistically identifying new areas of policy that it can incorporate into EU competencies (Cram 1997:154-167). The Court, indifferent to the Parliament's suits and generally hostile to the member states, shows a marked

tendency to defer to the Commission (Jupille 2004:98; Poiares Maduro 1998; Stone Sweet 2005). That increases the effects of Commission activities.

But the treaty bases for health legislation do not just empower the EU institutions as a whole; they also empower particular parts of the Commission. This matters because each DG involved in the contest has a different outlook and manner of proceeding (Cram 1997; Spence 2006). Born of its particular history and available legal instruments, a DG's style of proceeding can shape policy. Thus, for example, almost every interview highlighted how the young, weak DG Health and Consumer Protection ("Sanco") is much more solicitous of incumbent health policy communities than its rivals DG Employment and Social Affairs or DG Internal Market ("Markt"). DG Health and Consumer Protection finds in incumbent health policy communities a natural base of support, and one that is well integrated with the member state health ministers who usually deal with it. It is the DG that sends officials in force to the annual European health policy conference in Gastein, it is the DG that runs the European Health Forum, the leading consultative health policy group set up to give the Commission good information, and it is the DG that is trying to find ways to fund EU-level health policy groups in order to create a constituency for itself (Greer forthcoming 2007). DG Employment and Social Affairs and DG Internal Market already have their constituencies (especially unions and employers, respectively) and strong connections with member states' economics, industry and labor, rather than health, departments. The balance of power between the weak DG Health and Consumer Protection, with its limited treaty bases, and the two others might be seen in the fact that its European Health Forum's recommendations are usually commenting on proposals issued by DG Internal Market or DG Employment or Social Affairs.<sup>7</sup>

Third, the same disjointedness affects many governments. Some of the most important legislation affecting health, as well as the conceptual categories used to interpret health policy, are shaped by trade, economics, and industry departments rather than health departments. Two member state officials spoke in 2004 and 2006 interviews of health ministers' irritation when they found the Court, and colleagues in industry and trade ministries, were "reshaping their systems while their health ministers] discussed cancer research." The degree to which health departments know what trade and industry departments are doing, or to which trade and industry departments understand the health consequences of their actions, is often limited. Even if there is communication, this might not mean coordination, and health ministers do not always outrank economics ministers (Kassim et al. 2001; Kassim et al. 2000; Wright 1996).

Fourth, the EU health services policy community is still very much changing and developing. Even by the standards of EU interest representation, which is typically less structured than in member states, (Greenwood 2003:2; Mazey and Richardson 1995), interest representation in health services policy is weakly developed. Different interest groups in different countries are taking an interest in different aspects of the EU at different speeds. The result is a wide spread of tactics, goals, and investment, with member state groups' relations with the EU ranging from a total lack of interest, to participation in EU associations, to opening their own Brussels offices and hiring their own lobbyists (Greer 2006a; Greer forthcoming 2007).

## **Inertia**

In other words, EU health politics has yet to develop the degree of order found in other major policy areas of the EU- in Pierson's terms, contingency matters. It also has a high level of what he calls inertia. The EU is, compared to even complex states such as the US, exceptionally "sticky" (for the argument and a great deal of evidence, Pollack 2003). Decisions, once taken, are hard to reverse.

At most, they require revisions to treaties that must be unanimously agreed by 27 member states, some of which must ballot their populations in referenda; *Kohll* and *Decker*, which are based on the Court's direct reading of the Treaties, would take Treaty revisions to reverse. Even if were normal legislation, the EU policymaking system's complexity and the multiplicity of interests make additional legislation very difficult; while there is a great deal of member state agreement on the principle of revising the WTD to reverse *SiMAP* and *Jaeger*, actual legislation is caught in a logjam with other WTD issues such as the UK's opt-out (UK official, May 2006; lobbyist, October 2006). Finally, once the Commission is pursuing a policy in its role as an executive, with its attendant implementation, enforcement, and personnel decisions (Page 1997:104-110), it is able to circumvent restrictions that member states attempt to impose. In other words, EU health services policymaking is contingent now but the policy instruments and dominant bureaucracies, once chosen, will be very difficult to change and very likely to enjoy positive feedback from their new role as dominant players in EU health services policy.

## **Selecting a path in European health services policy: sequencing and multiple equilibria**

The EU's health services policy is, therefore, unstable, and prone to inertia. This section focuses on the remaining condition from Pierson's list: the presence of multiple possible outcomes (equilibria). We are at a moment in EU health services policy in which there are multiple, credible, possible equilibria made up of different policies or combinations of policies, and politics now is about choosing one (Jorens et al. 2005). The policy options come from diverse sources in social and economic policy; this diversity reflects the uncertainty over treaty bases and responsibility for health services within the Commission. Some would integrate health into the internal market; some would integrate it with other areas of EU social policy; and some would enhance its distinctiveness. The choices the EU makes now are progressively ruling some of them out, and decisions taken now change the significance of other policies that still might be chosen.

### **Health within the internal market 1: Services**

"The health services would prefer...time for discussion, with time to work out these complex issues, rather than whacking it all into Article 23 of the Directive"

-Lobbyist, London, October 2004

"All we are doing is codifying what the Court has already said"

- DG Markt official, Sept. 2005.

“Even the UK and France were agreed. That means we can be sure it was a bad idea.”  
 - French permanent representation, Brussels, July 2006

The first path proposed by the Commission, one that would have had a dramatic effect on all EU health systems, was the Services Directive (COM(2004)2), initiated by the controversial Dutch Liberal Commissioner Frits Bolkestein towards the end of the Prodi Commission in 2004. It was in the eyes of the new Barroso Commission and many member states the best way to advance a competitiveness agenda. It would have extended two key principles of internal market law to the service sectors: the country of origin principle, which means service providers are subject primarily to the law of the country in which they are established (rather than the one in which they are providing the service), and freedom of establishment (banning discrimination against nationals of one state who would like to practice in another state). It also incorporated health, which was a surprise to many health services policy observers.

DG Internal Market was surprised at the ferocity of the reaction from the health sector (interviews, lobbyist and official, London, June 2005, October 2005; DG Market officials, Brussels, September, October 2005). The health sector's response got much less attention, though, than the impressive negative reaction from unions and defenders of the classical public service model across Europe (especially in France where, memorably, angry electricians cut off the electricity to Bolkestein's holiday house; Buck and Bickerton 2005). The French and Dutch negative referendum results on the constitution might also be taken as evidence of dissatisfaction with the EU and its liberalizing activities- the “Bolkestein directive,” as it came to be known, probably played a role in at least the French negative (Fondation Jean-Jaurès 2005).

The Commission drew back after seeing the hostile reaction, while lobbies worked to defeat or heavily modify the directive (including health services lobbies, which usually sought simple removal of the health sector)(Greer forthcoming 2007). The eventual result was a deal between the leaderships of the two largest parties in the Parliament- the Christian Democratic European People's Party and the Party of European Socialists. This stripped out both health and the country-of origin principle. DG Markt retired from the field, although its officials still point out that it has the option of starting infringement proceedings against member states that fail to comply with freedom of movement in health (interview, March 2006; statement by Geraldine Fages on 30 March 2007<sup>viii</sup>). Fundamentally, this approach remains in play for two reasons. One is the power of DG Markt within the Commission, and the associated power of liberalizing ideas. The other is that the DG Markt approach fits health under Article 49- which is what the ECJ decisions on patient mobility have also done.

## **Health within the internal market 2: Services of General Interest/ Services of General Economic Interest**

“From the French side, we tried to promote a common approach, a broader approach focusing on the social services of general interest. We think that health care services are not really specific”

- French official, Brussels, July 2006

“Or do you mean a service of general *economic* interest? Or a *social* service of general economic interest? What’s a service of general interest? What’s the treaty base? Definition? [sets down coffee and points at interviewer]. What? What? What?”

-UK official, London, May 2006

The second “horizontal” approach that can be drawn from internal market law is one built on the concept of services of general economic interest. Known by a variety of names, and most often discussed in arguments about the legality of state aid, they are (broadly) services that are exempted from part or all of internal market law because they fulfill public service functions (see Baquero Cruz 2005). Their treaty base is article 16, which specifies that services of general economic interest be allowed to “operate on the basis of principles and conditions which enable them to fulfill their missions.” The concept responded to the conviction, particularly strongly articulated by France, that it should be possible to regulate public sector organizations with a public service mission differently from purely private activities. Much of the policy content came from telecommunications and postal services, where there had been long debates about ways to combine liberalization with the obligation to provide subsidized universal service. Universal service and other rules cut against the Commission’s preference for general, as against segmental, legislation, but their logic could be generalized into a principle (Smith 2005:70).

A 1996 communication (COM(1996)443) accordingly tried to codify the concept of a service of general interest. It is a service in which there is a need to sustain principles of equality, universality and continuity, and which therefore requires a balance between the internal market and public service. Later, the Commission began to consider more seriously the development of a general framework for those services. It released a green paper in May 2003 (COM(2003)270), conducted a consultation on it, and then produced a white paper in May 2004, COM(2004)374). Health was included in the “recitals” (preliminary statements of intent) in both, but not specifically discussed otherwise, which would have left it open to later inclusion in a policy adopted for other reasons. Interest groups, which were extensively consulted over this topic, and were mostly surprised by health’s sudden inclusion in the proposed Services Directive, now wonder if the whole debate was a feint to distract them (interviews, Brussels, October 2005).

A statement clarifying the application of the concept to health and other social services had, in fact, been under preparation in DG Employment and Social Affairs for a long time, but publication was repeatedly delayed until the Services Directive was first proposed, amended, and passed. The eventual document (COM(2006)177), published in April 2006, specifically excluded health on the grounds that it should receive special consideration; it prepares the way for a 2007 communication on the topic- although until March 2006, health was still included in draft versions seen by the author during interviews at the Commission. But the fact that article 16 provides justification for the concept as a limitation on the internal market, the stance of some states (especially France) that health is not a specific problem but rather a service of general interest, and ongoing skepticism about the usefulness of sectoral health legislation as defense against the application of internal market and competition law by courts across the EU mean that it is unlikely to go away.

## Health as a distinct policy field: The High Level Working Group

“Oh yes, we’re doing something- we had a meeting and it decided to form a committee”  
 - Commission (DG Sanco) official, London, July 2004

Member states, faced with the court and the fact that an EU health services policy arena would develop, initially came together in a purely defensive mode. This is the High Level Working Group. This is what its ungainly name suggests: a standing committee of member state representatives that responds to the problems thrown up by EU law and developments such as cross border patient flows. Its remit is to solve problems caused on the European level and seek harmless improvements (such as exchange programs) rather than formulate an EU health services policy where none has been.

It began with the High Level Process of Reflection. The political impetus was the German minister Seehofer’s order to his officials to “destroy” *Kohll* and *Decker*. Intellectually, it was structured by an influential book produced by the European Health Management Association (EMHA, with, in true *communautaire* style, funding from the Commission’s research budget)(Busse et al. 2002). At the same time, books commissioned from the influential and respected European Observatory by the Belgian presidency alerted many to the issues (McKee et al. 2002; Mossialos et al. 2002). These projects and books, with features such as analyses of the increasing amount of legislation with health impacts, coincided with major cases surrounding patient mobility that alerted health ministers and policy experts to the importance of the EU. Health ministers, whose Councils had been about (rather minor) public health issues, suddenly began to decide that they were discussing the wrong issues in European politics (interview, UK Department of Health, July 2004).

The December 2003 “Outcome of the Reflection Process” (DG Health and Consumer Protection, COM(2003)) proposed that a permanent working group should be established, and member states duly created the High Level Group on Health Care in an implicit acceptance that some mechanism for coping for EU health spillover would be required for the indefinite future (DG Health and Consumer Protection 2003). DG Health and Consumer Affairs serviced the Reflection process and the Working Group, which began to assemble itself in late 2004 and in made its first statements in 2005. The problem of the Group to date is that it produces nothing that looks like hard law. It has not allowed health ministers to get control of a process they are not driving, which means its relative head start has not prevented other mechanisms appearing.

## Health as a distinct policy field: Sectoral legislation

“There are a lot of high level groups in Brussels. You won’t solve it with High Level Groups. What we need is political- a common approach in health, especially the internal market sector.”  
 - Official, French permanent representation, Brussels July 2006.

The failure of the Services Directive’s inclusion of health, and the decision by the Commission and many health interest groups not to pursue the services of general interest approach leave a vacuum that “sectoral” health legislation can fill. Filling that vacuum fell to DG Sanco after the passage of the amended Services Directive in 2006. Legislation had been opposed by member

states that generally oppose legislation, such as the UK, Ireland, and most of the accession states, and viewed with skepticism by those who would prefer a pre-*Kohll*, pre-*Decker* repatriation of health services policy to the member states. But, given that the EU role is almost certainly irremovable the constituency for such a law grew (with the UK, ever the skeptic, coming around in mid-2006; remarks by Nick Boyd at the European Health Forum Gastein, October 2006).

DG Sanco launched a consultation (SEC(2006)1195/4) on the problems and the possible content of a specific health law in September 2006. Interviewees after its publication were all surprised its openness. Its questions focused on just what kind of legal clarity was sought, and views about the appropriate locus of responsibility for different issues. The outcome is almost guaranteed to be a proposal by Sanco to the College of the Commissioners for sectoral health legislation, but it is very likely, given the weak treaty bases and dissension among member states, that it will be tightly drawn, with recitals that strongly discourage further Article 49 judgments by the Court. If that works- if the Court is genuinely discouraged- then the impetus for more health services policy activity will largely go away. Mutual learning and networking, rather than efforts to head off the Court and DG Markt, will probably drive any activity.

## **Health as Social Security**

The focus on the Court's Article 49 judgments, the Commission's Article 49 proposals on services, and the consequent interest in specific health instruments can obscure the extent to which EU health law is still a question of social security. In fact, most EU patient mobility takes place under the old social security regime, whose foundational law is the 1971 Regulation 1408/71. This is the basis for most Europeans' patient mobility experiences- first through E112 and similar forms, which were required to preauthorize non-emergency treatment for non-residents, and now the European Health Insurance Card (EHIC)(Hervey 2007 (forthcoming); Rosenmöller et al. 2006). This instrument's treaty bases are in social security, a complex and well established area of EU law that usually requires unanimity and is therefore both inflexible and firmly under member state control. It is possible to imagine hybrids in which specific health legislation or services of general interest law will satisfy the Court's Article 49 jurisprudence, while a more attractive EHIC system continues to be the basis of most actual patient mobility. Given the extent to which the concerns about both the ECJ decisions and the Services proposals are actually about their regulatory consequences rather than the financial consequences of patient mobility, this is entirely possible.

## **Health as part of the European social model: The OMC**

The Open Method of Coordination is form of EU-level soft law- based on benchmarking, peer review, and information exchange- that essentially tries to force the development of norms through a focus on shared policy goals. It follows a basic template in each case. Member state representatives agree a set of issues. They form these into a questionnaire that will identify indicators and give a general sense of where different countries are. This makes possible benchmarking and further development of indicators. Member states, meanwhile, agree goals and action plans, which they present to the OMC peer review process on a regular basis. There is no formal penalty for failure.

The literature on the OMC is extensive.<sup>ix</sup> Sabel and Zeitlin, treating it among a range of other mechanisms of new governance, argue that it will work best when there are shared problems, there is no agreed solution and there is an unattractive “default penalty”- i.e. when the alternative to making experimentalist governance is less tolerable for states (Sabel and Zeitlin 2007). The default penalty, applicable to most of the mechanisms here, would be Article 49 decisions by the Court.

The goals of OMC Health and Long-term Care were set by the 2002 Barcelona meeting of the European Council, at which it determined that accessibility for all, high quality care, and long-term financial stability were the chief goals of the process (COM(2004)304, COM(2001)723). The OMC Health and Long-term Care, whose creation was mandated in 2004, has taken time to develop; member states had picked indicators and developed their “National [sic] Action Plans” when a “streamlining” process began to fold it into back a larger single Social Protection Committee (COM(2005)76). Whether it matters is still being debated in literature based on the experience of older OMC processes. There is no necessary reason why a thriving OMC would save health services from “default penalties” such as Article 49 decisions by the Court, and mutual learning can take place without an OMC. It seems that the mechanism that might make it work is “name and shame,” and that depends on domestic interest groups using laggardliness revealed by OMC procedures to drive their governments to change (interviews, European Commission, February, March 2006)(Borras and Jacobsson 2004; de la Porte et al. 2002; Greer and Vanhercke 2008; Sabel and Zeitlin 2007; Szyszczak 2006; Wincott 2003).

## **Conclusion: When is a path chosen?**

Some of these policies some preclude others, some are duplicative, and any one, once enacted, changes the likelihood and meaning of future policies. This fills in the last component of Pierson’s definition- the importance of sequence.

For example, the Commission put forth one synthesis in 2004, arguing that the Services Directive would be the legal basis for regulation, the High Level Group would cope with issues of patient mobility and spread technical best practice, while the OMC would allow states to learn from and benchmark each other’s overall system governance (COM(2004)301). This excluded services of general interest, reduced the role of social security (1408/71) law, and relegated the OMC and High Level Group to the role of mechanisms that would permit member states to better cope with their firmly Europeanized health systems. This synthesis is obviously off the table, but it could well have happened if the Services Directive had passed intact. All the other policies would have gained their meaning in light of the new regulatory basis for health services. Likewise, if member states pass a sectoral health law and it persuades the Court to reduce the rate and daring of its Article 49 decisions, pressure for health to be a Service of General Interest might dissipate. Each of these thought experiments makes one point: the sequence of these policies changes their meaning.

It also allows us to tell when a critical juncture is over – when a path has been chosen. It is imaginable, after all, that uncertainty might just continue for the foreseeable future. The main reason to expect that it will not is member states’ complaints about legal instability. Case-by-

case decisions using internal market law combine unpredictability with developments and led to calls for legal stability by member states and stakeholders (DG Health and Consumer Protection 2003, SEC(2006)1105/4) and scholars (Hervey and Trubek 2007 (forthcoming)) alike. The Commission was happy to answer these calls with the variety of instruments reviewed here. Instability and liberalizing Court decisions serve the interests of very few people.

What would stability look like? We can infer from Pierson's conditions that it will be over when the range of outcomes is narrowed to one and identifiable positive feedback mechanisms are at work. This, concretely, would mean that responsibility for health services would be lodged in one DG; that legal uncertainty diminished; and that the relevant treaty bases would become relatively established. Broad health legislation (such as the health directive being considered) would do that. So would legislation on services of general interest or an internal market law or a clarification of the status of health in the successor to the failed Treaty Establishing a Constitution. Otherwise, there will be no decisive blow; instead, there will be less and less attention to some mechanisms- and probably more Article 49 decisions by the ECJ, until what soft law remains is about coping with the internal market. Ultimately those will narrow the options down Article 49 and complementary, subordinate, soft law.

Self-reinforcing processes such as the shape of interest groups, judicial interpretations, and the legal bases for future commission decisions would flow from decisions, while softer forms of law such as the OMC would take their shape and meaning from the new legal position. At the same time, less attractive options would receive less effort and attention. Several of these options are defensive instruments by states; if the High Level Group, or Regulation 1408/71, or even the OMC do not help them avoid the default penalty of Article 49 law, then there is a good chance states and sponsoring DGs will drop them.

The politics of Europeanization in health are now about who can harness not so much decisions as the EU policy arena- and thereby shape its importance and parameters. This could mean further integration with the internal market, incorporation into EU social policy, a distinctive legal status, or a combination of all three. At the extreme, the health systems of Europe could, within a few years, be set irrevocably on one of several very different policy trajectories, and they could be set on them by what appear to us today as flukes in the processes that brought us the different models in the debate today. At the very least, there will be an EU health services policy section in many textbooks, and it will exclude some of the half-forgotten options discussed here. EU health services policy well might reshape or remain marginal to the health systems of the continent- but decisions taken now will do much to decide that.

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<sup>i</sup> For example: Case 238/82 *Duphar* [1984] ECR 523, para 16; Cases 159 & 160/91 *Poucet and Pistre* [1993] ECR I-637, para 6; Case C-70/95 *Sodemare* [1997] ECR I-3395, para 27; Case C-120/95 *Decker* [1998] ECR I-1831, para 21; Case C-158/96 *Kohll* [1998] ECR I-1931, para 17; Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, para 44; Case C-372/05 *Watts* 16 May 2006, para 146.

<sup>ii</sup> Case 158/96, *Raymond Kohll*. ECR 1998 I-01931. 28 April 1998. Case 120/95 *Decker*. ECR 1998 I-01831.

<sup>iii</sup> *Geraets-Smits and Peerbooms*. Case C-157/99. Case C-372/05; *Watts* 16 May 2006.

<sup>iv</sup> Case 303/98 *Sindicato de Médicos de Asistencia Pública (SiMAP)*. ECR 2000 I-07963. Case 151/02 *Jaeger*. ECR 2003 I-08389.

<sup>v</sup> Most recently, Case 205/03 *Federación Española de Empresas de Tecnología Sanitaria (FENIN)* I-6295. Also *Poucet and Pistre* joined cases C-159/91 and 160/91 ECR-I637; *AOK Bundesverband*, joined cases C-264/01, C-306-01, C-354/01 and C-355/01 I-2493.

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<sup>vi</sup> One example is the “BUPA case” (T-289/03) The government of the Republic of Ireland decided to liberalize health finance and invited the UK health insurer BUPA into its market and then imposed an equalization charge. BUPA viewed this as a subsidy to its public-sector rival and BUPA sued the Commission for not starting an enforcement action. BUPA withdrew the case after the Republic altered the insurance rules.

<sup>7</sup> It has made five recommendations as of July 2007. Only one, on health information, was not primarily about internal market issues. The recommendations are posted at [http://europa.eu.int/comm/health/ph\\_overview/health\\_forum/health\\_forum\\_en.htm](http://europa.eu.int/comm/health/ph_overview/health_forum/health_forum_en.htm)

<sup>viii</sup> “Shaping the Future for Community Action on Health Services”, Brussels.

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<sup>ix</sup> See the OMC bibliography at <http://eucenter.wisc.edu/OMC/open12.html>