

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

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Health policy in the European Union is at a critical juncture: a moment in which decisions are highly contingent but, once taken, will shape politics and policy for the future. EU health policy is contingent because of its sideways development; it has emerged as an issue due to the decisions of the European Court of Justice rather than member state volition. There is, accordingly, no established EU health policy community or trajectory. Instead, there are a range of different models of health policy, each with different logics, lineages, policy tools and bureaucratic sponsors. But the decisions taken in this fluid situation will shape future policy because of the importance and “stickiness” of the EU- once the European Court of Justice has taken a decision, or legislation has passed, it is difficult to undo it. This article explains the nature of the external shock that created an EU policy arena where none had been; the reasons that decisions taken now will be subject to the logic of path dependency; and the different models that are being put forward for the EU.

The treaties that constitute the European Union and allocate the powers (“competencies”) of its institutions are explicit about the extent of its health powers, and they are limited. Explicit powers over health policy are largely confined to public health issues such as blood regulation (art. 152)(for key summaries: Hervey and McHale 2004; Lamping 2005; McKee et al. 2002; Mossialos and McKee 2004). Health services- the organization and finance involved in medical care- are not mentioned in the treaties. This presumptively denies the EU a competency. The European Court of Justice has repeatedly stated that the organization and finance of health services are the responsibility of member states¹.

But health policy, like other areas of European life before it, is demonstrating that European Union competencies can expand according to rules other than the ones contained in the treaties (Pierson and Leibfried 1995). The basic logic is easy to explain: while health services might not be part of the explicit domain of the EU, a core activity of the EU- the creation of a single market through EU-wide regulations- can shape the environment of health services. To paraphrase a slogan of Britain’s road transport lobby, if it got into a hospital, it came via the internal market. And the European Court of Justice, since 1998, has been extending the reach of internal market law piecemeal into health.

This has given rise to a constitutive politics of health policy in the EU- a “critical juncture” that will shape future constraints and actors. The EU health policy arena is a rapidly changing system in which the borders (what is health policy?), the institutions charged with making policy, the structural balance of powers among them, the role of states and interest groups, the policy tools in routine use and the privileges accorded different interest groups are all still to be determined. This article argues four points, one in each section. The next section argues that comparative political science provides the tools to tell that contemporary EU health policy is a “critical juncture”- a moment in which the decisions taken will be difficult to reverse and go on to shape politics and policy. To be a critical juncture requires a cause of the sudden instability, a high degree of contingency, multiple possible trajectories, and a high likelihood that the results will prove self-perpetuating. The second section explains that this critical juncture was created by the irruption of the European Court of Justice into health services, which had previously been a matter for member states. The third section identifies the characteristics of EU politics that make current health policy debates unpredictable, and health policy decisions likely to stick and shape future politics and policy. The fourth section considers the options- the various possible paths on which EU policy might embark. The conclusion is that the EU is indeed at a critical juncture in health policy, and that the decisions taken in the current highly uncertain climate will shape politics of EU health services policy, and could have significant effects on health services.

The primary source of data is 51 semi-structured interviews conducted with EU lobbyists (N=12), member state and regional government officials from the UK, France, Germany, and Spain (N=18), and lobbyists (N=21) between July 2003 and November 2006, with the main waves in October-December 2005 and March-July 2006. This is supplemented by secondary

sources, EU documents, and participation in practitioner events focusing on EU health policy over this time.

Why decisions taken now will matter later

If more almost two decades worth of studies of political institutions, primarily by historical institutionalists, have made any point, it has made the point that small decisions about institutions and policy tools taken at one time can have a major influence over what is possible and realistic in the future (this literature is voluminous. For its history and synthesis, Pierson 2004; Streeck and Thelen 2005; Thelen 1999; Thelen and Steinmo 1992). The key concept, borrowed from economics, is that of path dependency (David 1985). Path dependency means that decisions can, in a self-reinforcing process, raise the costs of changing to a (possibly welfare-enhancing) path because they shape the actors and institutions that will in turn shape the politics, costs, and benefits of decisions later. This is path dependence because even if the path turns out to be unattractive to many, it would be metaphorically too costly to go back to the fork and take the other path.

The forks are known as “critical junctures”, times at which the ordinary incrementalism of politics is temporarily replaced by uncertainty and the possibility of significant change, which will later stabilize and return to incrementalism (Jones and Baumgartner 2005; Krasner 1984). Carolyn Tuohy, in a study of health services, argued that the creation of a critical juncture in health usually takes an exogenous shock- a mobilization of political power and energy. Otherwise, the complexity of health services and power of the many policy actors involved tends to mean that they evolve according to their own internal logic (Tuohy 1999).

Pierson, in his synthesis of historical institutionalism, defines the situations- the critical junctures- in which path dependency matters, regardless of the cause (Pierson 2004:45). They are when there are:

- (1) *Multiple equilibria*; a range of different outcomes were possible under the initial conditions;
- (2) *Contingency*; relatively small events can have “large and enduring consequences;”
- (3) “a critical role for *timing and sequencing*” meaning that the order of events shapes political forces and possibilities; and
- (4) *Inertia*- “once a process has been established, positive feedback will generally lead to a single equilibrium,” which will then resist change.

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

Triggering the Europeanization of health services

There might be other ways to prompt health service change than the kind of exogenous shock Tuohy discusses, but in the case of an EU such an exogenous shock was administered. It was administered by the European Court of Justice (ECJ), the Luxembourg-based court that has over time become responsible for interpreting and enforcing EU Treaties and legislation- and “the most effective supranational body in the history of the world” (Stone Sweet 2005:108). The ECJ has been a key driver of European integration, by first establishing that EU legislation and its decisions overruled states’ decisions, then through a large jurisprudence that is critical of measures that discriminate on the basis of citizenship within the EU (Alter 2001; Burley and Mattli 1993; Rasmussen 1986; Stein 1981). It has certainly played that leading role in extending European integration in the case of health services policy (Greer 2005; Greer 2006b). There is by now an extensive literature on the law and policy implications of the ECJ’s decisions, with some excellent overviews (Hatzopoulos 2005; Hervey and McHale 2004; McKee and Mossialos 2006; McKee et al. 2002; Mossialos and McKee 2004); this section merely makes the point that it was an exogenous shock sufficient to create a critical juncture as defined by Pierson.

The ECJ previously played almost no role in health services, and some have even compared the impact of ECJ rulings on health to the foundational decisions that established the “direct effect” of EU law (Giubboni 1998). As Gareth Davies writes of ECJ rulings on the welfare state, including health policy, “it is striking to a lawyer in what an un-European way this process is occurring...It is not legislation that is harmonising welfare states, but principles developed reactively, inductively, and out of individual situations, by the Court of Justice... Moreover, those judges are not even applying welfare law. They are using principles of economic liberty and regulation. Welfare reform is not being led by welfare policy at all” (Davies 2006:5).

The Court made decisions on three basic issues that extended its authority over health services. The first major issue was patient mobility. This burst on to the European health policy scene with two dramatic 1988 decisions, *Kohll* and *Decker*.² In both cases a Luxembourg lawyer used a service outside the country, requested reimbursement from a Luxembourg health insurance scheme, had the request denied, and sued. The Court ruled in both cases that the Luxembourg insurance funds’ denials were unjustified discrimination on the basis of the member state of the provider. The crucial issue is that the Court in these cases defined the issue as one of the internal market (Art. 49) rather than social security. Practical costs are limited so far (Ackers and Dwyer 2002; Rosenmöller et al. 2006). The problem is that there is a large *acquis* of internal market law with which health systems often do not seem to comply; closure has been both an administrative and philosophical characteristic of member state welfare states (Ferrera 2005). Insofar as the Court (and member state courts) apply Article 49 law or principles to health services, they could oblige major changes health services organization (by, for example, reducing member state payers’ ability to discriminate in favour of providers that they control, or their ability to make purely member-state decisions about what kinds of treatment are justified)³. The current pattern- case by case decisionmaking- does not make it clear how radical the principles truly are or what the effects will be. They primarily introduce intolerable legal uncertainty, as member states and stakeholders (DG Health and Consumer Protection 2003, SEC(2006)1105/4) and scholars (Hervey and Trubek 2007 (forthcoming)) alike argue.

The second major issue arose with judicial interpretation of the Working Time Directive (WTD, 93/104/EEC). The WTD regulates working times across Europe, limiting the total number of hours that can be worked and ensuring rest periods for employees between shifts. Applied to health services, it was always going to have controversial consequences, raising labor costs by demanding more hires to cover the same hours (Sheldon 2004). The ECJ, however, did a great deal to make it more controversial with two decisions that meant member states would incur more costs and more changes than they had expected. The two major cases are *SiMAP*, decided in 2000, and *Jaeger*, decided two years later⁴. *SiMAP* established that time spent asleep while on call amounts to work for purposes of the WTD. *Jaeger* decided that the WTD's provision for immediate compensatory rest after a shift therefore applied to the shift after the shift spent on call. Both were unexpected, and compliance, costly.

The third issue is still more difficult to work out, but potentially more serious. It is the extent to which the economic activities of health services are folded into competition, public procurement, and other internal market law. One scholar (Giubboni 2006) speaks of the "infiltration" of competition law into social security and health systems, undermining the risk-pooling mechanisms that underpin solidarity in many systems. A number of private providers and operators in health have brought cases, arguing (Morgan 1983) that public systems enjoy unjust exemptions from competition law.⁵ The threat is that courts or (since the decentralization of EU competition law enforcement in 2004) competition authorities in member states could invoke competition or internal law against "solidarity" mechanisms (Dawson et al. 2005; Jost et al. 2006). Even if that does not happen, there is a potential "ratchet" effect, since it could be difficult to expel private firms from areas where the public sector has opened itself to competition⁶.

It is unlikely that EU health policy could stabilize at this point. In terms of the division of powers, the status quo is an unstable combination of extreme intergovernmentalism (which is what health services were until recently, i.e. wholly outside the supranational EU structure) and extreme supranationalism (i.e. policymaking by the Court). In practice, this means that member states are at best able to guess what the Court (and the litigants and referring courts across Europe) might do next, but scarcely able to channel or predict it. The result, as one observer put it, is that "After the Court, the policy-makers get down to work" (Baeten 2005).

The indeterminacy and inertia of EU health policy

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

-French official, Brussels, July 2006

The ECJ essentially threw an undefined but potentially large part of health policymaking into the EU, an arena with no established health services policy players. That means contingency matters more in EU health policy than even in most other arenas of EU policy. The politics of EU health policy at the moment are, above all, about defining the nature of health policy, the legitimate

participants in its making, and the legitimate policy instruments (Lascoumes and Le Gales 2007).

Indeterminacy

In general terms, this means that the scope of health policy conflict is yet to be determined, and doing that in an advantageous way the major object of many actors (Schattschneider 1960[1975]). More specifically, the indeterminacy of the issue creates indeterminacy of political process for four reasons.

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

Second, the treaty base game is entangled with the internal bureaucratic politics of the European Commission. The Commission has a well-documented propensity to act as a “purposeful opportunist”: to expand EU competencies by opportunistically identifying new areas of policy that it can incorporate into EU competencies (Cram 1997:154-167). The Court, indifferent to the Parliament’s suits and generally hostile to the member states, shows a marked tendency to defer to the Commission (Jupille 2004:98; Poiares Maduro 1998; Stone Sweet 2005). But the treaty bases for health competencies do not just empower the EU institutions as a whole; they also empower particular parts of the Commission. This matters because each DG involved in the contest has a different outlook and manner of proceeding (Cram 1997; Spence 2006). Born of its particular history and available legal instruments, a DG’s style of proceeding can shape policy. Thus, for example, almost every interview highlighted how the young, weak DG Health and Consumer Protection (“Sanco”) is much more solicitous of incumbent health policy communities than its rivals DG Employment and Social Affairs or DG Internal Market. DG Health and Consumer Protection finds in incumbent health policy communities a natural base of support, and one that is well integrated with the member state health ministers who usually deal with it- it is the DG that sends officials in force to the annual European health policy conference in Gastein, it is the DG that runs the European Health Forum, the leading consultative health policy group set up to give the Commission good information, and it is the DG that is trying to find ways to fund EU-level health policy groups in order to create a constituency for itself (Greer

forthcoming 2007). But DG Employment and Social Affairs and DG Internal Market already have their constituencies (especially unions and employers, respectively) and strong connections with member states' economics, industry and labor, rather than health, departments. The balance of power between the weak DG Health and Consumer Protection, with its limited treaty bases, and the two others might be seen in the fact that its European Health Forum's recommendations are usually commenting on proposals issued by DG Internal Market or DG Employment or Social Affairs.⁷

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

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

Inertia

In other words, EU health politics has yet to develop the degree of order found in other major policy areas of the EU- in Pierson's terms, contingency matters. It also has extremely high properties of what he calls inertia. The EU is, compared to even complex states such as the US, exceptionally "sticky" (for the argument and a great deal of evidence, Pollack 2003). Decisions, once taken, are hard to reverse. At worst, they require revisions to treaties that must be unanimously agreed by 25 member states, many of which must ballot their populations in referenda; *Kohll* and *Decker*, which are based on the Court's direct reading of the Treaties, would take Treaty revisions to reverse (which is why member states often prefer to attempt very constrained interpretations of decisions, Conant 2002). Even if were normal legislation, the EU policymaking system's complexity and the multiplicity of interests make additional legislation very difficult; while there is a great deal of member state agreement on the principle of revising the WTD to reverse *SiMAP* and *Jaeger*, actual legislation is caught in a logjam with other WTD issues such as the UK's opt-out (UK official, May 2006; lobbyist, October 2006). Finally, once the Commission is pursuing a policy in its role as an executive, with its attendant implementation, enforcement, and personnel decisions (Page 1997:104-110), it is able to circumvent restrictions that member states attempt to impose. In other words, EU health

polycymaking is contingent now but the policy instruments and dominant bureaucracies, once chosen, will be very difficult to change and very likely to enjoy positive feedback from their new role as dominant players in EU health policy. There is a very good chance that decisions taken in this contingent situation will stick.

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

The EU's health policy is, therefore, unstable, and prone to inertia. This section focuses on the remaining condition from Pierson's list: the presence of multiple possible outcomes (equilibria); and the effects that different sequencing can have on the prospects for success and practical meaning of options. We are at a moment in EU health policy in which there are multiple, credible, possible equilibria made up of different policies or combinations of policies, and politics now is about choosing one (Jorens et al. 2005). The choices the EU makes now is progressively ruling some of them out, and decisions taken now change the significance of other policies that still might be chosen. This section starts with one that is ruled out for the immediate future- the Services Directive- and then runs through each major contender, discussing their sponsors, current status, potential interaction with other instruments, and the nature of the policy instruments they involve. It then highlights the role of sequencing.

Health within the internal market 1: Services

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

- Lobbyist, London, October 2004

“Even the UK and France were agreed. That means we can be sure it was a bad idea.”

-French official, Brussels, July 2007

The first path proposed by the Commission, one that would have had a dramatic effect on all EU health systems, was the Services Directive (COM(2004)2), proposed by the controversial Dutch Liberal Commissioner Frits Bolkestein towards the end of the Prodi Commission in 2004. It was in the eyes of the new Barroso Commission and many member states the best way to advance a competitiveness agenda. It would have extended two key principles of internal market law to the service sectors: the country of origin principle, which means service providers are subject primarily to the law of the country in which they are established (rather than the one in which they are providing the service), and freedom of establishment (banning discrimination against nationals of one state setting up practice in another state). It also incorporated health, which was a surprise to many health policy observers, but appears to reflect the Commission's preference for general (services) over sectoral (health) legislation; tactics (placing a high initial bid in a sort of political Dutch auction); and compliance of the Services Directive with a judicial direction that folds health under Article 49 as a service anyway (DG Internal Market officials, December 2005, March 2006).

DG Internal Market was surprised at the ferocity of the reaction from the health sector

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

The Commission drew back after seeing the hostile reaction, while lobbies worked to defeat or heavily modify the directive (including health services lobbies, which usually sought simple removal of the health sector)(Greer forthcoming 2007). The eventual result was a deal between the leaderships of the two largest parties in the Parliament- the Christian Democratic European People's Party and the Party of European Socialists. This stripped out both health and the country-of origin principle. DG Markt retired from the field, although an official pointed out that it had the option of starting infringement proceedings against member states that failed to comply with freedom of movement in health (interview, March 2006).

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

"From the French side, we tried to promote a common approach, a broader approach focusing on the social services of general interest. We think that health care services are not really specific"
-Official, French permanent representation, Brussels, July 2006

"Or do you mean a service of general *economic* interest? Or a *social* service of general economic interest? What's a service of general interest? What's the treaty base? Definition? [sets down coffee and points at interviewer]. What? What? What?"
-UK official, London, May 2006

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

could be generalized into a principle (Smith 2005:70).

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

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

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

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

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

It began with the High Level Process of Reflection. The impetus was partly an influential book produced by the European Health Management Association (EMHA, with, in true *communautaire* style, funding from the Commission’s research budget)(Busse et al. 2002). At the

same time, books commissioned from the influential and respected European Observatory by the Belgian presidency alerted many to the issues (McKee et al. 2002; Mossialos et al. 2002). These projects and books, with features such as analyses of the increasing amount of legislation with health impacts, coincided with major cases surrounding patient mobility that alerted health ministers and policy experts to the importance of the EU. Health ministers, whose Councils had been about (rather minor) public health issues, suddenly began to decide that they were discussing the wrong issues in European politics (interview, UK Department of Health, July 2004).

The December 2003 “Outcome of the Reflection Process” (DG Health and Consumer Protection, COM(2003)) proposed that a permanent working group should be established, and member states duly created the High Level Group on Health Care in an implicit acceptance that some mechanism for coping for EU health spillover would be required for the indefinite future (DG Health and Consumer Protection 2003). DG Health and Consumer Affairs serviced the Reflection process and the Working Group, which began to assemble itself in late 2004 and in made its first statements in 2005. The problem of the Group to date is that it produces nothing that looks like hard law. It does not have enough of a head start to shape the EU framework faster than the courts, and structurally it does not have the power to shape an EU regulatory framework to member states’ taste or allow health ministers to get control of a process they are not driving.

Health as a distinct policy field: Sectoral legislation

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

From the point of view of health incumbents, the High Level Group is inadequate to the problem of heading off other proposals. From the point of view of the European Commission and member states interested in legal stability for health services, the failure of the Services Directive’s inclusion of health, and the decision by the Commission and many health interest groups not to pursue the services of general interest approach leave a vacuum that “sectoral” health legislation can fill. This fell to DG Sanco, in 2006. Legislation was initially opposed by member states that generally oppose legislation, such as the UK, Ireland, and most of the accession states, and viewed with skepticism by those who would prefer a pre-*Kohll*, pre-*Decker* repatriation of health policy to the member states. But, given that the EU role is almost certainly irremovable the constituency for such a law grew (with the UK, ever the skeptic, coming around in mid-2006; remarks by Nick Boyd at the European Health Forum Gastein, October 2006).

DG Sanco launched a consultation (SEC(2006)1195/4) on the problems and the possible content of a specific health law in September 2006. Interviewees after its publication were all surprised at the open nature of it. Its questions focused on just what kind of legal clarity was sought, and views about the appropriate locus of responsibility for different issues. At the time of writing, responses to the consultation (which closed in January 2007) were still being posted. The outcome is almost guaranteed to be a proposal by Sanco to the College of the Commissioners for sectoral health legislation, but it is very likely, given the weak treaty bases and dissension among

member states, that it will be tightly drawn, with recitals that strongly discourage further Article 49 judgements by the Court.

Health as Social Security

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

Health as part of the European social model: The OMC

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

The literature on the OMC is extensive.⁸ Many authors stress its potential as a route to democratic open-ness and as an instrument of governance (in health, Jost 2006). Others stress usefulness to social democrats as a means to overcome the problems of the Euro-zone constraints (Johnson 2005; Schäfer 2004), or point out the extent to which it fits most of all with the liberalizing "Lisbon" agenda (Carmel 2005).

The goals of OMC Health and Long-term Care were set by the 2002 Barcelona meeting of the European Council, at which it determined that accessibility for all, high quality care, and long-term financial stability were the chief goals of the process (COM(2004)304, COM(2001)723). The OMC Health and Long-term Care, whose creation was mandated in 2004, has taken time to develop; member states had picked indicators and developed their "National [sic] Action Plans" when a "streamlining" process began to fold it into back a larger single Social Protection Committee (COM(2005)76). Whether it matters is still being debated in literature

based on the experience of older OMC processes. It seems that the mechanism that might make it work is “name and shame,” and that depends on domestic interest groups using laggardliness revealed by OMC procedures to drive their governments to change (interviews, European Commission, February, March 2006)(Borras and Jacobsson 2004; de la Porte et al. 2002; Szyszczak 2006; Wincott 2003).

Sequencing

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

Conclusion

The ECJ destabilized EU health systems with its decisions on patient mobility and working times, creating a “critical juncture,” a time of great indeterminacy when policy is not operating according to standard procedures. This is because it translated much policymaking to the EU level, where there was no established way of making health policy and a great deal of controversy about the scope of an EU role. In the wake of the breach it opened, the Commission proposed a variety of policy frameworks to incorporate health.

EU policymaking now fulfills Pierson’s four conditions for a situation in which paths diverge with major future consequences: there are multiple options, a high degree of indeterminacy, a critical role for timing, and a high likelihood of inertia- in the sticky, insulated, EU, it is very difficult to get rid of policies once they are made and almost impossible to get rid of competencies once they are established.

The politics of Europeanization in health are now about who can harness not so much decisions as the EU policy arena- and thereby shape its importance and parameters. At the extreme, the health systems of Europe could, within a few years, be set irrevocably on very different policy trajectories, and they could be set on them by what appear to us today as flukes in the processes that brought us the different models in the debate today. At the very least, there will

be an EU health policy section in many textbooks, and it will exclude some of the half-forgotten options discussed here. EU health policy well might reshape or remain marginal to the health systems of the continent- but decisions taken now will do much to decide that.

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¹ For example: Case 238/82 *Duphar* [1984] ECR 523, para 16; Cases 159 & 160/91 *Poucet and Pistre* [1993] ECR I-637, para 6; Case C-70/95 *Sodemare* [1997] ECR I-3395, para 27; Case C-120/95 *Decker* [1998] ECR I-1831, para 21; Case C-158/96 *Kohll* [1998] ECR I-1931, para 17; Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, para 44; Case C-372/05 *Watts* 16 May 2006, para 146.

² Case 158/96, *Raymond Kohll*. ECR 1998 I-01931. 28 April 1998. Case 120/95 *Decker*. ECR 1998 I-01831.

³ *Geraets-Smits and Peerbooms*. Case C-157/99. Case C-372/05; *Watts* 16 May 2006.

⁴ Case 303/98 *Sindicato de Médicos de Asistencia Pública (SiMAP)*. ECR 2000 I-07963.
Case 151/02 *Jaeger*. ECR 2003 I-08389.

⁵ Most recently, Case 205/03 *Federación Española de Empresas de Tecnología Sanitaria (FENIN)* I-6295. Also *Poucet and Pistre* joined cases C-159/91 and 160/91 ECR-I637; *AOK Bundesverband*, joined cases C-264/01, C-306-01, C-354/01 and C-355/01 I-2493.

⁶ One example is the “BUPA case” (T-289/03) The government of the Republic of Ireland decided to liberalize health finance and invited the UK health insurer BUPA into its market and then imposed an equalization charge. BUPA viewed this as a subsidy to its public-sector rival and BUPA sued the Commission for not starting an enforcement action. BUPA withdrew the case after the Republic altered the insurance rules.

⁷ It has made five recommendations as of February 2007. Only one, on health information, was not primarily about internal market issues. The recommendations are posted at http://europa.eu.int/comm/health/ph_overview/health_forum/health_forum_en.htm

⁸ See the OMC bibliography at <http://eucenter.wisc.edu/OMC/open12.html>