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The hard politics of soft law: the case of health

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1. Introduction

Talk of networked ‘new governance’ is everywhere. It elicits strong reactions – from scorn to extreme enthusiasm and from unthinking participation in new fora to excited applications of recondite social philosophy. Familiarity with the phenomenon also varies. Some forms of new governance are often found in health, but they are not necessarily known as such, while others have long histories outside health but are largely unknown within.

This chapter discusses new governance in EU health policies, examining the mechanisms and frameworks that EU institutions and Member States have introduced into health policy-making. These mechanisms promise to induce law-like behaviour by creating norms and networks (whether they will have that effect, or are intended to have that effect, varies). There are four obvious questions about any new policy development including ‘new governance’, and we answer them in the next three sections. What is it? How did it get started? Why is it happening? And what effect might it have?

A fifth question, naturally, is what has it done? Unfortunately, we cannot reasonably ask that question. For better or for worse, there is not much impact to study. Most new governance processes in health care became operational after 2005, or even later. Furthermore, many of the effects will be on process rather than outcomes – the direct effects will be on the networks and worldviews of policy-makers. The effects on infant mortality or leukemia deaths will often have to be

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inferred from those process changes. In this chapter, we introduce some of the definitional issues involved in the discussion of new governance and soft law; the EU's versions of new governance, including the open method of coordination (OMC); the mechanisms by which new governance might work; and the possible future for new governance mechanisms in EU health policy.

We first explain what new governance is, highlighting the conceptual difficulties and uncertain status that it occupies in the academic literature and practical politics. New governance is built on networks rather than hierarchies, but networks are not new and hierarchies have not vanished. As a result, defining it is always difficult. The second section asks why it started. It explains the history of new governance, highlighting the extent to which it is a tool of some groups (whom we call 'social') in a multisided contest to frame the questions of EU health policy and define its agenda. The third section asks why it is happening. It examines new governance in the EU, working with the open method of coordination as our case study, and identifying the effects it has in light of broader theories of new governance. The European Union has few forms of new governance that are unique to health. Most of its policy instruments, including Member State groups, networks of specialists or the OMC, are policy tools that it uses in many sectors and has also generalized to the health sector. We find that it can be popular because it strengthens networks among officials and advocates, and it potentially will interact with, channel and shape 'harder' law made by the Court or internal market law.¹

The fourth section, then, asks what it might do, inferring its effects from activities to date and the experience of new governance in other EU policy areas. New governance in health is often dominated by the European Commission, and will continue to be a feature of EU health politics. This is partly because networks will always exist, but it is mostly because the learning and networking function it provides can be attractive to a good number of Member State and Commission officials. The conclusion argues that it will continue to exist because it is a tool for Member States to enter into 'dialogues' with the Court and Commission – even if learning or policy influence does not matter, it is possible that the Court and Commission will be warned off health

¹ See Chapter 2 in this volume.

systems policy by clear statements from the Member States. Given its relatively low cost, that should be enough to sustain it. It will matter more, though, if some new governance mechanism can become the framework for EU health policy. In other words, it will matter most if it displaces the Court and internal market law as the key norm entrepreneur in this policy area. The data used in this chapter comes from 170 interviews conducted since 2004 among lobbyists and officials in the EU, reviewed in Greer,² and Hamel and Vanhercke,³ as well as an analysis of official documents (national governments and EU institutions).

2. New governance and soft law

The scope of government has never been as great as the scope of ordered social activity. The writ of states has always been supplemented by a wide variety of networks, coalitions, professions and groups with shared ideas. That fact is the basis for the conversation about new governance: new governance is governance that takes place outside ‘traditional’ hierarchical, legal mechanisms such as the ‘Community method’ of legislation taught in EU textbooks.⁴ It is also the basis for some of the conceptual confusion surrounding ‘new governance’, ‘soft law’, ‘experimentalist governance’ and other such concepts. We know better what they are *not* than what they *are*. And if it is hard to say what ‘new governance’ is, then it is also hard to say if it is actually new, or if it actually governs anything.⁵ Nor is it easy to work out what it means in practice. Jordan and Schout, for example, observe that the ‘EU governance literature still has not fully explored

² S. L. Greer, *The politics of European Union health policies* (Buckingham: Open University Press, forthcoming 2009).

³ M. -P. Hamel and B. Vanhercke, ‘The OMC and domestic social policymaking in Belgium and France: window dressing, one-way impact, or reciprocal influence?’, in M. Heidenreich and J. Zeitlin (eds.), *Changing European employment and welfare regimes: the influence of the open method of coordination on national labour market and social welfare reforms* (London: Routledge, 2009).

⁴ G. Majone, *Dilemmas of European integration: the ambiguities and pitfalls of integration by stealth* (Oxford: Oxford University Press, 2005), p. 59.

⁵ An overview by Treib, Bähr and Falkner avoids ‘the fashionable labels of “old” and “new” modes of governance. ... Whether a given mode of governance is “new” or “old” is an empirical rather than an analytical question. ... Should we consider a mode of governance new if it emerged

what governance *actually* means in terms of implementation ... In fact, academics are still struggling to agree common definitions of ... terms like the “open method of coordination (OMC)”.⁶

A. *Why discuss ‘new governance’?*

New governance involves ‘a shift in emphasis away from command-and-control in favour of “regulatory” approaches, which are less rigid, less prescriptive, less committed to uniform approaches, and less hierarchical in nature’. The idea of new (or experimental, or soft) governance ‘places considerable emphasis upon the accommodation and promotion of diversity, on the importance of provisionality and reversibility ... and on the goal of policy learning’.⁷ In practice, EU policy often fits these criteria. It is increasingly: (a) deliberative (consensus is often regarded as provisional); (b) multilevel (connecting different levels of government – crucially, this means that it is not strongly hierarchical, or hierarchical at all); (c) a departure from norms of representative democracy (accountability is defined in terms of transparency and scrutiny by peers); (d) a combination of framework goals set from above combined with considerable autonomy for lower-level units and agents to redefine the objectives in light of learning; and (e) built on reporting (on their performance) and participation in peer review (in which results are compared with those pursuing other means to the same general ends).⁸

within the last five or ten years, within the last two or three decades, or within the last century? ... Moreover, the question of whether a given mode of governance should be considered “old” or “new” also depends on the specific policy area one is focusing on’. Many supposedly innovative forms of governance that occurred rather recently in one particular field of study ‘may turn out to be quite old in other contexts’. O. Treib, H. Bähr and G. Falkner, ‘Modes of governance: towards conceptual clarification’, *Journal of European Public Policy* 14 (2007), 1–20.

⁶ A. Jordan and A. Schout, *The coordination of the European Union: exploring the capacities of networked governance* (Oxford: Oxford University Press, 2006).

⁷ G. de Búrca and J. Scott, ‘Introduction: new governance, law and constitutionalism’, in G. de Búrca and J. Scott (eds.), *New governance and constitutionalism in Europe and the US* (Oxford: Hart, 2006), pp. 2–3.

⁸ C. Sabel and J. Zeitlin, ‘Learning from difference: the new architecture of experimentalist governance in the European Union’, *European Law Journal* 14 (2008), 271–327.

The intellectual and political history of the concept explains why these definitions might seem vague. The newness of new governance in the EU (and elsewhere) is partly intellectual. Theorists of new governance are often reacting against needlessly reductive theories that ascribed far too much dominance to states and formal public bureaucracies.⁹ A health ministry will often share power over health care with organized professions; therefore, accounts that focused on the ministry would have been incomplete. Even more difficult to grasp, however, are the networks only partially captured by the organized profession. Academic, professional and other networks allocate resources and shape outcomes without having any formal power or even existence. ‘New governance’, intellectually speaking, is part of a family of theories that incorporates these forms of governance into social sciences and legal doctrines that often pay too little attention to actors outside the formal, legal state.

Practical efforts to develop new governance, or at least the more theorized ones, emerge from the same source. Frustration with the various incapacities of states, public bureaucracies or the EU institutions combines with a practical sense of what networks can do – and the result is a series of attempts to harness networks as tools of public action.

The development of new governance in the EU reflects both of these roots. Just as scholars began to speak of governance, a diverse group inside and outside the EU institutions began to seek ways to address policy problems in ways that are foreign to the EU’s traditional approach. The specific ‘problems’ that the EU institutions face are all clear from the Treaties. First, the ‘Community method’ of legislation is slow, rigid, sometimes difficult to meaningfully enforce, and capable of producing some strange outcomes when implemented in complex situations. Its very representativeness and concern for consensus means that it can frustrate policy advocates. Second, the EU is constrained by its Treaty bases. Its powers in health are very limited, and in health care its specific competences are negligible. This does not mean that it is restricted to those areas in which Member States

⁹ For examples from international relations, see A.-M. Slaughter, *A new world order* (Princeton: Princeton University Press, 2004). For a discussion of the concept in EU politics, see L. Hooghe and G. Marks, *Multi-level governance and European integration* (Lanham: Rowman and Littlefield, 2001).

have seen fit to allocate it a competence. It does mean, however, that its engagement with those areas (such as health services) does not just lack democratic legitimacy or an obvious useful purpose; it is also badly distorted by the requirement that it operate on the basis of internal market, social security or other Treaty bases.

The formal institutions of the EU, if they are to operate according to the Community method, must regard health care not as health care but as something else (probably the single internal market). Many see that as unsatisfactory: it does not recognize the specificity of health, it could create vast transition costs as well as damage solidarity, and it is difficult to see how it allows the EU to address some of the issues, such as health inequalities, where many Member States are interested in sharing experiences and learning at an EU level. Note, for example, that the first ever peer review on health care issues in the context of the OMC was held (with nine peer countries, stakeholder representatives and the European Commission) with a view to developing ‘a European perspective on access to health care and the reduction of health inequality’.¹⁰ If the EU is to have a role in health services, many believe it is better that it be channelled in a coherent direction that improves health care.

B. Defining new governance in EU health policy

Discussion of new governance in EU health policies suffers from the basic definitional problem of all discussions of new governance: the tension between definitions that rely on intention (i.e., whether something is intended to be new governance), definitions that rely on mechanisms (standard-setting, norms, credentialing) and definitions that rely on identifiable impact. If we define new governance based on the intention of members, then every committee that sets out to define standards or promote convergence counts, even if nobody notices it. If we define new governance by mechanisms, then almost any decent international conference qualifies. And if we define it by impact, then we cannot identify new governance other than by tracing an event

¹⁰ C. Masseria, ‘Access to care and health status inequalities in a context of healthcare reform’, Synthesis Report, Peer Review and Assessment in Social Inclusion, Hungary, 17–18 January 2007, p. 3, http://ec.europa.eu/employment_social/spssi/docs/social_inclusion/2007/pr_hu_En.pdf.

backwards and finding something other than hierarchical law-making by states. Given this problem, it is not surprising that new governance is often defined by its negative.

To avoid the problem, we take advantage of the fact that the EU is one of the great producers of explicit new governance mechanisms. It is relatively rare among formal political institutions in its formal, declared use of new governance.¹¹ As a result, we choose to take the EU at its word and focus on the intention, ignore other (unintended) examples of the mechanisms at work, and discuss ways to identify their impact. In other words, new governance instruments are those that are intended by their creators to work through norms and networks rather than hierarchies and traditional legal instruments. If they work, they start to authoritatively allocate resources and change behaviour, and if they are successful they might even have advantages (flexibility, experimentation) that traditional, democratically legitimated legislative procedures do not have.

Linda Senden has built a set of definitions on the intentions of EU institutions. She divides EU new governance into three broad categories. A first, rather general, category is 'soft governance', which Senden designates as 'preparatory and informative instruments'. This means green papers, white papers, action programmes and informative communications. These instruments are adopted with a view to preparing further Community law and policy and/or providing information on Community action. As such, they can also be regarded as fulfilling a pre-law function.¹² As we will see further on, this category also includes preparatory documents and recommendations of expert groups. 'Interpretative and decisional instruments' are instruments that:

[A]im at providing guidance as to the interpretation and application of existing Community law. ... The decisional instruments go further than mere interpretation by indicating in what way a Community institution – usually the Commission – will apply Community law provisions in individual cases when it has implementing and discretionary powers. To this category belong notably the Commission's communications and notices

¹¹ European Commission, 'European governance', White Paper, COM (2001) 428 final, 25 July 2001.

¹² L. Senden, 'Soft law, self-regulation and co-regulation in European law: where do they meet?', *Electronic Journal of Comparative Law* 9 (2005), 18–9.

and also certain guidelines, codes and frameworks frequently adopted in the areas of competition law and state aid. ... As such, they can be considered to fulfill primarily a post-law function.¹³

A nice example of such an instrument is the 'Altmark package' discussed in Chapter 9.¹⁴

In this chapter, we concentrate on a third category of soft law instruments. These are 'steering instruments'. Box 4.1 lists some of the main such mechanisms at work in the EU health policy sector. These aim at establishing or giving further effect to Community objectives and policy or related policy areas. Sometimes, this means declarations and conclusions, but it can also mean other efforts to create closer cooperation or even harmonization through recommendations, resolutions and codes of conduct, which are 'used as alternatives to legislation and, in view of this, they can often be said to fulfill a para-law function'.¹⁵

The most widely known of these policy coordination mechanisms is, without doubt, the open method of coordination (OMC). We use it as our main case study because OMC has become, as we will illustrate, a template for soft governance in the EU, and also because it is well researched.

C. New governance at work: the OMC

The OMC, described in Box 4.1, has attracted considerable – and according to some – unduly favourable scholarly as well as political attention since its inauguration by the European Council at the Lisbon Summit.¹⁶ Since there is no legal definition of the OMC in the Treaty or other binding texts, it is reasonable to rely on the Presidency Conclusions of this Lisbon Summit. They introduce it as 'the means of spreading best practice and achieving greater convergence towards the main EU goals'. According to the Conclusions, this involves: fixing *guidelines* (with specific timetables); establishing quantitative and qualitative *indicators* and *benchmarks* (against the best in the world);

¹³ *Ibid.* ¹⁴ See Chapter 9 in this volume.

¹⁵ Senden, 'Soft law', above n.13, 19.

¹⁶ European Council, 'Presidency Conclusions', 23 and 24 March 2000, para. 7, www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/ec/00100-r1.en0.htm.

Box 4.1 Varieties of new governance in health

The Platform on diet, nutrition and physical activity

The Platform as it exists today was established in March 2005. It reflects the politics of that year – the new Barroso Commission’s focus on economic competitiveness; a shift to the right in the European Parliament, which made Community-method legislation less likely; and personnel changes in the Directorate-General for Health and Consumer Protection (DG SANCO) that made it more dynamic. Interested in addressing the interlocking problems of diet and activity that lead to obesity, the Commission brought together a wide variety of interested parties to produce the Platform. The process was simple enough: participants, including NGOs and private firms, as well as Member States, were invited to make commitments that would contribute to healthy eating and physical activity. They report annually on their progress. At the same time, the Platform and its subgroups were the venues for debates about improving health in Europe. These debates brought firms, civil society and others together, and gave the Commission a useful way to gauge reactions and test support for the policies that emerged as the Barroso Commission and the European Parliament became less liberal. It was a major contributor to the May 2007 Strategy on Nutrition, Overweight and Obesity-related Health Issues.¹⁷

The High Level Group on Health Services and Medical Care

The High Level Group on Health Care is the oldest of the EU new governance tools in health care, and its ancestry is certainly the longest. It is the successor to the High Level Process of Reflection, which was an initial effort to map out the consequences of (especially) internal market law for health services. The Process concluded in 2003 with a call for a more permanent structure, and the Group, that structure, was formed in 2004. While the Process that gave rise to it had a wide membership, putting nongovernmental organizations and Member States side by side, the Group itself is made up of officials from the Member States. It is serviced by DG SANCO. It was quite active between 2004 and 2006,

¹⁷ European Commission, ‘A strategy for Europe on nutrition, overweight and obesity related health issues’, White Paper, COM (2007) 279, 30 May 2007.

but became very quiet after September 2006. This should not have come as a surprise: in its 2006 report, the Group indicated that the Commission's intention to bring forward proposals to develop a Community framework for safe, high quality and efficient health services in 2007, on the basis of consultation beginning in 2006 'will have an impact on the future work of the High Level Group'.¹⁸ In retrospect, this sentence seems to have been the announcement that the Group would be stifled and replaced with something more amenable to Commission control. It was then reborn, rather dramatically, in 2008. According to Member State interviewees, this was because the delays to the proposed health services directive had left DG SANCO with no effective forum. The DG remedied that problem by resuming the Group's meetings.

The open method of coordination (OMC)

The OMC for health and long-term care was formally launched in 2004 and is administered by the Social Protection Committee (SPC). It became operational in 2006, when the Council merged the three social OMC processes (for pensions, social inclusion, and health and long-term care). The health care strand of the 'streamlined' Social Protection and Social Inclusion OMC involves:

- Common objectives, political priorities agreed by the Member States and subject to a variety of influences within Member States and in Brussels.
- The three shared objectives of the SPC in all subfields are: (a) social cohesion, equality and opportunities; (b) effective interaction between the Lisbon objectives; and (c) good governance (see Box 4.2). They were agreed in March 2006.
- The streamlining of the social OMCs did not change the older health objectives (agreed by the Council at Nice in 2000) of high-quality, financially sustainable health systems with access for all.
- Indicators developed by Member States to assess their progress towards reaching the common objectives (see Box 4.4). So far, progress in developing harmonized (EU) health indicators has been rather slow, and no targets (quantified objectives) have been set, even though the Commission is building up pressure on

¹⁸ European Commission, 'Work of the High Level Group in 2006', HLG/2006/8, 10 October 2006, pp. 15–6.

Box 4.1 (*cont.*)

Member States that provide long-term care in a devolved context to set national targets.¹⁹

- Peer review. The purpose of learning within the OMC is not just to oblige Member States to provide information in a transparent and consistent way. The Organisation for Economic Co-operation and Development and World Health Organization, among others, already do that. The OMC is designed to go beyond this by promoting genuine peer review – asking Member State officials, and outsiders from civil society, to participate in a structured and contextualized exchange of information. Multiple interviewees in the Commission commented that in order to have real exchanges of practical knowledge, the important thing is to send line officials responsible for specific policy areas, rather than the international division of health ministries.
- National reporting obligations. These give the peer reviewers something to review, and take two forms:
 - National reports on strategies, initially, present the status of the country and its current strategies; Member States report on what they see as national ‘best practices’, some of which are then retained in the joint reports (see below).
 - The subsequent reports respond to both changes in the indicators and to the advice of OMC peers, reporting on both the evolution of the policy approaches and the changes in outcomes.

The European Commission (in the form of the Directorate-General for Employment, Social Affairs and Equal Opportunities) also participates in peer review, taking advantage of its ability to muster expert views and its position as a hub of the OMC process. Thus, the health care section of the 2007 Joint Report highlighted challenges and planned strategies with regard to (inequities in) access to health care, including those resulting from decentralization; the

¹⁹ European Commission, ‘Joint report on social protection and social inclusion 2008: social inclusion, pensions, healthcare and long-term care’, Directorate-General for Employment, Social Affairs and Equal Opportunities (2008), p. 90, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/joint_report_En.pdf.

insufficiency of current long-term care and the priority given to home care services; coordination between primary, outpatient and inpatient secondary and tertiary care and between medical, nursing, social and palliative care; the striking differences in expenditure and personnel employed and the need to control costs; problems with regard to retention and supply of medical staff; and, finally, the search for win-win strategies, where Member States recognize the interlinkages between access, quality and financial sustainability.²⁰

national and regional *targets*; and periodic *monitoring*, evaluation and *peer review* organized as *mutual learning processes*.²¹ It is a common EU policy tool; it was applied firstly and most prominently to economic policies (1992) and employment (1997), and more recently to social inclusion (2000), pensions (2001) and health care (2004). According to Metz, a dozen OMCs are up and running,²² and more are coming. In the field of health, the European Commission is thinking out loud about starting new applications of OMC-type processes to areas such as organ donation and transplantation,²³ as well as nanosciences and nanotechnologies.²⁴ Others would like to see the method applied to obesity and cancer screening, or to e-health.²⁵

We focus on the OMC because it is the most clearly defined and well researched process, with its roots traced and effects studied.²⁶ To

²⁰ European Commission, 'Joint report on social protection and social inclusion 2007: social inclusion, pensions, healthcare and long-term care', Directorate-General for Employment, Social Affairs and Equal Opportunities (2007), pp. 10–2, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2007/joint_report_En.pdf.

²¹ *Ibid.*, para. 37.

²² A. Metz, 'Innovation in governance? Six proposals for taming open co-ordination', Center for Applied Policy Research (C.A.P.) Working Papers Policy Analysis No. 1 (2005), p. 7.

²³ European Commission, 'Organ donation and transplantation: policy actions at EU level', COM (2007) 275 final, 30 May 2007, p. 10.

²⁴ European Commission, 'Nanosciences and nanotechnologies: an action plan for Europe 2005–2009', COM (2005) 243 final, 7 June 2005, p. 4.

²⁵ European Commission, 'Making healthcare better for European citizens: an action plan for a European e-health area', COM (2004) 356 final, 30 April 2004, p. 16. Interview with DG SANCO.

²⁶ See the citations in V. Hatzopoulos, 'Why the open method of coordination is bad for you: a letter to the EU', *European Law Journal* 13 (2007), 309–42.

a great extent, we know what an OMC process is. It is a framework, recognizable to its participants, that fits the definition given in the Lisbon Council's Conclusions. It has been further discussed in the Commission's White Paper on governance,²⁷ as well as a host of academic publications.

Furthermore, it has already been applied in a variety of other areas. This means that we can draw on large-scale studies of its effects elsewhere for indicators and expectations.²⁸ This does not mean that the OMC is the oldest or only network in health; if anything, the Directorate General for Health and Consumer Affairs (DG SANCO) is one of the leading Directorates-General in creating new forums for civil society dialogue beyond traditional forms of EU comitology.²⁹ Nor does it mean that new governance, in at least its weakest forms, is wholly new or unique to the EU. If anything, the World Health Organization (WHO) 'Health for All' programme is the pioneer for structured comparisons of programmes.

3. The development of new governance in EU health policy

There is no single reason why health care emerged on the EU agenda. A few determined individuals and groups had advocated, since the 1980s, for EU health action on issues as diverse as cancer care and professional mobility, while the Commission, Parliament and Court, in their different ways, were receptive to proposals for the extension of EU competences. EU activity triggered more EU activity; each action provoked others to 'come to Brussels' to advance or just defend their positions in the new arena.³⁰ The EU health care agenda

²⁷ European Commission, 'European governance', above n.12.

²⁸ Heidenreich and Zeitlin (eds.), *Changing European employment*, above n.3; R. Dehousse (ed.), *L'Europe sans Bruxelles?: Une analyse de la methode ouverte de coordination* (Paris: L'Harmattan, 2004); J. Zeitlin and P. Pochet (eds.), *The open method of co-ordination in action: the European employment and social inclusion strategies* (Brussels: PIE-Peter Lang, 2005); J. Zeitlin and D. Trubek (eds.), *Governing work and welfare in a new economy* (Oxford: Oxford University Press, 2003).

²⁹ A. Slob and F. Smakman, *Evaluation of the civil society dialogue at DG Trade: assessment of relevance, effectiveness and efficiency of CSD policy and procedures* (Rotterdam: ECORYS for DG Trade, 2006).

³⁰ S. L. Greer, 'Uninvited Europeanization: neofunctionalism and the EU in health policy', *Journal of European Public Policy* 13 (2006).

is a mixture of arguments over competences and substantive policies, with protagonists often switching emphases between their substantive goals and their views of the legitimate distribution of responsibility for health care. This section traces the role played by new governance mechanisms and their advocates in the history of the EU's health policy role.

The key point is that new governance mechanisms are like anything else in politics: intensely political. They do not transcend the strategies and calculations of EU institutions, states and interest groups. Rather, new governance mechanisms and their products are deeply affected by those interplays. Explaining the life of the two main new governance mechanisms – the OMC and the High Level Group on Health Services and Medical Care – requires an understanding of the cleavages between three groups. Each has a different interpretation of the 'problem' that EU health policy might solve, and a different overall vision and set of biases. We call them the 'economic' group, organized around the Directorate-General for the Internal Market and Services (DG MARKT), compatible with much European Court of Justice (ECJ) jurisprudence, and focused on the internal market; the 'social' group, organized around Directorate-General for Employment, Social Affairs and Equal Opportunities (DG Social Affairs) and labour or social affairs ministries, and sponsor of both the OMC and much of the rhetoric about a European Social Model; and the youngest, the 'health' group, which is organized around DG SANCO and the health ministries and experts of the Member States.

A. Health care appears on the agenda

What brought social protection (including health care) firmly to the European political agenda, then?³¹ An important push factor was the fact that the finance ministers (through the Economic and Financial Affairs Council (ECOFIN) and its main advisory body, the Economic Policy Committee (EPC)), were starting to raise their voice in the health care debate at the dawn of the new millennium – for example, by issuing reports on the necessity to curb health care spending in order to be able to cope with the financial burden on welfare spending

³¹ For a detailed account of the slow move of health care to the EU agenda from the beginning of the 1990s onwards, see Chapter 2 in this volume.

of the ageing population (see Chapter 2 for more details). Clearly, Court rulings such as the *Kobll* and *Decker* cases³² were an important trigger as well, as were a number of other landmark cases during the second half of the 1990s, notably with regard to the application of competition law to pension funds.³³ Taken together, these cases made it clear to the Member States that social welfare services may fall under internal market rules.

‘Framing’ EU health policy would not just mean defining the problem; it would also mean defining the Treaty bases for future action, ‘ownership’ of health policy by different DGs and the policy mechanisms at work.³⁴ The direction of jurisprudence after *Kobll* and *Decker* suggested that health would be defined as one more service, or service of general interest, in the internal market. That galvanized proponents of alternative framings.

One group focuses on health as part of a broader social model. While the EU has a strong bias towards market-making policies built on its ‘four freedoms’,³⁵ there are other contending views of the EU’s meaning. For example, it could be seen as the defender and exponent of a ‘European Social Model’ (ESM).³⁶ Advocates view health policy as part of a range of social policies that mark out a distinctive, shared, European approach to social policy and welfare. Proponents of this

³² See Chapters 11 and 12 in this volume.

³³ Case C-67/96, *Albany International v. Stichting Bedrijfspensioenfonds Textielindustrie* [1999] ECR I-05751; Joined Cases C-115–117/97, *Brentjens v. Stichting Bedrijfspensioenfonds* [1999] ECR I-06025; Case C-219/97, *Drijvende Bokken* [1999] ECR I-06121.

³⁴ S. L. Greer, ‘Choosing paths in European Union health policy: a political analysis of a critical juncture’, *Journal of European Social Policy* 18 (2008), 219–31; B. Vanhercke, ‘Is the OMC growing teeth? The governance turn in EU social policy co-ordination’, Second Year Paper, University of Amsterdam (2007).

³⁵ F. Scharpf, *Governing in Europe: effective and democratic?* (Oxford: Oxford University Press, 1999); S. Greer, ‘Power struggle: the politics and policy consequences of patient mobility in Europe’, *OSE Policy Paper* 2 (2008).

³⁶ J. Kvist and J. Saari (eds.), *The Europeanisation of social protection* (Bristol: Policy Press, 2007); M. Jepsen and A. Serrano Pascual, ‘The concept of ESM and supranational legitimacy-building’, in M. Jepsen and A. Serrano Pascual (eds.), *Unwrapping the European social model* (Bristol: Policy Press, 2006); S. L. Greer, ‘Ever closer union: devolution, the European Union, and social citizenship rights’, in S. L. Greer (ed.), *Devolution and social citizenship in the United Kingdom* (Bristol: Policy Press, 2009).

'social' framing generally include trade unions, many Member States' ministries of labour and social affairs, some Member States (often France and Belgium), intellectuals concerned with the definition of the 'ESM'³⁷ and, crucially, DG Social Affairs within the Commission. Note that the latter now has to compete with the Commission's Bureau of European Policy Advisors (BEPA), which works directly with the Commission president and has taken a very active stance in this debate lately.³⁸ Advocates of this 'social' framing would seek to incorporate health into the overall policy goal of reinforcing the social model, vest concomitant responsibilities in DG Social Affairs and use mechanisms linked to DG Social Affairs, such as the OMC.

Another approach to health issues draws its intellectual reference from the traditional complexity and autonomy of health policy. These 'health' advocates generally call for recognition of the specificity of health services and have their institutional bases in established health policy communities, including health academia, ministries of health, professions and some EU-level health groups, such as the European Health Management Association, EuroHealthNet and the European Public Health Alliance (EPHA). Their affinity is with DG SANCO – a young and relatively weak DG that has had incentive to seek them out.

The prospect of an EU competence governed entirely by internal market law and the priorities of ECOFIN galvanized proponents of these alternative framings. The 'social' group, which would aim to incorporate health into an expansive 'European Social Model', moved through DG Social Affairs within the European Commission. It published, in July 1999, a Communication in which it proposed a 'concerted strategy for modernising social protection'.³⁹ The ministers for social affairs followed the Commission's lead and identified 'high quality and sustainable health care' as a key objective that should be pursued at the EU level.⁴⁰

³⁷ Such as A. Giddens, P. Diamond and R. Liddle (eds.), *Global Europe, social Europe* (Cambridge: Polity, 2006).

³⁸ R. Liddle and F. Lerais, 'Europe's social reality', Consultation Paper, Bureau of European Policy Advisors (2007).

³⁹ European Commission, 'A concerted strategy for modernising social protection', COM (99) 347 final, 14 July 1999.

⁴⁰ Council Conclusions on the strengthening of cooperation for modernizing and improving social protection, OJ 2000 No. C8/7.

That same year, DG SANCO led a parallel initiative with its roots in the ‘health’ groups. The High Level Committee on Health,⁴¹ which is an advisory body of the Commission’s Directorate-General for Health and Consumer Protection, received a mandate to analyse the consequences of the above-mentioned *Kohll* and *Decker* ECJ rulings, and the impact of Community provisions on health systems. Note that the request to discuss the consequences of these judgements in political terms came from the health (and not the social affairs) formation of the Council.

B. New governance mechanisms in the developing EU health policy sector

By 1999–2000, therefore, there were already three different groups trying to define EU health policy. Using our shorthand, they are the ‘economic’, ‘social’ and ‘health’ advocates. The ‘economic’ actors, such as the ECJ, DG MARKT and ECOFIN, were defined by their focus on the place of health care in the internal market and government budgets. ‘Social’ actors, led by DG Social Affairs, were more concerned with incorporating health into a European Social Model. The newest were the ‘health’ actors, led by DG SANCO, the ministers in the Health Council, and the experts and lobbyists of the embryonic EU health policy community, who were trying to mark out a distinctive health policy arena and debate by calling for recognition of the ‘specificity’ of health services.⁴²

The presence of three different sets of actors with different agendas and understandings of health policies in an area with unclear EU powers and little basic agreement did not speed up policy-making. But it did create the framework within which new governance was created and operates. New governance mechanisms are favoured by the ‘social’ advocates, in the case of the OMC, and by incumbent health actors, in the case of the High Level Group. From the point of view of a Member State that wishes to maintain its health policy

⁴¹ The High Level Committee on Health is composed of senior civil servants from the health ministries of the Member States. It meets two to three times a year and operates with a number of working groups. See http://ec.europa.eu/health/ph_overview/co_operation/high_level/high_level_En.htm.

⁴² Greer, ‘Choosing paths’, above n.34; Vanhercke, ‘Is the OMC growing teeth?’, above n.34.

autonomy, the new governance of health within the EU is worse than the pre-1998 status quo of no health policy at all, but it is better than the 'economic' option of governing health through internal market law and the strictures of the Stability and Growth Pact. That is because the new governance mechanisms, by definition, are more subject to alteration, permit more divergence, are harder to enforce legally and are set up to be more responsive to the concerns of health ministries. New governance mechanisms, therefore, became attractive to Member States at approximately the same time that they realized that the alternative was health policy made by the ECJ, DG MARKT and possibly ECOFIN. The new governance mechanisms that the Commission offered were the OMC, associated with DG Social Affairs, and the High Level Process of Reflection and, later, the High Level Group.

They were originally presented, in spite of Member States' reluctance to admit that there is an EU health care debate, by DG SANCO and DG Social Affairs, in April 2004. In fact, since there was no agreement on who was to take the lead in an overall strategy, this was done through two separate (announced as 'complementary') communications, published on the same day. One responded to the final report of the High Level Process of Reflection on Patient Mobility, which had been set up in 2002.⁴³ The other proposed an extension of OMC to health care and long-term care.⁴⁴ The latter initiative was rather surprising in view of the fact that the European Commission had tried (but failed) to obtain a mandate in this area from the March 2004 Spring European Council. Indeed, in its annual 'spring report', the Commission asked the European Council to '[e]xtend the open method of coordination in the social protection field to the modernisation of healthcare schemes'.⁴⁵ Significantly, the 2004 Spring European Council did *not* adopt the proposal.

⁴³ European Commission, 'Follow-up to the High Level Reflection Process on Patient Mobility and Healthcare Developments in the European Union', COM (2004) 301 final, 20 April 2004. See Chapter 2 in this volume for more details.

⁴⁴ European Commission, 'Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for national strategies using the 'open method of coordination'', COM (2004) 304 final, 20 April 2004.

⁴⁵ European Commission, 'Report from the Commission to the Spring European Council, delivering Lisbon. Reforms for the enlarged Union', COM (2004) 29 final, 20 February 2004, p. 26.

So, why did the Commission propose an OMC on health care to the Member States again within two months?⁴⁶ And why did the Health Council, after years of refusal to accept an EU role in health care, agree with the Commission's proposal to set up a permanent 'High Level Group on Health Services and Medical Care'⁴⁷ (see Box 4.1) to take forward the recommendations of the High Level Process of Reflection on Patient Mobility?

Even if the European Parliament's request to the Council in March 2004 'to adopt as a matter of principle the application of the open coordination method' in the field of health care⁴⁸ may have had *some* influence, there were three catalytic events. One was the implementation of the Working Time Directive against the background of the *Jaeger* and *SiMAP* decisions; few Member States had prepared adequately for the Directive's implementation, and the Court's decisions made that implementation more expensive. This concentrated attention on the EU. The second factor, highlighted by many national and European actors in this area, and which opened up new possibilities and galvanized many health actors, was the publication of the draft proposal for a 'Services Directive'.⁴⁹ Finally, it can be argued that the right balance between the Commission's 'social' and 'health' DGs could only be found after DG SANCO found sufficient legitimacy in the recommendations of the aforementioned High Level Process of Reflection to claim part of the territory. So the Council formally launched the health care OMC in October 2004.⁵⁰

There are three signs that Member States meant the soft governance of health care – the OMC and the High Level Group alike – to be their instrument, rather than a new platform for an ambitious Commission. First, this OMC was launched with a provisional

⁴⁶ European Commission, 'Modernising social protection', above n.44.

⁴⁷ European Commission, 'Commission decision setting up a High Level Group on Health Services and Medical Care', C (2004) 1501, 20 April 2004.

⁴⁸ European Parliament Resolution on the Communication from the Commission – Proposal for a joint report on 'health care and care for the elderly: supporting national strategies for ensuring a high level of social protection', Doc. No. A5-0098/2004, 24 February 2004, para.7.

⁴⁹ European Commission, 'Proposal for a Directive of the European Parliament and of the Council on services in the internal market', COM (2004) 2 final, 5 March 2004. See, further, Chapters 11 and 12 in this volume.

⁵⁰ Council Meeting on Employment, Social Policy, Health and Consumer Affairs, Council Press Release Doc. No. 12400/04, 4 October 2004.

institutional architecture (provisional common objectives, no common set of indicators, preliminary reports instead of action plans, etc.).⁵¹ Second, the Council was very clear about its lack of enthusiasm. The Social Affairs Council not only stressed that this OMC should be introduced ‘in a progressive and flexible manner, while placing a strong emphasis on added value’,⁵² but also decided it should:

[B]e subject to the following conditions: it should not impose an excessive administrative burden; health ministries should be directly involved in the OMC process; overlaps with the follow-up of the high level reflection on patient mobility should be avoided; coherence of views should be ensured within the single EU Council formation of ministers of health and social policy; the joint working with the Economic Policy Committee should continue.⁵³

This is not the prose of the newly enamoured.

Third, the ministers for health opted to vest control of the European health care agenda in the Council. In 2005, health ministers agreed to draw up a statement on the core values and shared principles that unite the health systems of the Member States. Significantly, these values and principles were not elaborated by the High Level Group on Health Services and Medical Care. Instead, this work was done by a Committee of Senior Officials on Public Health (CSOPH), which is, in fact, a special gathering of the regular Council Working Party on Public Health and which was set up at exactly the same time as the High Level Group.⁵⁴ Arguably, Member States felt the need to be able to undertake discussions in a setting that would not be limited in its deliberations to public health and consumer issues and would be controlled by the Member States – and, more particularly, the EU presidencies and the Council Secretariat, rather than by the European Commission.

Even after its official kick-off, the political level remained prudent: the 2005 Spring European Council did not confirm the

⁵¹ Vanhercke, ‘Is the OMC growing teeth?’, above n.34.

⁵² European Commission, ‘Council High Level Group on Health Services and Medical Care – information from the Commission’, Doc. No. 15190/04, 1 December 2004, p. 9.

⁵³ Council Press Release, above n.50, p. 9.

⁵⁴ Council Public Health Working Party Meeting at Senior Level, ‘Report from the Presidency’, Doc. No. 15281/05 SAN 204, 2 December 2005.

launch of the health care OMC. This clearly did not stop cooperation taking off at the administrative level: responding to the Council's request, Member States submitted preliminary national reports on health care and long term care. The reports identified a wide variety of issues for further work.⁵⁵ In fact, a senior civil servant in the Commission claimed that 'after all this hesitation, the Member States now "discovered" the OMC. If we were to follow all the issues they proposed, it would completely flood the Social Protection agenda for years to come.'

Perhaps most importantly, the initial reports helped, in the words of a Belgian senior civil servant, to 'occupy the health care territory vis-à-vis the Economic Policy Committee and the High Level group on Health Services and Medical Care' – in other words, to support the 'social' agenda of DG Social Affairs and its network over the alternative 'economic' and 'health' frameworks and networks.

The national preliminary reports also inspired the European Commission's 'streamlining' proposal of late 2005, in which it proposed to integrate the social inclusion, pensions and health care OMCs into one single framework – i.e., the social protection and social inclusion OMC.⁵⁶ Since the adoption of this 'streamlining' reorganization by the 2006 Spring European Council, the health care OMC now has become one of the 'strands' of the social protection and social inclusion OMC. In practice, it is managed by the Social Protection Committee (SPC), a group of high-level officials that was established in 2000, as well as by its Sub-Group on Indicators (created in February 2001). The SPC is an advisory body to the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) of the EU and is composed of two delegates from each Member State and the Commission, which provides the secretariat. Every three years, in a 'national report on strategies for social protection and social inclusion' (which includes a section on health and long-term care), Member States explain the progress made in reaching a number of policy objectives (priorities) specific to social inclusion, pensions and

⁵⁵ Social Protection Committee, 'Review of preliminary national policy statements on health care and long-term care', Memorandum of the Social Protection Committee, November 2005.

⁵⁶ European Commission, 'Working together, working better: a new framework for the open coordination of social protection and inclusion policies in the European Union', COM (2005) 706 final, 22 December 2005.

Box 4.2 Common objectives with regard to health care

Member States should provide accessible, high-quality and sustainable health care and long-term care by ensuring:

- (a) access for all to adequate health and long-term care; that the need for care does not lead to poverty and financial dependency; and that inequities in access to care and in health outcomes are addressed;
- (b) quality in health and long-term care, and the adaptation of care, including developing preventive care, to the changing needs and preferences of society and individuals, notably by developing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients; and
- (c) that adequate and high-quality health and long-term care remains affordable and financially sustainable by promoting a rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination between care systems and public and private institutions. Long-term sustainability and quality require the promotion of healthy and active life styles and good human resources for the care sector.

Source: European Commission.⁵⁷

health care policies (see Box 4.2 for the full set of common objectives with regard to health care and long-term care).

Member States subscribed to three ‘overarching objectives’, which apply to the three strands of the streamlined OMC. For example, with the third overarching objective, Member States commit themselves to promote ‘good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring’⁵⁸ of their social inclusion, pensions, and health care and long-term

⁵⁷ European Commission, ‘Joint report on social protection and social inclusion 2007: social inclusion, pensions, healthcare and long-term care’, Directorate-General for Employment, Social Affairs and Equal Opportunities (2007), p. 83, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2007/joint_report_En.pdf.

⁵⁸ *Ibid.*

Box 4.3 Overarching objectives covering the three strands of the open method of coordination for social protection and social inclusion

Promote:

- (a) social cohesion, equality between men and women and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies;
- (b) effective and mutual interaction between the Lisbon objectives of greater economic growth, more and better jobs, and greater social cohesion, and with the EU's sustainable development strategy; and
- (c) good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring of policy.

Source: European Commission.⁵⁹

care policies (see the full list of overarching objectives in Box 4.3). Once the Commission (DG Social Affairs) has received all the national strategy reports, it analyses and assesses Member States' progress towards the common objectives with the help of national and European indicators. The assessment is then published in a joint report, which is adopted by the Commission and the Council and submitted, every year, to the (Spring) European Council to inform heads of state and government on the progress in the area of social protection and social inclusion.

As far as indicators are concerned, work within the health care strand is clearly less advanced than in the areas of pensions and (especially) social inclusion, for which there is an agreement on a full battery of commonly agreed *EU* indicators (i.e., harmonized at EU level). In contrast, for health, a 'preliminary portfolio' of

⁵⁹ European Commission, 'Working together, working better: a new framework for the open coordination of social protection and inclusion policies in the European Union', COM (2005) 706, 22 December 2005.

mostly *national* health care indicators was adopted in June 2006 (see Box 4.4 for more details).⁶⁰ At the time of writing, the full list of indicators and their meanings have not been agreed upon; difficulties in data collection and handling, as well as political risks, have all slowed down the work on indicators (even though it continued throughout 2007 and 2008), and therefore the health care OMC as a whole.

Consider, by way of illustration, the fact that the European Scrutiny Committee of the House of Commons in the United Kingdom refused to scrutinize the afore-mentioned Commission's Communication through which it proposed to extend the OMC to health care.⁶¹ The Committee in fact wondered 'why such exchanges of views as are required could not be achieved by other, less intrusive, means (the Minister refers, for example, to the existing or proposed Commission and Council groups on health services and medical care)'.⁶² In his response to the Committee, the Minister said that he detected no wish by Member States to use the OMC as a means to devise 'new legislation or new targets or new EU indicators' and that 'we are not having [new] targets foisted upon us by anyone'.⁶³ Apparently, this convinced the Committee: in March 2005, the Committee explained that it had assuaged its concerns when the Minister 'told us repeatedly that the application of the method would not lead to the imposition on the United Kingdom of new targets and indicators'.⁶⁴ And yet it warned the government: the Committee looks 'forward to receiving the progress reports the Minister has offered to provide. We shall scrutinize them, in particular, to see if they include any targets or indicators for Member States'.⁶⁵ In other words, the OMC might look 'soft' but, in some cases, it feels quite hard to those who are touched by it.

⁶⁰ European Commission, 'Portfolio of overarching indicators and streamlined social inclusion, pensions, and health portfolios, social and demography analysis', 7 June 2006, pp. 40–50, http://ec.europa.eu/employment_social/social_inclusion/docs/2006/indicators_En.pdf.

⁶¹ European Commission, 'Modernising social protection', above n.44.

⁶² UK Parliament, House of Commons, European Scrutiny Committee, Health care and long-term care, 32nd Report, 9 DOH (25576), 2004, para. 9.9.

⁶³ UK Parliament, House of Commons, European Scrutiny Committee, 11th Report of Session 2004–05, 2005, para. 9.12.

⁶⁴ *Ibid.*, para. 9.14. ⁶⁵ *Ibid.*, para. 9.15.

Box 4.4 Preliminary portfolio of indicators in the health care open method of coordination

1. Health-related 'Overarching' Indicators

Key dimension	Name/source
Health outcome, inequality in health	Healthy life expectancy (NAT).* Source: Eurostat
Financial sustainability of social protection systems	Projected total public social expenditures (NAT). Source: EPC/AWG
Inequalities in access to health care	Unmet need for care.** Source: EU-SILC

2. Indicators Reflecting Each of the Common Objectives in the Area of Health and Long-term Care

Key dimension	Name/source
Access and inequalities in outcomes (Common Objective 1)	Self-reported unmet need for medical care.** Source: EU-SILC
	Self-reported unmet need for dental care.** Source: EU-SILC
	Infant mortality (EU).*** Source: Eurostat
	Life expectancy (EU). Source: Eurostat
	Healthy life years (NAT). Source: Eurostat
	The proportion of the population covered by health insurance (NAT). Sources: OECD and national data
	Self-perceived limitations in daily activities (NAT). Source: EU-SILC
	Self-reported unmet need for medical examination (NAT). Source: EU-SILC

Quality (Common Objective 2)	Self-reported unmet need for dental care (NAT). Source: EU-SILC Acute care beds (NAT). Sources: Eurostat, OECD, WHO Physicians (NAT). Sources: Eurostat, OECD, WHO Nurses and midwives (NAT). Sources: Eurostat, WHO, OECD Self-perceived health (NAT). Source: EU-SILC
Sustainability (Common Objective 3)	Prevention measures: vaccination (NAT). Source: OECD Total health expenditure per capita (EU). Source: SHA Total health expenditure as a percentage of GDP (EU). Source: SHA-OECD General government expenditure on health as a percentage of total health expenditure (EU). Source: NHA Private health expenditure as a percentage of total health expenditure (EU). Source: NHA Total expenditure on main types of care (EU). Source: SHA-OECD Projections of public expenditure on health care as a percentage of GDP (NAT). Source: EPC/AWG Projection of public expenditure on long-term care as a percentage of GDP (NAT). Source: EPC/AWG

Box 4.4 (cont.)

* NAT: Commonly agreed national indicator⁶⁶

** Use, definition and breakdown to be agreed upon once data is available for all countries

*** EU: Commonly agreed EU indicator

EU-SILC: European Union Statistics on Income and Living Conditions; SHA-OECD: System of Health Accounts of the Organisation for Economic Co-operation and Development; NHA: National Health Accounts of the World Health Organization; EPC/AWG: Economic Policy Committee/Ageing Working Group.

Source: European Commission 2006;⁶⁷ European Commission 2007.⁶⁸

At the beginning of this section, we asked why the OMC and other soft law instruments were developed in EU health care policy. It has become clear by now that the emergence of soft law with regard to health care did not just come ‘out of the blue’: it is the result of bargaining between different sets of strategic actors who have specific, sometimes conflicting, interests.

4. The ambiguity of new governance instruments

‘Soft’ processes have also been an instrument to increase the political weight of social affairs players vis-à-vis ‘economic’ players such as the Economic Policy Committee and the ECOFIN Council.⁶⁹ Both the health and social affairs players had (and still have) a case to defend

⁶⁶ Commonly agreed national indicators based on commonly agreed definitions and assumptions that provide key information to assess the progress of Member States in relation to certain objectives, while not allowing for a direct cross-country comparison, and not necessarily having a clear normative interpretation.

⁶⁷ European Commission, ‘Portfolio of overarching indicators and streamlined social inclusion, pensions, and health portfolios’, D (2006), 7 June 2006, pp. 7–13, 40–50.

⁶⁸ European Commission, ‘Joint report on social protection and social inclusion 2007: social inclusion, pensions, healthcare and long-term care’, Directorate-General for Employment, Social Affairs and Equal Opportunities (2007), p. 412, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2007/joint_report_En.pdf.

⁶⁹ B. Vanhercke, ‘Political spill-over, changing advocacy coalition, path dependency or domestic politics? Theorizing the emergence of the social

against economic players, all of which have tried to shape the terms of the EU health care debate, and expand their influence in it. Together, they have created a very crowded political debate and some political instruments whose purpose and seriousness are ambiguous and mean different things to different people.

Although the evidence is rather limited, some have illustrated the use of soft law to ensure compliance with Court rulings (soft law as a tool to implement hard law).⁷⁰ Others claim the exact opposite: that soft law is being used to avoid specific legislation on health care by 'keeping the Commission busy'.⁷¹ In this view, Member States strategically accept soft law to prevent any further surrender of formal national competences to the European level.⁷² Among our interviewees, some see it as a way for the Commission to keep the Member States busy, and divert them into a process that the Commission controls more closely than the High Level Group, while soaking up time and energy that Member States could spend blocking EU policy.⁷³ Others saw it as a way to reinforce the position of DG SANCO or DG Social Affairs within the Commission,⁷⁴ while at least one of its founding fathers considers the EU to be an appropriate venue in which to find and tackle (at least superficially shared) 'highly similar challenges'.⁷⁵ Governments have used 'soft' European processes as a way to blame Europe for tough decisions at home.⁷⁶

protection OMC's', Paper presented at the Conference on 'Governing Work and Welfare in an Enlarged Europe', University of Wisconsin, Madison, 19–20 May 2006.

⁷⁰ H. Gribnau, 'Soft law and taxation: the case of the Netherlands', *Legisprudence* 1 (2008), 291–326; J. B. Skjærseth, O.S. Stokke and J. Wettestad, 'Soft law, hard law, and effective implementation of international environmental norms', *Global Environmental Politics* 6 (2006), pp. 104–20.

⁷¹ Interview with Belgian Civil Servant.

⁷² R. De Ruiter, 'To prevent a shift of competences? Developing the open method of coordination: education, research and development, social inclusion and e-Europe', PhD Thesis, European University Institute (2007).

⁷³ Interviews with French and German officials.

⁷⁴ Interview with European Commission, November 2007.

⁷⁵ F. Vandembroucke, 'Open co-ordination and the European pension debate', Speech at the International Conference 'Open Co-ordination and Retirement Provision', Berlin, 9–10 November 2001.

⁷⁶ M. Ferrera and E. Gualmini, *Rescued by Europe? Social and labour market reforms in Italy from Maastricht to Berlusconi* (Amsterdam: Amsterdam University Press, 2004), p. 208.

Most EU soft law processes are just as ambiguous in their intent as Member States' calls for frameworks and legal certainty. Member States can declare that they seek good health care and a framework for EU policy and mean that they would like restraints on the activities of the Court and Commission. Anti-obesity advocates can see the Platform on Diet, Nutrition and Physical Activity as a way to undermine junk food companies, while those companies can see it as a way to deflect regulatory threats and charges of bad corporate citizenship. The OMC process can be a way to channel Commission and Court pressures for European-level activities into a relatively harmless, ameliorative direction. Nobody, after all, will declare that they want bad, inegalitarian health care financed by a 'Ponzi scheme'.⁷⁷ Few would say that they cannot learn from other EU Member States (they can also, of course, learn from non-EU Member States. In many ways, the best comparator for the Netherlands, with its similar population size, is the equally urban Australia, notwithstanding its non-EU membership and its location eight time zones away.)

Ambiguous words are useful when there is no fundamental agreement: a combination of vagueness and homiletics will satisfy everybody around the table, defer the real arguments, diffuse them into different fora and possibly change their grounds. In retrospect, ambivalence can be seen as creating openings for new EU competences, but at the time it might look equally as if it were blocking them off. Extending this logic, instruments such as the OMC or the Platform are ambiguous processes. There would have been more efforts to block them if it had been clear what they were supposed to do.

This ambiguity means that it can be seen as increasing or decreasing the EU's competences, democracy and the 'quality' of policy debate.⁷⁸ An abundant literature has emerged over the last few years calling the OMC – and perhaps all new governance – 'weak and ineffective' and thus a 'paper tiger'. The 'delivery gap' of the OMC, which is often referred to, is predictable in view of the 'weakness of the

⁷⁷ 'Ponzi' schemes are a type of illegal pyramid selling scheme named for Charles Ponzi, who duped thousands of New England residents into investing in a postage stamp speculation scheme back in the 1920s. See US Securities and Exchange Commission, www.sec.gov/answers/ponzi.htm.

⁷⁸ J. Zeitlin, 'Introduction: the open method of co-ordination in question', in Zeitlin and Pochet (eds.), *The open method of co-ordination*, above n.28, pp. 22–4.

peer pressure system⁷⁹ and, more generally, the ‘design flaws’ of the process. Coordination processes are therefore dismissed as ‘rhetoric and cheap talk’, which appear ‘remote and irrelevant’. Or, worse, the OMC may even be a ‘fashionable red herring’, which distracts attention from other, more relevant issues. Some scholars have noticed the irony of the term ‘open’ method of coordination, which is perceived as being much more closed than the Community method.⁸⁰ Thus, due to its ‘lack of transparency and pluralism’, the OMC should instead be labelled a ‘closed method of coordination’ or even an ‘open method of centralization’.⁸¹

This is certainly a challenge. How do we reconcile these negative reviews with the volume of activity and the expectations that the OMC and other new governance strategies matter? One way is to identify the necessary conditions for successful new governance. One major study does just this. It identifies three principal conditions for new governance to work. They are simple. The first two are enough to create learning mechanisms and processes, discussed in the next section. The first condition is uncertainty. The solution should not be clear. In health, this is obviously the case – much of the time, the problem is not clear either. The second condition is a ‘distribution of power in which no single actor has the capacity to impose her own preferred solution’.⁸² If we assume that Bulgaria, Austria, Sweden and Ireland are indeed facing the same policy questions, or at least form a useful natural experiment, then health easily fulfils those criteria. The third criterion is something entirely different – namely, a penalty for failure. We discuss this later.

A. *The OMC as learning*

Meeting the first two criteria of uncertainty and relative equality of actors means that the OMC can have an influence by letting Member

⁷⁹ S. Collignon *et al.*, ‘The Lisbon strategy and the open method of co-ordination. 12 recommendations for an effective multi-level strategy’, Notre Europe Policy Paper No. 12 (2005).

⁸⁰ K. Jacobson and A. Vifell, ‘Integration by deliberation? On the role of committees in the OMC’, Paper prepared for the Workshop ‘Forging Deliberative Supranationalism in the EU’, Florence, 7–8 February 2003, p. 23.

⁸¹ S. Smismans, ‘EU employment policy: decentralisation or centralisation through the open method of coordination?’, European University Institute Working Paper LAW No. 2004/1, p. 15.

⁸² Sabell and Zeitlin, ‘Learning from difference’, above n.8, p. 13.

States learn from each other. This entails discussion between different Member States that allows them to draw lessons. Going beyond this idea requires abandoning the idea of states as unitary actors and, instead, disaggregating them. Talk of state 'peer pressure' is a metaphor rather than a theory or a mechanism. States are not unitary actors, and the complex mixes of public, para-public and private organizations that form health systems still less so. So identifying the impact of any form of new governance involves understanding who engages. That is initially a dispiriting exercise for partisans of new governance, but paying more attention to networks and less attention to mythical unitary states is ultimately a better way to identify or promote the policy consequences of the OMC or similar mechanisms.

Member States have very different ways of dealing with EU matters, and health ministries have been under less pressure than most to adapt to Europe (the EU might have been important for a long time in issues such as tobacco, medical products and pharmaceuticals regulation, professional qualifications and food safety, but most health ministries are overwhelmingly focused on the organization and delivery of health services and effectively delegate the other policy areas to their specialists).

The interaction of states with the health OMC is explained by some basic characteristics of EU affairs that we can paint with a broad brush. The default setting for any Member State when presented with a new EU policy task is to handle it through its established bureaucratic mechanisms.⁸³ This typically involves some combination of work by the Brussels permanent representation, in a coordinating or simply a servicing role, and a role for central coordinating agencies, whose power ranges from crucial in the United Kingdom (the Cabinet Office European Secretariat) and France (the *Secrétariat Général des Affaires Européennes*) to relatively weak in Germany. Most of these officials are European specialists, generalists or delegated officials from ministries with such a wide range of responsibilities that they are close to being generalists.⁸⁴

⁸³ H. Kassim *et al.* (eds.), *The national co-ordination of EU policy: the European level* (Oxford: Oxford University Press, 2001); H. Kassim, B. G. Peters and V. Wright (eds.), *The national co-ordination of EU policy: the domestic level* (Oxford: Oxford University Press, 2000); Jordan and Schout, *The coordination of the European Union*, above n.6.

⁸⁴ Greer, *The politics of European Union health policies*, above n.2.

The complexity of the policy issues means that every Member State relies on line officials from the functional ministries involved for information and opinions – ultimately, the process is one of circulating EU papers, draft positions or policy responses among the relevant divisions and seeing who is interested and has an opinion. If politicians do not have strong opinions (as they did, for example, on tobacco control), this puts a great deal of influence in the hands of the relevant parts of the health ministries. It also explains, for example, the wide diversity of issues raised by the Member States for the SPC to consider, as these are the issues raised by the different units of all the different health departments.

Typically, ministries of labour or social affairs lead on the ‘streamlined’ SPC processes, and health ministries, if they are different, contribute the health section and comment on the overall statement. Every EU state’s health ministry has an international division responsible for following, coordinating and allocating responsibilities for EU policy issues; these, in turn, rely on functional units that understand concrete policy when they need to prepare positions or interpret EU policy. Some countries also have strong regional governments, whose role in policy ranges from full involvement and a credible veto threat (Germany) to a legal requirement for consultation (the United Kingdom), to consultation as a hard-won victory for regional governments (Spain). Their engagement with the OMC varies: a delegate chosen from the German *Länder* shadows the federal representative at every step, while the United Kingdom Department of Health simply asked Northern Ireland, Scotland and Wales to fill out their own sections of the OMC questionnaire. At every stage, something can go wrong, and tradeoffs must be made, and there is a small subfield of political scientists who study the different ways Member States organize this process.

The OMC, like anything else, fitted into this process. International divisions of health ministries are typically charged with participating, as they know who has the data and are practiced at writing suitable statements of national policy. The problem, from the point of view of improving learning, is that international divisions do not design pharmaceutical co-payments or programmes for the reduction of iatrogenic infections. Increasing the technical complexity of a process is one way to engage line officials; international divisions, which tend to be very small in health departments, will happily cede responsibility to different parts of the bureaucracy and might appreciate the

opportunity to interest them in EU affairs. As a result, the health ministries tend to be the dominant actors in working meetings such as the OMC; even in highly centralized countries such as France and the United Kingdom, the high-level coordinators usually engage only when the state as a whole is adopting a position.

From the point of view of Member States, this is highly efficient. From the point of view of the EU institutions, it is also highly efficient; Member States act as peak-level aggregators of information and opinion. Furthermore, it does not preclude exploiting somebody else's internal tensions. But, from a learning point of view, it is not particularly satisfactory. In so far as habit and bureaucratic rationality keep it in the hands of the international divisions, it is likely to remain a limited form of learning because the wrong people will do the learning (i.e., not the line officials).

In other words, new governance matters when it escapes international units and strengthens transversal specialist networks that share worldviews or policy goals (political scientists have many names for these: epistemic communities and policy advocacy coalitions are the two most common).⁸⁵ The Platform on Diet, Nutrition and Physical Activity is a notable example; it increases legitimacy and resources for some groups that were previously weak at home and absent in Brussels, while apparently empowering the 'corporate social responsibility' arms of big food companies.⁸⁶

EU networks, such as those required by the Blood Directive, the EMEA or the European Centre for Disease Prevention and Control, bind together Member State agencies – and thereby homogenize and sometimes create those agencies.⁸⁷ They socialize blood,

⁸⁵ P. M. Haas, 'Introduction: epistemic communities and international policy coordination', *International Organization* 46 (1992), 1–35; H. C. Jenkins-Smith and P. Sabatier, 'Evaluating the advocacy coalition framework', *Journal of Public Policy* 14 (1994), 175–203.

⁸⁶ Cf. C. J. Martin, 'Nature or nurture? Sources of firm preference for national health reform', *American Political Science Review* 89 (1995), 898–913.

⁸⁷ J.-C. Faber, 'The European Blood Directive: a new era of blood regulation has begun', *Transfusion Medicine* 14 (2004), 257–73; A.-M. Farrell, 'The emergence of EU governance in public health: the case of blood policy and regulation', in M. Steffen (ed.), *Health governance in Europe* (London: Routledge, 2005), pp. 134–51; B. Hauray, *L'Europe du médicament: politique- expertise- intérêts privés* (Paris: Presses de Sciences Po, 2006); D. Rowland, *Mapping communicable disease control administration in the UK* (London: Nuffield Trust, 2006).

pharmaceutical and communicable disease experts to work together and legitimate a European model in each of those sectors.⁸⁸ In the area of regulating blood supplies, for example, it was necessary in many Member States to create a responsible agency that would conform to the Blood Directive.⁸⁹ The Commission organized networks that would bring together experts from existing Member State agencies and the officials responsible for organizing new ones. The result was much more homogeneity than the Directive required, as the information came from these mechanisms and the Commission's networks legitimated certain forms of organization. This European model served a reference point when the experts proposed new organizations or more resources in their home governments. It is one thing to mishandle blood supplies if they are handled on a largely domestic basis. This can be an oversight in an area that is usually low salience. Experience also shows that it can often be covered up for a short period, and, while the political consequences can be painful, they are also unpredictable. It is another thing to gather comparable data, make it public and then fail to meet EU obligations as defined by one's own experts. The latter situation makes failure more visible and failing countries are more likely to be shamed into action; at the same time, it empowers experts who promise to bring the network up to EU norms.

This mechanism can be powerful, but is highly variable. In so far as new governance penetrates within states, it is capable of strengthening and giving direction to networks that cross-cut them. These networks can become more capable of pursuing their own goals with the added ideas, legitimacy and technical support of being part of an established kind of European network. Its efficacy, therefore, depends on the extent to which it finds allies and to which they are in a position to effect policy change. Many policy instruments depend on finding allies on the ground – empowering people who already agreed with you or giving extra leverage to networks.⁹⁰ The newly empowered

⁸⁸ See Chapter 3 in this volume.

⁸⁹ European Parliament and Council Directive 2002/98/EC setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components and amending Directive 2001/83/EC, OJ 2003 No. L33/30. Interview with DG SANCO, autumn 2005.

⁹⁰ C. Erhel, L. Mandin and B. Palier, 'The leverage effect. The open method of co-ordination in France', in Zeitlin and Pochet (eds.), *The open method*

members of transversal networks have to be in a position to have an impact. A Member State's agreement to health targets is worthless if its regional governments or para-statal organizations pursue different goals. Box 4.5 illustrates how target setting in the context of OMC can work in practice.

These two conditions – lack of hierarchy and lack of an agreed solution (or problem) – create an environment where new governance has been shown to work. Detailed analyses of the effectiveness of OMCs that have been operational for a longer period of time – for example, in the field of social inclusion, pensions and employment – show that European soft governance increasingly is used as ‘leverage’ by a variety of actors, particularly through mechanisms such as: (a) rationalization of policies (e.g., initiating a culture of assessment and monitoring); (b) horizontal coordination (e.g., between and within administrations); (c) vertical coordination (e.g., strengthening of cooperation between national and subnational levels of government, and exchange of experience between them); (d) legitimation (e.g., to underpin bargaining arguments and new policy priorities, indicators and targets being key to this process); and (e) participation (e.g., increased involvement of grass-root organizations and trade unions).⁹¹

New governance of health care also might work under such conditions as learning and a consensus might influence priorities and policies. In fact, the Commission is already encouraging Member States that provide long-term care in a *devolved* context to adopt the kind of *national* targets that were illustrated in Box 4.5: ‘[n]ational guidelines and targets can ensure uniform provision across the wide spectrum of service providers and the different levels of government involved in

of co-ordination, above n.28; J. Visser, ‘The OMC as selective amplifier for national strategies of reform. What the Netherlands want to learn from Europe’, in Zeitlin and Pochet (eds.), *The open method of co-ordination*, above n.28.

⁹¹ Hamel and Vanhercke, ‘The OMC and domestic social policymaking’, above n.3; and M. van Gerven and M. Beckers, ‘Unemployment protection reform in Belgium, Finland, the Netherlands and the UK. Policy learning through OMC?’, in Heidenreich and Zeitlin (eds.), *Changing European employment*, above n.3; M. Lopez-Santana, ‘Soft Europeanization? The differential influences of European soft law on employment policies, processes, and institutional configurations in EU Member States’, PhD thesis, University of Michigan (2006).

Box 4.5 Target setting in the framework of the open method of coordination

The Belgian National Action Plan on Social Inclusion (NAP/Inclusion) 2006–8 proposes to increase the proportion of (subsidized) social housing for rent as a percentage of the total number of private households according to the following timeline:

2003	2004	2008	2010
6.2%	6.3%	7%	8%

Importantly, these are (national) ‘Belgian’ targets, whereas housing is mainly a subnational (regional) competence in this country. Hamel and Vanhercke have identified a number of effects of setting national targets for subnational competencies, which:

- puts pressure on increased coordination of regional policies (if the regions do not perform well, the national targets may be missed as well);
- strengthens the demand for coordination at the national level since some kind of institution has to do the job (even if the subnational level has the bulk of the competencies in a given issue area);
- increases the visibility and legitimacy of the issues at stake, which are, as a consequence, picked up by a wider range of stakeholders; and
- puts pressure on the strengthening of national statistical capacity, as well as of tools for monitoring and evaluating social policies (without these, there is no way to check whether targets have been met).

Source: Hamel and Vanhercke.⁹²

⁹² M.-P. Hamel and B. Vanhercke, ‘The OMC and domestic social policymaking in Belgium and France: window dressing, one-way impact, or reciprocal influence?’, in M. Heidenreich and J. Zeitlin (eds.), *Changing European employment and welfare regimes: the influence of the open method of coordination on national labour market and social welfare reforms* (London: Routledge, forthcoming 2009).

the management and financing of long-term care services'.⁹³ There is no *a priori* reason why such targets could not be extended later on to, say, drug prescriptions for general practitioners or other health related issues. The operation of other soft law mechanisms (economic policies, employment, social inclusion) has made it very clear that once target setting has become an accepted instrument of a given OMC, the pressure to establish national or even EU-wide targets is hard to ignore for any Member State.⁹⁴ This will create serious new questions for regional governments that value their autonomy, as well as important new opportunities for those who prefer shared standards.

But it need not work. It will work principally if the learning mechanisms create or empower transversal health networks within Member States.

B. The OMC as soft law

Learning can be good, but any process with no hierarchy and no agreed solutions can degenerate into a conference. Sabel and Zeitlin add, therefore, that experimental governance will be most powerful when there is an unattractive 'default penalty' – i.e., something worse that will happen if the experimental governance fails. This can include a 'destabilization regime', in which the direction of policy creates a search for alternatives 'by in effect terrorizing them into undertaking a search for novel solutions'.⁹⁵

The history of health care policy clearly has such a feature – the penalty for lack of action is progressive submission to internal market law as extended in an unpredictable, case-by-case manner. So far, this destabilization has terrorized interest groups and states alike into paying much more attention to EU health care policy (the High Level Process of Reflection on Patient Mobility is the instrument most clearly intended to head off the Court, and the initial Services Directive proposal contains the most clearly 'terrifying' default penalty). The ultimate question is whether any of the soft law instruments

⁹³ European Commission, 'Joint report on social protection and social inclusion 2008: social inclusion, pensions, healthcare and long-term care', Directorate-General for Employment, Social Affairs and Equal Opportunities (2008), p. 90, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/joint_report_En.pdf.

⁹⁴ Hamel and Vanhercke, 'The OMC and domestic social policymaking', above n.3.

⁹⁵ Sabel and Zeitlin, 'Learning from difference', above n.8, p. 39.

will prevent the default penalty. Will a properly functioning OMC, or High Level Group, or something else, slow or stop Article 49 jurisprudence, state aid and competition cases that are assimilating health into the internal market? Will participation in these new governance processes increase the Member States' willingness to accept new ('positive') EU legislation in this politically sensitive area?

There is, of course, no textbook reason why the ECJ should listen to the OMC or the conclusions of other new governance mechanisms such as the Platform or the High Level Groups. So the analytically conservative answer is that new governance is irrelevant. But that is not the way that courts in general or the ECJ in particular work. Courts engage in dialogue, more or less formally, with other institutions, and rarely make decisions that frontally attack a strong consensus. Consider the health decisions alone: they began with almost comically small issues (orthodontia and spectacles in Luxembourg), constantly reiterated that Member States are responsible for their health services, and nevertheless created a large and novel jurisprudence of health care.

If that is the case, then the statements of consensus from new governance can head off the Court by allowing certain DGs, interest groups and Member States to take a unified stance. There have been legal and political science studies of the Court that specifically ask how it tends to take sides in its decisions. It shows no favours to Member States and is neutral towards the European Parliament, but the strongest finding is that it generally defers to the positions of the European Commission.⁹⁶ When it evaluates a policy, it engages in 'majoritarian activism': it sides with a majority of Member States, hammering down the ones that stick out.⁹⁷

This argument is to some extent conjecture. There are no studies of the specific effects of the OMC on the Court's decisions because there are not enough decisions and the mechanisms would be methodologically difficult to find, but the Court has been shown to participate in these dialogues – or, as political scientists would have it, be sensitive to the political consequences of its decisions. It also means that

⁹⁶ J. Jupille, *Procedural politics: issues, influence and institutional choice in the European Union* (Cambridge: Cambridge University Press, 2004); A. Stone Sweet, 'Judicial authority and market integration in Europe', in T. Ginsburg and R. A. Kagan (eds.), *Institutions and public law: comparative approaches* (Frankfurt: PIE-Peter Lang, 2005).

⁹⁷ M. Poiares Maduro, *We the Court: the European Court of Justice and the European economic constitution* (Oxford: Hart, 1998).

new governance need not actually change any health policy; its ability to make consensus statements that deter the Court from further advancing internal market law is independent of its ability to change or improve health systems. Of course, a block on the Court's liberalizing direction in policy (and future legislation such as the Services Directive), and the option of learning and policy change, is what the 'social' and 'health' groups seek.

5. New governance in EU health policy: what future?

We began by pointing out that new governance instruments in EU health policy share the burden of confusion that has always surrounded the concept. That confusion is not surprising, given that 'new governance' mechanisms are not new and do not always produce governance. But they are obviously rife in the EU as a whole, and the EU has done us the service of making them explicit and giving them names such as OMC and High Level Group. We found an answer to the question of what new EU governance is in the 'steering mechanisms' of Senden's typology.

Second, we asked why new governance has developed in EU health care. The answer was a political story of a competition to frame EU health policy as an economic (internal market), social or health policy issue. That framing would determine the debates and possible responses. The new governance mechanisms emerged as a reaction of those focused on social and health policies to the development of EU law – principally, decisions by the ECJ but also the pressures of European Monetary Union. The direction of ECJ decisions both created an EU competence and gave it a concrete form – the internal market (patient mobility), state aids, competition and public procurement law. That form did not reflect the priorities, values or expertise found in health systems. Consequently, health ministries and health interest groups were at least grudgingly receptive to the Commission when it proposed new governance mechanisms; the OMC and the High Level Group (and the later Platforms).

Third, we asked what might be the effect now that the new governance mechanisms have been created. In health, they are both recent and still provisional, as reflected by the recent emergence of EU health policy issues and the reluctance of Member States to permit even this relatively unthreatening expansion of EU competence. But there are

conditions, identified in studies of the most-researched mechanisms (the OMCs for other policy areas), that allow us to judge the likelihood of an effect. We found that there are two conditions that health easily satisfies: lack of hierarchy and lack of agreed solutions. Those are both fertile ground for networks, but not necessarily learning or the development of binding norms. Learning and norms depend on the extent to which Member States' officials and interest groups engage and use new governance mechanisms as leverage. The third condition that new governance mechanisms generally satisfy (if they are effective) is an unattractive default penalty. While the unattractiveness of the default penalty – market-oriented policy-making by the ECJ – is clear, the extent to which new governance would prevent it is not clear. Nor is it clear that new governance mechanisms would have to actually affect health systems or policies in order to 'head off' the Court. New governance might affect policy without staving off the expansion of internal market law, and it might equally deter the Court and DG MARKT without affecting a single doctor or patient, and it might achieve almost nothing.

What, then, is the likely future of new governance in health policy? Understanding the likely influences requires understanding its practical and institutional context. This means understanding that new governance mechanisms compete for time and political attention with other health policy issues – and that they are tools of political actors with distinct interests. We identify the basic problem, which is that new governance tools are both competitive with each other (time spent on the OMC might be time subtracted from time spent on the Platform) and are at this point part of a contest over the nature and priorities of EU health policy. So, they might be abandoned if Member States do not get adequate use out of them. Furthermore, they might be abandoned if one or more EU institution dislikes their consequences.

The following subsections identify the cost that new governance imposes on EU institutions and Member States in relation to the benefits. We think them sufficient to keep new governance mechanisms alive, even if they might not be sufficient to shape policy or carry the day for a social or health framing of EU health policy.

A. Using scarce resources

One obvious conclusion from the step-by-step retracing of the emergence and development of EU soft law on health care is that this is a

very crowded place, even if we have simplified by leaving a number of processes and groups – and the whole structure of comitology – out of this chapter.⁹⁸ Different combinations of interest groups, Member States, Commission DGs and individual entrepreneurs have created, in a remarkably short time span, (multiple) networks, (high level) committees, groups, reflection processes, forums and the like, each of them with the aim of influencing, through ‘soft’ (as opposed to legal) tools such as deliberation, some aspect of Member States’ health care policies. As we have shown, this influence of soft law is by no means ‘automatic’ or the isolated work of ‘experts and bureaucrats’, but is shaped through ‘hardboiled’ politics in the national and EU arenas.

In real life, the same people (high-level civil servants and political advisors) are in charge of following several (if not all) of these health care processes, and they must decide how much to invest in them, and what they can draw from them. Their time is scarce. This finding concurs with the fact that many contributors (in particular, several national governments) to the Commission’s consultation on a Community action on health care services were ‘concerned about division or duplication of work on health care between different bodies at European level, and argued for a rationalization of activities and resources concerning health care at Community level’.⁹⁹ More pragmatically, three interviewees (one in Germany, two in Spain) asked, at the end of an interview, why the OMC was such a focus of academic attention instead of more important health issues. But it also crosscuts the logic of learning – while the processes can look duplicative to an international department of a ministry, a line official might only see and value (or be annoyed by) a single thread.

B. Commission ... Council, Member States ... Parliament

The second likely influence on the future is the role of the different EU institutions. Above all, this means the role of the Commission. The

⁹⁸ Greer, ‘Choosing paths’, above n.34.

⁹⁹ European Commission, ‘Summary report of the responses to the consultation regarding “Community action on health services”’, SEC (2006) 1195/4, 20 April 2007, p. 32.

Commission is the key actor in any of these processes; for instance, by framing the same issue differently in different contexts to persuade the Member States, by creating new allies from scratch (for example, by inventing the European Health Forum or European patient groups), but also with regard to the timing of releasing, or putting on hold, communications, reports, etc. Thereby, the Commission, from a very early stage, set the terms of the debate, brought along the Member States when they dragged their feet, and made different new governance mechanisms operational in an incremental way.

The Commission naturally has its own preferences: the High Level Working Group's on-again, off-again history is in large part due to those preferences. The Group is largely an intergovernmental body that writes its own reports – and has a far higher degree of autonomy from the Commission than that enjoyed by other consultative groups. This naturally makes it the Commission's least favorite group. It is moribund now, and the Commission helped make it so. One simple way to do this is to avoid calling Working Group meetings. Another is to avoid making its documents public. Working Groups met in 2006 and 2007, but less and less often. The Commission's (Europa) web site, which most researchers take as a complete record of EU activities, did not post all of the results of the Group's meetings; an official showed one of us dozens of emails asking the Commission to post the minutes of Working Group meetings. Those minutes never did appear on Europa, and the best that Member State officials could do was insert obscure references in the 2006 annual report.¹⁰⁰ This combination of laggardly secretarial work and bad web management might have been a reflection of Commission priorities (which do not include helping out with intergovernmental policy forums) and might have been strategic, knocking off a competitor to the Commission's chosen fora. Either way, they helped smother the High Level Group. It gained a reprieve, then, from the delays to the proposed directive on health services. DG SANCO made moves to revive it in early 2008 when the directive faced troubles and the DG needed some ongoing forum in which to develop health policy.

This is not to say that Member States do not play an important role in all this. Both individual Member States (e.g., the Belgian

¹⁰⁰ European Commission, 'Work of the High Level Group in 2006', HLG/2006/8, 10 October 2006.

and Spanish Presidencies in 2001 and 2002) and small groups of Member States do have an important influence on the debates, especially when they manage to set up networks that include national and European civil servants, academics and politicians. Now that Member States have discovered the potential of this OMC, they have circularized their health departments, which predictably has flooded the agenda (see also section three above). The real meaning of the OMC remains in dispute, and Member States' attitudes vary. In late 2007, one French interviewee became very irritated when one of us suggested that his country supports the OMC, arguing that it was a waste of time and diverted Member State attention from the real Commission agenda. British officials agreed in less pungent terms.

The one actor that is largely absent from this story, however, is the European Parliament. In that sense, one can understand why it recently complained about the institutional and legal (read, democratic) implications of the use of 'soft law' instruments.¹⁰¹ This is hardly surprising: many efforts to increase the legitimacy of EU policy, including these, rely on interest representation, rather than procedural democracy.¹⁰²

These factors point to more new governance in the future. The Commission is the most active EU institution, and its fragmentation and internal competition generally enhance its entrepreneurialism. As a result, it is likely to continue offering new governance mechanisms in much the same way that it offered the High Level Group to health policy communities and the OMC to more socially engaged groups.

C. Persistence and usefulness

Against the context of scarce resources and elective affinities with the Commission, what is the future likely to be for new governance? Above all, it is clear that soft law and new governance in

¹⁰¹ European Parliament, 'Draft report on institutional and legal implications of the use of "soft law" instruments', Doc. No. 2007/2028(INI), 15 March 2007.

¹⁰² S. L. Greer, E. M. da Fonseca and C. Adolph, 'Mobilizing bias in Europe: lobbies, democracy, and EU health policymaking', *European Union Politics* 9 (2008), 403–33.

the field of health care exist in the shadow of hard law. The legal debates require intellectual energy and time, and the OMC is seen as a 'luxury' by many actors involved, who will invest time in it if they have it.

There are some strong indications, however, that formal recognition and use of new governance in EU health policy is here to stay. The Barroso Commission, no special advocate of social models or new governance, 'has continued to propose new OMC processes when faced with the perceived need for joint action in politically sensitive institutionally diverse policy fields'.¹⁰³ And in spite of all the skepticism (especially from academics), many (if not all) of the 'other' Commission-led new governance processes on health care (including the European Health Policy Forum, the High Level Committee on Health and the High Level Process of Reflection on Patient Mobility) sooner or later refer to the OMC as a 'goal to attain'.¹⁰⁴ Thus, the OMC seems to have become a 'template' for EU soft law mechanisms, and we have illustrated that, even within the limited field of health care, new proposals for launching OMC processes arise on a regular basis.

New governance might do better than survive. If new governance seems likely to prevent the 'default penalty' of internal market law, then it will be favoured by many more actors. The default penalty, or destabilization regime, is incorporation into the single internal market. That prospect helped explain the emergence of the High Level Group and the OMC in health. The problem is that the default penalty is administered by the European Court of Justice interacting with Member State courts and, intermittently, by allies in the Commission. If the Court responds to the OMC (or other fora), then the OMC will gain importance as a form of soft law that becomes intertwined with, and may eventually even head off, hard law. If the OMC turns out to

¹⁰³ Sabell and Zeitlin, 'Learning from difference', above n.8, p. 25.

¹⁰⁴ EU Health Policy Forum (EHPF), *Recommendations on EU Social Policy* (Brussels: EHPF, 2003), p. 7; European Commission, 'The internal market and health services', Report of the High Level Committee on Health, 17 December 2001, p. 26, http://ec.europa.eu/health/ph_overview/Documents/key06_En.pdf; European Commission, 'Minutes of the meeting of the High Level Process on Patient Mobility and Healthcare Developments in the European Union', HLPR/2003/2 REV 1, 3 February 2003, p. 5; M. Kyprianou, 'The new European healthcare agenda', Speech at the European Voice Conference 'Healthcare: Is Europe Getting Better?', Brussels, 20 January 2005, p. 6.

be a way to run academic health policy colloquia while the Court is rewriting the fundamental rules of the game, it would be legitimate for states to lose interest. Member State officials lack tools to influence the European Court of Justice; they do not lack opportunities to attend international conferences.

Obviously, there may be different reasons why the OMC or other groups are supported by those who play a role in it. And that is the case for soft law and new governance in general. It is very easy to argue that they are irrelevant, and perhaps non-existent. But they keep reappearing, in policy as well as in theory. The different mechanisms we enumerated provide the reasons why. Even if they never replace the Community method, and fail as the countermove to ECJ jurisprudence, the different groups fulfil multiple functions. Strengthening networks, opening up new possible EU competencies, contributing to epistemic Europeanization and shaping political consensus are all evanescent activities that lack consistent, visible, empirical outcomes – but which matter. And the staying power of EU new governance in health policy is evidence of its multiple functions. Even if a process fails to change policy, it might be a useful learning opportunity for officials or lobbies. By making trade-offs, such as balancing the competition and social protection objectives of health care systems, increasing transparency and discussing varying solutions to solve problems among Member States, the OMC can provide policy-makers with equipment to tackle such difficult issues. If this is indeed the case, the OMC increasingly will be perceived by the actors involved as a useful tool in the domestic policy-making tool kit. Feedback mechanisms will further ensure its continuation. In other words, new governance in EU health care is here to stay – because it serves the different purposes of many actors and is often a simple recognition of networks that exist already. The challenge will be working out when, how and why it matters.