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POWER STRUGGLE: THE POLITICS AND POLICY CONSEQUENCES OF PATIENT MOBILITY IN EUROPE

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“Power struggle” might seem an odd title to give to a paper about patient mobility law. Patient mobility is about lots of things – legal innovation, cross-border regions, medical tourism, competition, and, of course, patients. But power?

I argue that patient mobility policy is about power, because it causes two kinds of shifts in the distribution of power. First, it is about shifts in power between governments- also known as “authority migration” (Gerber and Kollman, 2004; Orren and Skowronek, 2004). The fact that patient mobility fits into a larger EU regulatory framework driven by EU institutions, means that it comes with a transfer of power to the EU, loss of Member State autonomy, and disruption to relationships between governments within Member States. Second, it can also be a shift in power between different advocates and interest groups, with their different substantive preferences. That depends on different advocates' ability to exploit new power relationships. As a result, the development of EU patient mobility law is a power struggle. The stakes are which governments do what, how do they constrain each others' autonomy, and what substantive policy objectives will win as results of the shifting intergovernmental relations sparked by the extension of EU competencies.

My approach focuses on policy issues- if nothing else because a political scientist's ability to contribute to legal knowledge is limited compared to the issues to the level of the sophisticated literature on the topic (see especially Mossialos *et al.*, 2008; Steffen, 2005). The policy perspective is a distinct one that focuses on policymakers' views of the sources, contexts, and consequences of EU policies. Compared to a more legal approach, a focus on policy has three effects. First, it changes emphases. The ECJ's repeated assurance that it respects the centrality of Member States in the organization and finance of health care was derided by Member State officials I interviewed. On the other hand, they also, more or less freely, admit to ignoring other points of EU law that go against them when they feel that a challenge is unlikely. Second, it mixes legal and policy issues, because it seeks out the unintended consequences from the interaction of law and existing policy. For example, the principal effect of *Watts*, some UK interviewees suggested, was to increase the power of consultants (specialist doctors) whose “clinical judgment” had gained weight at the expense of managers charged with rationing scarce health resources. That change in the balance of power within the NHS might be compatible with the ideas of the judges, but it is highly unlikely that they knew enough to expect it or put serious effort into working out such possible consequences.

And third, it means that the organization, formal and informal, of health policymaking becomes crucial to understanding the law and its consequences. The meaning of decisions that undermine pre-authorization requirements, and their force, is different in the UK and France because the former system maintains much tighter control over patient pathways. Member states' organizations, cultures, and contacts with the EU matter greatly here because it shapes real and practical responses and engagement.

Its goal is to try to identify the consequences of the development of that part of EU health policy carried out under the rubric of patient mobility. We can see it as not just a chapter in the ongoing expansion of the EU's power to regulate Member States, but also one with

noticeable costs and effects on policy. It is based on interviews (N=92) conducted in waves at approximately six-month intervals since 2004, with officials and lobbyists from four Member States (France, Germany, Spain and the UK) and the EU, as well as a quantitative study of EU health lobbying. That gives a particular bias that might complement other studies; it focuses on the Member States' top policymakers more than, for example, the people on the ground who make patient mobility and make it work more or less well (Rosenmöller *et al.*, 2006).

1. THE POLITICS OF HEALTH IN EUROPE

At a basic level, the politics of patient mobility, and the effects of patient mobility jurisprudence, can be understood by keeping two simple facts in mind. Both of them come from classic analyses of policymaking and the EU; neither is particularly controversial but both are very easy to forget.

The first is that policy advocates drive policies, and that behind most snap decisions there is somebody, or many somebodies, who have been pressing for the policy in question for some time. Their loyalty, typically, is to a substantive outcome as much or more than to a particular institutional form (Jenkins-Smith and Sabatier, 1994; Kingdon, 1995). This makes them strategic actors in intergovernmental relations, regardless of whether they are good or bad at it; they seek substantive ends, be they ideologies, particular pet policies, or solutions to their particular problems, and they tailor their approach to questions of territorial politics to reflect their substantive interests. A medical association might ask its Brussels office to lobby against any and all expansion of internal market law and a public health association might invest in its own Brussels office and networks to help it win grants, but those are almost always tactical decisions about which forums will be most responsive to the different organizations' concerns. Neither the doctors paying their dues nor public health activists are likely to be paying for services to subsidiarity or European integration.

The second is that the EU institutions, like any set of institutions, have defined and observable capacities, constraints, and preferences. They are more able to do some things than others, and have characteristic policy tools (for example, they can use grants and core funds to spark interest in their agenda; they do not have the money to actually fund health services). Their cultures and interests adapt to focus on what works best for them, and their participants will filter out irrelevant options (Scharpf, 1997: 64).

Put those two together, and we have a small, even banal, but sturdy model of politics. Advocates will lobby the Commission or file suits based on the policy ideas that they think the EU is most likely to pick up and the EU institutions will pick up the ones that promise to combine substantive accomplishment with an expansion of their role. Perhaps the EU institutions will overstep their competencies and others' toleration, or the substantive justification for the policy will turn out to be inadequate, but politics is a game of probabilities. What else do we expect from policy advocates in Brussels, with the tools they have, or judges in Luxembourg, with the tools they have, or officials of the Commission, with the tools that they have?

So substantive policy will reflect institutional capabilities. The European institutions- and EU policymaking overall- will pick up the policy ideas that they *can* use (and obviously not ones that they cannot use). Some policy advocates will therefore develop elective affinities with the EU. The process of filtering that takes place in the relationship means that advocates who come to the EU institutions will seek what the EU institutions deliver best, fitting their expectations to their target's capabilities. Others, such as trades unions, will draw back after disappointment, or conclude that much of what they can do in the EU

is defensive because it generally cannot develop the kind of broad-based labor law they once sought (Johnson, 2005; Streeck, 1996). The result is that the expansion of EU competencies will often come with substantive justifications and support from lobbies. The nature of the EU institutions, though, will shape the policies that succeed.

What are the policies those institutions tend to produce? The key aspect to remember in analyzing the EU's institutions, and their elective affinities, is that its role is regulatory. Regulatory politics are distinctive because the regulator can control the level of exposure and involvement (Lowi, 1964: 690-691; Majone, 1996: 9-27). Unlike policies that require budgets, or resources, or hiring large workforces, regulators can simply go quiet when they lose interest or political support- and reappear later. Regulatory power does not necessarily mean a commitment to act. In turn, that means that extending regulatory competencies is relatively low-cost. The Court and Commission, in their different ways, can draw back from the more extreme conclusions they might reach but leave behind principles that permit them to return to the field. When they retreat, it is never clear if they have retreated permanently or as a tactical retreat. So the establishment of an EU competency is what matters, as much as its actual content. The authority will remain after the politics have moved on. In the same way, the decisions initially enunciated major principles in substantively unimportant cases- spectacles and orthodontia in Luxembourg make up a comically small issue, even if the issues were not. This kind of role- power without administrative responsibility- is attractive to elite bureaucrats in most settings, and there is no clear reason to assume that EU officials do not share the preference for it (Dunleavy, 1991: chapter 4).

There is a secondary kind of EU power, which is its ability to direct interest to itself through networks, soft governance mechanisms of many sorts, and grants. None of these need have any effects, and there is a rich seam of skepticism about all of them. But they do have effects: grants create networks that at a minimum bid for grants and create EU-focused careers among bidders; participation in EU-funded networks creates personal connections and shared interests as well as larger policy or professional results; at a minimum, expanding EU networks engages more people with the EU, deepening and broadening its information sources and perhaps elite support. And they so shape policy, albeit unpredictably (Greer and Vanhercke, 2008). Cris Shore works out how this *engrenage* (a word that cannot really be translated) works to enhance the role of the EU and its connections with more and more sectors and people (Shore, 2000); Wolfram Lamping explores its contribution not just to networks but also to "epistemic Europeanization" processes that define problems as European rather than local, state-level or international (Lamping, 2005).

The combinations are easy to imagine and relatively easy to meet: for example, the European Commission official eager to improve health who uses the EU's tools to aid policies that would improve health; the Member State official who sees an opportunity to use EU engagement to strengthen his or her embattled team within an indifferent health ministry; the Member State official down the hall who views compliance with an EU directive as a diversion of valuable time and resources from patient care; the enthusiastic patient group lobbyist arriving in Brussels to see what can be done on the EU level; the professional group lobbyist talking up the importance of the EU in a bid to get the Brussels office doubled from two to four staff officers; the politician looking for a way to use people's fears about health to raise questions about the EU. These combinations, and the structural interaction between people who are interested in substantive policy and the EU institutions, which are more capable of responding to some substantive policy ideas than others, explains much of what is going on in health care.

2. STRATEGIC REGIONALISM: SHOOTING WHERE THE DUCKS ARE ⁽¹⁾

There is an admirable degree of consensus, it seems, in EU health politics. There are no public statements, to my knowledge, that suggest that any actor in the EU is motivated by the desire to make health services worse, or even impose costs on them. So far as I have been able to find, every significant EU health policy has been put forth in the name of better health care for the peoples of Europe and respectful attention to the systems that presently treat them. This should surprise nobody. Bad policies (by any definition of “bad”) will be presented either as good ones without proper costings, or, most commonly, by ignoring opportunity costs.

Successful policies are the ones that fit with the speaker's institutional position and estimate of the likelihood of success. That means that we can focus on the institutions – the EU institutions that have the power, however qualified and used, to trigger a shift in authority over health care. It is their preferences and elective affinities that shape the policy consequences and nature of authority migration to the EU in health.

For purposes of simplicity, this paper only talks about the two leading institutions of the EU: the Court and the Commission. There are reasons; they are the only two EU institutions that are powerful, that can take initiatives without being asked by another EU institution, and that have their incentives firmly aligned with the expansion of EU regulatory competencies. And it is hard to imagine any of the present discussion taking place if it were not for *Kohll*, *Decker*, and subsequent events such as the Services Directive debates.

2.1 The ECJ

There is a great deal of sensitive work on the role of top courts, an increasing share of it dedicated to the role of EU law in the EU (in political science, highlights are: Alter, 1998; Burley and Mattli, 1993; Mattli and Slaughter, 1998; Stone Sweet, 2000 and 2005). So it is necessary to qualify any generalizations. The generalizations are relatively simple: the ECJ is a very successful international court which has been able to establish ascendancy over Member States through the doctrines of direct effect and supremacy, which has become the center of a thriving EU law community that is remarkably closely tied to the EU institutions themselves (Schepel and Wesseling, 1997), and which has reshaped many areas of law over decades, even at times when formal integration through legislation was almost at a halt. It is not hard to see why affronted policymakers sometimes speak of it as having a sort of will to power.

The qualifications are important. We cannot say that there is a necessary will to power in the ECJ, because it is clearly able to demarcate its competencies when it wants to avoid becoming embroiled in endless regulatory oversight. Nor can we say it is insulated from politics; the best arguments here are the statistical ones that find it has, over many decisions, agreed with a majority of Member States and the Commission, is indifferent to the preferences of the European Parliament, and rarely pays attention to isolated Member States' policy choices. These relationships hold over many cases, which suggests firm structural underpinnings (Jupille, 2004; Poiras Maduro, 1998). Like most top courts, it does not normally make decisions that leave it politically exposed without support, and it has been known to retreat from such decisions when it does (Epp, 1998; Vanberg, 2005). Likewise, as with other top courts, the actual policy consequences of its decisions, once implemented, are often unknown- but can be much less than the principles would suggest (Conant, 2002; Smith, 2005).

¹ The quote is from Richardson (1993).

But that only reduces the role of the ECJ to a pair of probabilistic statements: it is most likely to engage when it can make a legally strong decision, and a combination of teleology and the “four freedoms” of factors of production is what policymakers look for when trying to predict its legally strong decisions. There are a variety of reasons, from workload to political backlash, why it would limit adventures in new policy areas. But that does not rule out feelers. Arguably, in cases such as *Watts* and *FENIN*, comparing the radical reports of the Advocates-General with the eventual, moderate, decisions, we might be seeing examples of the Court extending feelers and then retracting them. That is only politically sensible, it might seem.

The key point is that the ECJ is not just responsible for EU law (which is still less than an entire legal code, even if its extent is impressive), and constrained to make decisions with the materials contained within it. It is also clearly prone to build on a number of key principles, such as the four freedoms of movement. Those are strong points of law for those who would file or refer a case. And they have policy consequences- towards policies compatible with nondiscrimination, freedom of movement, and integration. Those are the Court's usual priorities, and they are likely to become key priorities of any policy area in which the Court is involved.

2.2 The European Commission

One of the first serious articles in political science about EU social policy coined a completely apt description for the European Commission: a “purposeful opportunist” (Cram, 1993). Purposeful, because it very rarely tries to reduce its own potential role (even if, like any rational, autonomous, organization, it is willing to forego involvement on a case by case basis). Opportunistic, because it will react quickly to substantive policy ideas (such as “centres of reference”) and opportunities (as seen, most strikingly, with the inclusion of health in the proposed Services Directive with the justification that it merely codified patient mobility law) ⁽²⁾.

The Commission is famously open to lobbies from around the continent (Coen and Richardson, forthcoming 2008). For a purposeful opportunist, that pays off. They supply information, which eases policymaking and implementation, and also keep the Commission up to date with opportunities for it to make policy for Europeans. But if they want the policy regardless of the government, as many policy advocates do, then they are essentially forming an alliance, however temporary and tactical, with the Commission when they help it develop policy. The fact that they have a pronounced insider/outsider dimension, with the Commission tightly connected to a “constructive” inner circle that regularly provides it with useful feedback, merely increases the odds that the advice it gets supplies it with substantive policies it could usefully carry out. This is *engrenage*, the process of “gearing” policy experts, officials, and lobbies into the European Union (Shore, 2000).

Some writers have suggested that the enormous amount of lobbying in Brussels provides a democratic legitimacy for the EU that it would otherwise lack (Bellamy and Castiglione, 2004; Smismans, 2006). Apart from the questionable face validity of such an argument, given what we know about lobbies, the selection mechanisms suggest that the most influential organizations are chosen by the Commission, and tailor their suggestions to its capacities and opportunism (Brodscheid and Coen, 2003; Greenwood, 2003: 272; Jarman, 2008; Mazey and Richardson, 1995). Furthermore, it rewards the groups with the most

² Its ingenuity in using the word market in order to promote the EU deserves, and gets, an entire book of its own: Jabko (2006).

resources, and is biased towards Northwest and German-speaking countries, which reinforces inequalities (Greer *et al.*, 2008). That is not very good policymaking or much of a democratic commendation.

The Commission, furthermore, is a very entrepreneurial organization and dedicates resources to policy entrepreneurship. It is an often-repeated point that the Commission has fewer employees than many of Europe's local governments. This is not entirely fair, as Edward Page argues (Page, 1997). The Commission, unlike local governments, does not provide any labor-intensive services. Once we account for the fact that it does not employ road builders, social workers, nurses or police, and instead compare it to the policymaking resources of Member States, it looks rather more impressive. If we assume that half of the Commission staff make policy, that is still a 12,000 person machine for the production of policy ideas. Few Member States enjoy such a resource. The extensive use of comitology, networks, *engrenage*, and agencies, in the Commission as in most other governments, further extend its capacity for policymaking.

But where are all those people? The literature routinely speaks of its small size. That sense of the Commission's smallness is one that is reinforced by many interviews, of course; on any given issue there are rarely more than three or four people at work. Some important issues, such as Services of General Interest, have a full-time staff of one. The answer is in part that an extremely broad engagement with a variety of policy areas as well as a reflection of the genuine workload in areas such as the Common Agricultural Policy. The Commission is rationally spread thin; this allows it to be a "purposeful opportunist" looking for a role in areas of European life (and somebody can usually supply a substantive justification). It can add resources if need be, or use various kinds of working groups to expand its expertise. Given that what it produces is a right to participate in policy areas — with or without an explicit competency — then relatively weak personnel resources in any one area is an acceptable tradeoff. One staff officer is capable of assisting in the development of safe blood regulation in Europe, and it is difficult to object on policy grounds to safe blood. Likewise, only one or two Commission employees are required to start a forum or advisory committee and engage a wider range of people in admirable tasks at the EU level, such as reduction of obesity (Greenwood, 2003: 259-262 is a highly entertaining and accurate, if stylized story, of such competence creep).

The other principal characteristic of the EU, to use the same author's phrasing, is that it is a "multi-organization" — which roughly means that it is internally fragmented (Cram, 1997). Internal coordination of the European Commission is relatively weak, with a central coordinating unit that many Member States put to shame and a collegial structure that provides little political basis for directed coordination (Spence, 2006). At the same time, enlargement has multiplied commissioners and therefore portfolios (and therefore the number of EU level politicians seeking to make a mark by doing something substantive). The various DGs each have, more or less formally, jurisdiction over a given treaty base. The hierarchy among them, and to some extent their distinctive cultures, can be inferred from their treaty bases — for example, DG Trade and DG Competition are extremely powerful and autonomous because their treaty bases give the Commission impressive power and autonomy, DG Agriculture and DG FISH are powerful but less autonomous because they are confined to clearly delineated policy areas where they are dominant, and DG Markt is powerful but under constant political challenge because it "occupies" the powerful and contentious rights to initiate legislation and enforcement actions for the huge body of internal market law. The nature of the Commission and the agenda of the President can shape legislative proposals and some enforcement actions, with marked effects (such as a reduction in the power of DG Employment and Social Affairs and DG Environment under Barroso), but central coordination is weak. We see the consequences in the slow return of items that do not interest Barroso (such as environment, now inserted

into the Lisbon Agenda). We also see it in the failure of transversal policies such as environmental policy integration in the Commission or, even more so, health impact assessment (Jordan and Schout, 2006). Barroso could not stop the Commission developing new environmental policy, but neither has any environment Commissioner been able to apply the policies to the rest of the Commission.

Each DG, therefore, comes with different treaty bases (despite the theory of collective responsibility at the level of the College of Commissioners), a different culture, different interest groups (including the groups it funds), and as a result a different policy agenda suggested mostly by distinctive groups of policy advocates. To take a small example, NGO umbrellas funded by other DGs participate in forums run by DG Sanco – but they have a very low rate of participation, much lower than we would find if it were simply a random effect. The explanation is that DG Sanco does not welcome NGOs funded by other DGs, such as the elderly platform AGE (funded by DG Employment and Social Affairs), and while DG Employment and Social Affairs might like to influence DG Sanco, its interests are mostly in developing its own information sources and policy ideas in its chosen community (Greer, forthcoming 2008; Greer *et al.*, 2008).

Leadership in patient mobility has moved from DG Employment and Social Affairs (when it was social security) to DG Sanco (after the formation of the High Level Group) to DG Markt (during the Services Directive debate, despite a challenge led by DG Employment and Social Affairs and France, which viewed it as a Service of General Interest), and now to DG Sanco. Discussion of whether a given DG “wanted” responsibility for health is slightly beside the point; what matters is that they traded it off. And that changed the policy proposals, because each DG has different structural interests; DG Markt is the self-appointed guardian of the internal market, DG Employment and Social Affairs of the “European Social Model”, and DG Sanco is a weak, young DG scarcely moved to Brussels that has its best relationships with the health sector.

Just as the Commission has a regulatory bent and a penchant for *engrenage*, which could probably be derived just from reading the treaties and the EU budget, it has a tendency to fragmentation based on the reinforcing connection between DG treaty bases, cultures, and interest group constellations. And that fragmentation, while collectively maximizing opportunities for opportunists, also creates uncertainty as to the consequences of legislation for substantive policy and patterns of authority (Greer, 2008a).

3. WHAT IS AT STAKE?

Focusing on institutions amounts to holding substantive policy steady- there is always a large supply of policies available for consuming governments if they want it – and looking instead to the institutions to see what sort of policies they will enact. This tells us two things about EU policy. First, the Court and Commission will opt for regulatory policies that fit with their institutional capabilities and preferences rather than some broader form of policymaking. The Commission will also engage in networks and soft governance of various kinds, to complement regulation or substitute where it is not an option. There is not much evidence that the Court pays attention to compliance costs, and it is quite plausible that it should not (that is a slippery slope for the rule of any law). But it shapes the policy consequences.

Second, opting for regulatory policies that fit with their institutional capabilities reliably rules out a cost-benefit analysis. They are unlikely to cost their policies (and ECJ decisions often are policies); they are unlikely to conduct a cost-benefit analysis that compares, for example, the costs of compliance with patient mobility law against the costs of investment in improved cancer care or anti-obesity policy; and they are especially unlikely to cost

compliance with EU law against other policy goals such as education or transportation. In their different ways, the Court and Commission are regulatory organizations, and could rightly add that if Member States do not like the substantive policy then they are free to change the treaties.

But what it means is that their institutional forms give them clear policy preferences and limit their obligation to make tradeoffs between conflicting goals. The basis of their activity builds in a hierarchy of priorities- towards the key precepts of EU law for the Court, and towards the most enterprising policy entrepreneurs for the Commission. Increasing the cost of health services is not a problem because the EU does not pay for them. Equity concerns are not very important – it takes a creative mind to argue that patient mobility is anything other than a boon to the wealthy and articulate. Solidarity is not much of a problem because EU law on the subject is softly spoken compared to the talkative jurisprudence of the four freedoms (Jost *et al.*, 2006). What, then, are likely to be the policy effects?

3.1 Policies and Principles

In principle, EU patient mobility law is relatively harmless. All it does is cast severe doubt where it usually casts doubt- on Member State level laws and policies that restrict the movement of goods, services, capital and people. It could, in principle, be answered with the same kinds of policy changes seen in many other EU areas, mostly development of patient mobility policies that are proportional to the EU interest, transparent, and not obviously designed to prevent cross-border mobility. Furthermore, it is hedged with repeated assertions that the ECJ respects the primacy of Member States in the organization and finance of health care (“They’d better,” snapped a Member State health ministry official, “they certainly don’t pay for the health services”).

■ Policies

The question policymakers might naturally ask is whether the costs of conducting this operation are worth the benefits. Those costs and benefits would have to be calculated in terms of tax revenue, health priority-setting, and the balance of domestic actors such as insurance funds and doctors in priority-setting.

The cost is compliance. It has direct costs (some of them now sunk); forms, regulations, and procedures must be changed to avoid discrimination and comply with jurisprudence. This was a time-consuming effort for bureaucracies, but not intolerable. German interviewees commented that the technical challenge of responding to *Kohll*, *Decker*, and subsequent decisions was less than they expected. Compliance with internal market law in general, or public procurement, state aids, and competition law could also impose simple costs of compliance even in areas where the EU touch is relatively light, by obliging bureaucracies to work differently.

The second kind of compliance cost is more substantial. It is in the changed priorities and the range of policies that are no longer possible. For example, rationing by waiting lists escaped the *Watts* decision, when the Court declined the opportunity to specify unacceptable waiting times, but that form of rationing remains suspect. Rationing by waiting underpins a number of other efficient and equitable procedures, and as England has demonstrated over the last ten years, reduction in waiting times can be very expensive and energy- intensive. That is not to say it is or is not a good thing (ridiculing UK waiting times appears to play an in these debates as a blanket justification for EU competency creep). It is to say that the compliance costs include entire categories of policies with little obvious connection to the promotion of European integration or the legal substance

of European citizenship, and the direct costs of having priorities set by a new and not particularly democratic actor with little expertise.

The third kind of compliance cost is the “legal uncertainty” that annoys scholars and Member States alike. Much has been said about this; the key point is that health planning, or policymaking, is very difficult when the role of the EU, the course of future decisions, future challenges, and the policy implications of decisions are all opaque. Involving the Commission, which can propose legislation, might not be the entire cause of the post-1998 policy free for all, but the fragmented purposeful opportunist introduced a range of policy options as diverse as the High Level Group, the OMC, the Services Directive, the family of Services of General Interest, and now health legislation (Greer, 2008a). It is easier for Member States, professions, managers, providers, disease groups and others to lobby and influence these debates, but there is still profound uncertainty until there is a framework authoritative enough to deter the Court and its litigants for the time being.

Exaggerated and unpredictable compliance costs are a feature of regulatory politics for the relatively obvious reason that the regulator does not bear the costs of compliance (the grain of truth in the chaff of the American “takings” debate). The regulator is free to develop and impose a principle without regard to the consequences for other principles. The accountability of the regulator to the regulated is what prevents total distortion of priorities. That accountability varies; the EU institutions are a fair distance from patients and taxpayers, and accountability is principally through the states in the Council.

These three types of compliance costs – the costs of uncertainty about the rules, the costs of compliance with the established rules, and the costs that come with the loss of policy options – must be subtracted from the benefits of patient mobility under article 49. But that calculation – at once difficult (what are the opportunity costs of policy options?) and seemingly cold – masks an issue that is even more difficult but much less cold. That is the set of principles surrounding citizenship and the welfare state.

■ *Principles*

Policy and principles are intertwined because the deadweight costs of compliance with patient mobility law directly affect the capacity of Member States to deliver entitlements to their citizens that they guarantee in principle – citizenship rights. Social citizenship has great logical problems, but is relatively easy to identify in policy terms – and the trend of EU law is not good for social citizenship (Marshall, 1950[1992]). In a similar vein, competition law’s “infiltration” of social security law, much of which subsumes health, is an alarming case of one branch of EU law undermining both policy and principle (Giubboni, 2006). There are a variety of redistributive mechanisms within states that might, on the face of it, be wholly compatible with a modern European welfare state but are not compatible with the particular implementation of nondiscrimination. There are others that are somewhat discriminatory, and can seem so in the Court’s teleological way, but hardly seem worth abolishing ⁽³⁾.

The capacity to deliver entitlements- to make citizenship rights tangible- depends on the ability of health systems to deliver what is asked of them in light of the costs. Imposing

³ As with Austria’s limitation on admission of medical students from other EU states enjoying its free medical education, which fell victim to the ECJ despite lack of any compelling policy argument against it C-147/03, 01/20/2005. The result was a deadweight loss from the point of view of both policy and principles. There is no visible policy benefit but now Austria must charge for education; limit admissions despite a shortage; or subsidize German students. It was also a rather weak decision, given that Article 12 prohibits discrimination “within the scope of this treaty” and the Treaty is silent on the subject.

compliance costs and a detailed regulatory framework does not advance social citizenship (Greer, 2008b). That should not be a surprise; the effects of regulation on efficiency are difficult to predict, and negative integration is a poor fit with social citizenship anyway. Principles are affected because the costs of compliance with new priorities and regulatory structures, foreclosed options, and uncertainty translate into a reduction in the resources, time, and money that can be spent on making principles of social citizenship into tangible realities. The lack of closure in welfare states that comes from patient mobility reduces both the ability of Member States to make social citizenship real by taxing and setting priorities (Ferrera, 2005).

3.2 Power

So EU patient mobility law is one of several moves to submit health to internal market law- and thereby submit states to EU regulation. This has deadweight costs that are difficult to measure but probably significant; little in EU law suggests that they will be appropriately considered. And the policy justifications for the EU decision are often extraordinarily weak. The obvious question is: why do Member States put up with this?

The first kind of answer depends on reducing the importance of the EU's democratic deficit. In a species of *tu quoque* argument, they argue that the EU does not look so bad when we compare it to states' decision making processes in the same policy areas. This is the case Giandomenico Majone argues in an otherwise perplexing book: the EU has traditionally focused on policy areas that are subject to "nonmajoritarian" (read: undemocratic) decision making in most countries, such as trade policy (Majone, 2005). In the grand scheme of things, the degree of delegation to the European Commission in trade or competition is not that much different from the degree of delegated power that of the United States Trade Representative or the British OFT. Even the ECB, effectively insulated from democratic accountability, is a member of a breed- central banks- that rarely have direct democratic accountability. This argument fits with the other particularly prominent opponent of EU democracy, Andrew Moravcsik, who extends his argument that the EU never was democratic into the proposal that it should not be (Moravcsik, 2002). It is and will stay an agent of Member States, he argues, and therefore enjoys their legitimation.

All that these authors' arguments suggest is that the European Union institutions are looking for trouble. Health is a politically important issue in all Member States, and at any given time it tops the agenda in a few of them. Public or elite support for an EU role is essentially lacking⁴. It is difficult to find any politically significant supporters of the EU's patient mobility regime, although they are slowly arising as EU policy creates niches for new kinds of healthcare providers. It is impossible to find Member States that supported any particular decision before it hit, or the inclusion of health in the original Services Directive. And furthermore, there is a large difference between a organization that a Member State has insulated from democracy for one purpose, and a general-purpose, insulated organization that is almost impossible to keep within its appointed slot, as is the case with the Commission and Court.

Another explanation for Member State acceptance of the patient mobility regime is much more likely to be right. It is that the costs to Member States of withdrawal are unbearable (Alter, 1998). For most, it is unimaginable as well. If the EU is, in large part, EU law, then EU members have no way around formal compliance. So they must bear the EU's less attractive policies to gain the benefits of the more attractive ones. Furthermore, states do

⁴ That is not to say that the public opposes EU involvement if it is keyed to an attractive substantive policy. But that is not much of a qualifier. If we were to suggest sending 100 Euros to everybody in the EU, or curing cancer, there would be support regardless of the government we suggested should do it.

not agree on the attractive and unattractive policies; while health services overall are a rare case of agreement, there is no such agreement between Italy and the Netherlands on competition law or between France and Eastern Europe on Services of General Interest.

Furthermore, the costs to the states even of changing the relationship between the EU institutions would be excessive. Despite some murmurings from the UK under John Major, it is difficult to find leading politicians who propose reducing the power of the Court (such measures could come in a variety of ways, such as a simple Council vote to let a single Member State off for an infraction that they judge acceptable, as Fritz Scharpf suggests) (Scharpf, 2007). Rewriting the Treaties to change something so fundamental as the role of the ECJ might pass a cost-benefit test in policy terms, but it is highly unlikely to pass a cost-benefit test in political terms.

The argument that states would not withdraw or even rewrite the treaties because of the costs points to a third, persuasive, argument. Costs are born by different people in different places. The EU, no matter how well or poorly it delivers, wins at least some of the loyalty of policy advocates who work with it. Even if they are disenchanted with the payoff from EU participation, there is no obvious reason to oppose it when it might deliver benefits that they seek (or even a source of personal expertise useful to them in their careers). This appears to be the attitude of medical professional organizations. Their power base is classically at the Member State level, and Brussels offices are insurance against untoward EU activity- but like any good lobbyists, they also engage in EU politics and seek positive proposals to build their credibility as useful members of the EU policy community. This is *engrenage* at work. Even if a Member State might reasonably conclude that EU health policy is bad for its health care system, the odds are that many of its own experts and officials would wish to defend particular EU policies that are useful for them.

4. LESSONS

What can we learn from this rather dreary review of EU regulatory politics and their expansion through patient mobility? There are three conclusions. The first is that patient mobility is a case study in regulatory politics more than patient movement; the second is that the current trend of the EU's patient mobility politics is a blocking game that tries to establish norms that might constrain the Court; and the third, rather optimistically, summarizes the problems with the regulatory politics of patient mobility in order to suggest countervailing principles for policy.

4.1 *For Policy: It's not about the patients*

It takes only a few words to draw out one implication: the issues at stake are not about the patients. They are about regulation. The actual number of patients moving around the EU is significant, unknown and likely to stay so, despite valiant efforts of the Europe For Patients project and its uncovering of the complexity of the issue and of patient movements (Glinos and Baeten, 2006: 103-104). But Member State officials rarely cite the actual mobility of patients and their bills as an issue; one regional government policymaker was surprised to be told in 2005 that the Member State was paying for his region's patients treated abroad. What is worrisome is the regulatory adjustment required to cope with patient mobility. Those costs probably outweigh the actual costs associated with patients (although in the EU context we will probably never know just what those costs are), and it is far harder to gauge the policy consequences of the ECJ and its decisions than it is to count the number of Germans submitting claims for treatment in Spain. The only remaining interesting question is who brings patient mobility cases, and who will start to bring them? Private health care groups that might benefit from liberalization have kept a low profile, usually working through commercial consultancies in Brussels and rarely

engaging in litigation, but cases are already starting to appear and it will eventually become rational to file suit. Cases such as *Asklepios* in Germany or *BUPA* in the Republic of Ireland will be the future, in which private providers resist what they see as state aids to their competition.

4.2 For the EU, on present trends

For the EU, the question is what the future direction of policy might be. The institutions, as I have argued, have a neoliberal bent and a tendency to cluster policy advocates who appreciate the attention they receive from the EU. This produces its characteristic combination of macro-level liberalization, micro-level charitable grants, interesting new networks, and an enormous volume of talk about a European Social Model (scholars' views of it tends to vary with their data sources on the subject; mine should be clear by now).

The EU, as a regulatory organization with an entrepreneurial Commission and a powerful top court, caters extremely well to advocates of either liberalizing substantive policy, such as Messrs. Kohll and Decker and Mrs. Watts, and to relatively niche policy advocates whose principal aims are grants and support for networks. It does not cater well to the bulk of Member State health systems, which deliver health services, pay costs, and have a far more complex task of priority-setting than any part of the EU or the EU as a whole (recall the insignificance of the EU budget and revenue, especially in health). These are the groups- providers, social funds, management associations and major professions- that have the best connections with Member State health ministries. But having Member States for allies – or being Member States – is a strong position in Brussels. What can Member States, allied with the leaders of their incumbent health service organizations, do?

They have a number of tactical options but only one obvious strategy. The obvious strategy is to broadcast the limits of their tolerance by developing their own EU-level norms and priorities (Greer and Vanhercke, 2008). The same statistics that show the ECJ being hard on Member States that diverge suggest that there is a political restraint on the Court's activity, and it is both logical and the view of many interviewees that a united front of Member States on health policy questions would deter the Court and advocates of particular liberalizing substantive policies. There are a number of such mechanisms; the High Level Group, which DG Sanco muffled in 2007 and then brought back to life when the draft health directive froze; the OMC, which promises to create an influential pan-European policy network with deep roots into many Member State ministries; political influence through, for example, Commissioners' *cabinets*, and simple declarations, such as the EPSCO Council's declaration adopted on 2 June 2006 (10173/06), which declares a set of shared principles that include Member State responsibility for health care. Domestically, noncompliance, or contained compliance, can also work but only if matched it is by an accommodating court system and lobbies (Conant, 2002). It did not work in health because it meant the Court could develop a fairly substantial jurisprudence without much resistance.

Of course, these mechanisms have other consequences; for a true euroskeptic, an OMC process that reshapes domestic politics and creates a transnational policy network in the health ministry might be only slightly less noxious than a simple ECJ decision. But if we assume that institutions shape substantive policy options, then it is hard to imagine the OMC or the High Level Group opting for high-cost distortions of priorities. The open question is whether the Member States, remarkably united as they are, can create a durable alternative to single market law, or whether the Court's retreats are only tactical.

4.3 For the EU, on a different trajectory

The fact that “soft law”, or at least repeated declarations of shared opinions, might slow or divert integration is a function of EU politics rather than a function of policy desiderata. But what might we want from policy? Where might we want policy to go?

The EU is regulatory. It will never become a full-service democratic government because it lacks a demos or much of a budget, so it will always be much better at delivering civil rights (in Marshall’s terms) than social or political rights. Nor can it be expelled from health. There is negligible historic evidence of it retreating from a policy area once it has established its competency. And it has clearly established a competency in health care. So instead the goal should be to try to preserve and expand what is good. Much of that, triggered as it might have been by patient mobility, is now orthogonal to the issue; the OMC has its own life, for example.

So instead, what should be the desiderata of EU health policy? The problems were three types of compliance costs that had direct implications for time and resources and indirect implications for the social citizenship rights of Europeans. The types of compliance costs were direct administrative costs; opportunity costs of policy foregone; and costs of uncertainty. So the question is what the principles would be that would reduce those costs and turn patient mobility into a fringe benefit of Europeanization, like student exchange or low-cost airlines. They are desiderata derived from policy rather than clear injunctions, offered in the hope that some discussion of ultimate goals might contribute to debate.

The first desirable attribute is calculation of costs. The direct costs of compliance should be factored in, both to legislation (as is rather feebly done by the Commission) and, ideally, by the Court, which in its health decisions shows the pitiful understanding of bureaucracy that is typical of most top courts. That should include the *principle of cost-benefit evaluation*. Cost-benefit evaluation always has a substantial component of art, but what counts is the principle. Any given policy has costs that extend beyond the given policy area. The Court does not try hard to balance “its” four freedoms law against other needs that appear only in the Treaties as exemptions if they appear at all. So good EU law can be structurally blind to consequences; the Treaties put a finger on the scales when the Court balances four freedoms against the sustainability of health systems. Simple recognition of this fact would be helpful from a policy point of view and help to reinsert principles that are incompatible with the thrust of EU law, or that depend on administrative procedures that are suspect under EU law.

The second desirable attribute is *flexibility*. The costs of compliance vary from system to system, as do the abilities of any given policy to achieve their end. Given the extremely weak democratic legitimacy that the EU possesses in health, its lack of responsibility for key parts of health systems, and the institutions’ negligible expertise in health policy, humility is good. That would mean, at most, enunciating principles- and also avoiding involvement in ill-understood cases that appeal to EU law in pursuit of a policy or political goal understood by few outside that country.

The third desirable attribute is, of course, *legal certainty*. Legislation would naturally help this as legislation is far more public, transparent, and subject to democratic influences than the present direction of policy. It might also create a level of useful flexibility by forcing actors to identify what is a real EU interest- not the routine obeisance to Member State competence that is so common, but statements of the policy objectives behind patient mobility policy.

To some extent, the stalled Directive on Health Services would be an improvement relative to the current situation. That is because it would create vehicles for Member State declarations of shared views- in other words, increase the chances that the Member States can formulate shared positions. Those shared positions, in turn, would be their best strategy for maintaining control over health policy because they might deter the Court. The price would be a major role for the Commission in structuring EU health care policy. That would be high, but it would at least reduce legal uncertainty and would entrench institutional mechanisms through which the Member States could formulate a consensus that might deter the Court from adventurism. The Directive's fate is unclear at the time of writing, but any application of the three principles here would rule out what we currently have. The current policymaking system is a set of tactical alliances between interests, often eccentric ones, and purposeful opportunists in Brussels and Luxembourg. The costs of that policy-making regime, counted in administration, principles, or procedural democracy, are certainly likely to be high.

CASE LIST

Case T-167/04, *Asklepios Kliniken v. Commission*, 25 August 2007

Case T-289/03, *BUPA and others v Commission*, 29 March 2008

Case C-120/95, *Decker v Caisse de Maladie des Employés Privés*, 28 April 1998

Case C-205/03, *FENIN vs. Commission*, 2 September 2006

Case 158/96, *Raymond Kohll v Union des Caisses de Maladie*, 28 May 1998

Case C-372/04, *Yvonne Watts v. Bedford Primary Care Trust, Secretary of State for Health*, 15 July 2006

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