Social Science & Medicine 108 (2014) 89–96

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The changing contours of experimental governance in European health care

Katherine Fierlbeck

Department of Political Science, Dalhousie University, PO Box 15000, Halifax, Nova Scotia B3H 4R2, Canada

ARTICLE INFO

Article history:
Received 5 August 2013
Received in revised form
23 January 2014
Accepted 25 February 2014
Available online 26 February 2014

Keywords:
Health policy
European Union
New governance
Soft governance
Fiscal crisis
Discursive institutionalism
Open method of coordination
Joint Action strategies

ABSTRACT

For over a decade, beginning in the late 1990s, discussion over softer modes of governance animated academic scholarship in the fields of law, politics, and public policy. This debate was especially pronounced in Europe. Since the late 2000s, however, discussion of this approach has declined precipitously. Is the "soft governance" model dead? Or, more precisely, has the economic crisis killed it? This article argues that, to the contrary, the EU's austerity measures have made softer governance more relevant in two quite distinct ways. Administratively, new mechanisms of health policy coordination are able to provide policy solutions in a much more effective way than could more formal and rigid forms of legal harmonisation. Politically, it establishes a normative perspective which unifies actors across a number of administrative units and challenges the dominant ideological force of the market-based principles upon which the EU's austerity policies are constructed.

For over a decade, beginning in the late 1990s, discussion over informal modes of political governance animated academic scholarship in the fields of law, politics, and public policy. This debate was especially pronounced in Europe. Since the late 2000s, however, discussion of this approach has declined precipitously. Is it simply the case that serious economic crises in Europe have focused attention away from softer political issues (such as forms of governance) in order to address more pressing issues of financial stability and economic growth? While the recession which began late in 2008 did, unsurprisingly, divert much political attention to economic issues, it did not eliminate interest in soft governance. Rather, these "softer" approaches remained quite relevant for two very discrete reasons: on the one hand, they provided a more efficient approach to policy development; on the other hand, they served as a political armature upon which to articulate normative alternatives to market-oriented principles.

The first section of this paper discusses the theoretical development of "experimental governance" (also known, *inter alia*, as " new governance," "soft governance," or "soft law"), and why it became particularly important in the field of health care within the European Union. It then explains how the restructuring of economic governance mechanisms within the EU in the wake of the financial crisis appeared to supercede this approach. The subsequent sections argue that, while the manifestation of soft governance has metamorphised considerably in the past decade, it has become far from irrelevant. To the contrary, it now performs two quite distinct functions. First, it provides a more efficient means to address complex health policy problems across overlapping jurisdictions. Second, it establishes a normative perspective which unifies actors across a number of administrative units and challenges the dominant ideological force of market-based principles upon which the EU's austerity policies are constructed. Conceptually, this analysis is informed by discursive institutionalism (Schmidt, 2008, 2013). However, it also suggests that discursive approaches tend to be rather weak in their explanation of how, precisely, politically contentious ideas are cultivated and diffused within specific institutional contexts to challenge dominant ideational approaches (and the consequent distribution of political power and economic goods). To this end, Sabatier's model of advocacy coalitions is employed in order to explain the ways in which political actors utilise the principles of soft governance for specific political ends. While this explanatory framework could potentially be applied to a number of institutional relationships outside of health care and even beyond the EU, the scope of this article is restricted to health policy within the EU.

E-mail address: k.fierlbeck@dal.ca.

http://dx.doi.org/10.1016/j.socscimed.2014.02.040

The methodology of this article combines qualitative methods of document and literature review with semi-structured key informant interviews of officials in European Commission Directorates and non-state actors in Brussels and Luxembourg from 2008 to 2013. The principal focus for interviews was DG-SANCO, as this Directorate has the most direct responsibility for health-related policy within the EU. Given the "snowball" methodology employed by the study, however, many officials within DG-EMPL were later added to the interview list. Ethics approval for this project was obtained from the author's university following the requirements outlined in the *Tri-Council Statement on Ethical Conduct for Research Involving Humans*. The funding sources for this project were the Canadian Institutes of Health Research (CIHR) and the European Union Centres of Excellence (EUCE).

1. What is "experimental governance"?

Formal legal systems require stability, predictability, and uniform applicability. Policy areas such as health care are highly complex, rapidly evolving, and involve actors with vastly different needs and capacities. The best institutional structures for modern health care governance often collide with the overarching constitutional structures that have evolved to address the broader political goals of conflict resolution and economic growth. The evolution of the European Union is one example of this disjunction. Designed to protect national autonomy over domestic affairs while promoting economic union and political amity between states, the laws and institutions of the EU were not constructed to facilitate the development of effective and sustainable health care policy. While contemporary health care increasingly requires greater collaboration and coordination across jurisdictions, the original provisions of the EU explicitly prohibited formal supranational coordination of health care across Member States. Because of this, European health policy from the late 1990s to the late 2000s witnessed the efflorescence of new experimental modes of governance that attempted to facilitate the sustainable development of European health policy within the more rigid framework of European law.

What, exactly, is meant by "soft" or "experimental" approaches to governance? Despite the huge volume of literature written in this area, there is still little agreement on how to define it or how to approach it analytically (Köhler-Koch and Rittberger, 2006; Tömmel and Verdun, 2009; Benz, 2009). While the term actually encapsulates a huge variation of principles and processes, at its most basic the concept simply refers to approaches that are not reducible to hierarchical command-and-control models. And, as Hervey and McHale write, while soft-law norms have always played a part in EU policy-making, it is nonetheless possible clearly to differentiate between "old-style legislative harmonisation" and "new approach harmonisation" (2004: 48–62) The distinction between hard and soft forms of law and governance is often represented in binary form: static/transformative; substantive/procedural; rigid/flexible; prescriptive/informative; demanding of uniformity/accepting of diversity; stable and lasting/provisional and revisable, and so on (Scott and Trubek, 2002; Eberlein and Kerwer, 2004; Walker and de Búrka, 2007; Sabel and Zeitlin, 2010; Armstrong, 2011). The problem is that what is considered under the rubric of "soft governance" is, in consequence, quite disparate and often contradictory. One encompassing definition of new governance has been articulated by Klein (2008: 10), who states that

> [i]nstead of a top-down, hierarchical rule-based system where failures to adhere are sanctioned, or unregulated market-based approaches, the new governance school posits a more participatory and collaborative model of regulation in which multiple stakeholders, including, depending on the context, government, civil society, business and nonprofit organizations, collaborate to achieve a common purpose. In order to encourage flexibility and innovation, "new governance" approaches favor more process-oriented political strategies like disclosure requirements, benchmarking, and standard-setting, audited self-regulation, and the threat of imposition of default "regulatory regimes" to be applied where there is a lack of good-faith effort at achieving desired goals.

What explains the explosion of new governance literature from the mid-1990s to the end of the 2000s? Intellectually, political scientists were beginning to move away from the study of formal institutions to a more discursive approach focussing on the construction of ideas (Schmidt, 2008), and from the study of "government" to the process of governing (Bell et al., 2010; Bakvis, 2010). This movement away from simple institutionalism was also influenced by schools of thought that focused upon collective action analysis (e.g., Ostrom, 1990). All of these analytical frameworks focused upon the role of *negotiation* between political actors as a complement to both market-oriented processes and formal hierarchical relationships.

But it was the evolution of a more integrated European Union following the Treaty of Maastricht in 1993 which gave these analytical tools so much immediate relevancy. The deeper integration of an increasing number of states meant that the "classic Community method" of harmonisation through binding legal texts was becoming more cumbersome and unwieldy. The European Union has always relied upon a softer form of governance compared to sovereign states (Tömmel and Verdun, 2009), as it depends upon Member States to adopt and enforce the myriad of "resolutions, recommendations, opinion, notices, communications, action programmes or plans, declarations, and communiqués" that comprise a significant part of its policy-making role (Hervey and McHale, 2004: 61). But the European Union was, like most sovereign states, experiencing a declining capacity to execute effective policy and provide public goods in an increasingly complex and rapidly changing social context (Sand, 1998). At the same time, the growth of complicated and distant bureaucratic processes led to a political backlash by European citizens against the institutions of the European Union itself; and by the mid-1990s the European Commission began to address the perceived democratic deficit of the EU (Decker, 2002). By embracing a rhetoric of consultation and collaboration, the European Commission hoped to shift public focus on the EU to a more innovative and inclusive democratic experiment in place of the source of impenetrable bureaucratic dictates to the EU (Hix, 1998).

A separate political motivation for the endorsement of new governance approaches within the EU stemmed from the explicit market-oriented agenda of the EU as an institution. Those Member States which valued a more solidarity-based "European social model" became increasingly concerned that the legal framework supporting greater economic integration would undermine their ability to operate more distributive social programmes in policy areas which had been considered matters clearly under national jurisdiction. In response to greater economic integration, these states entered into what has been termed a "constitutional compromise". Counteracting market-based strategies by ceding authority on social issues to unelected bureaucrats within the EU was just as unpalatable as the problem itself. But by accepting a common process that would coordinate social policy without undermining formal political authority, Member States could counterbalance the inherently fragmentary tendencies of free-market policies without relinquishing national authority (Dawson, 2010).

The application of new governance approaches to European health care has been subject to a remarkable level of discussion in the past decade. To an extent this should not prove exceptional, as Member States are, under Article 168(2) TFEU (ex Article 152(5) TEC) *required* to "coordinate amongst themselves their policies and programmes" to achieve public health goals. More interesting is the way in which the mechanisms of soft governance have also served larger political ends, though where the former ends and the latter begins is the subject of considerable interpretation. In simple terms, the conflict can be understood as a tension between Article 56 TFEU (ex Article 49 EC), which allows EU citizens to provide or to seek services anywhere in the EU (the two "fundamental freedoms" of the internal market), and Article 168 TFEU (ex Article 152 EC), which places Member States under a duty to ensure a "high level of protection of human health." Article 152 was itself a strengthening of the older Article 129, and was enacted under the Maastricht Treaty as a political response to the policy failures in Europe following the outbreak of BSE in the 1980s. Article 168 gives Member States the explicit authority over "the management of health services and medical care and the allocation of resources assigned to them." Yet a series of decisions rendered by the European Court of Justice interpreted the relative authority of Articles 56 and 168 to make the latter subject to the former (see Hancher and Sauter, 2012). In other words, Member States were still free "to determine the content and the scope of entitlements to medical treatment under their public national health (insurance) systems, *provided that* this is effected in such a way that any restrictions on free movement are objective, non-discriminatory on the basis of nationality or residence, subject to judicial review and interpreted in a non-discriminatory EU context" (Hervey and McHale, 2004: 133).

What this meant was that patients were free to find providers across the EU and to be reimbursed by insurance providers within their home country. The worry was that this practice could result in a high influx of individuals seeking treatment in specific states, which could lead to an excessive demand on these states' capacity to plan for or provide adequate and sustainable health services. Notwithstanding certain conditions, national health care systems in Europe "may no longer be viewed as 'closed systems'" (Neergraard, 2011: 36). In the face of this formal "deregulatory thrust" on health care systems imposed by consecutive decisions of the European Court of Justice, political actors within and outside of the formal state sector turned to softer forms of health policy coordination as "tools of public action" (Greer and Vanhercke, 2010: 82). By establishing an informal alliance protecting the capacity of Member States to preserve more solidaristic aspects of health systems across Member States, the political strategy was to establish a bulwark against the encroachment of Article 56 in the realm of health care. The political struggle over the direction of European health policy, then, has been informed by two interrelated dynamics: on the one hand is the tension between national authority over health policy (Art 168) and the pervasiveness of the market even in areas of ostensible national jurisdiction (Art 56). Both options lead logically to a highly fragmented system of health care across Europe. On the other hand is tension between the deregulation of health care through hard law (the decisions of the European Court of Justice) and the articulation of a more solidaristic "European Social Market" through softer mechanisms of policy coordination across states. Both options here lead to greater coordination, but on vastly different terms.

2. The "new economic governance"

The Lisbon Agenda of the 2000s was a blueprint for the evolution of the EU. It attempted to create a compromise between an economic and a social agenda, and between national sovereignty and a coordinated sense of direction. Softer modes of governance were an essential component of this approach. But the subprime meltdown in 2008 precipitated the financial crisis which, by 2010, caused the EU to begin negotiations to strengthen the Stability and Growth Pact which allowed the EC to enhance its surveillance of the budgetary polices of Member States *before* they came into effect. The purpose of this new approach to economic governance was to enhance budgetary discipline across states. One measure to this end was controlling public expenditure; and, as a sizable component of this was *social* expenditure, public health spending was directly affected. Did this "new economic governance" eradicate interest in softer forms of governance altogether? Or did it simply refine the ways in which soft governance could usefully be applied?

The key mechanism of the new economic governance was the "European Semester," an annual cycle of economic and fiscal coordination across the EU. Interestingly, this system is largely based upon the very discursive and iterative principles established within many new governance instruments. The Commission evaluates each Member State's proposed budget plan individually, and develops feedback and advice for each one. States are "invited" to implement the advice presented to them. Although follow-through is *formally* voluntary (hard sanctions are only applicable to those countries – Ireland, Greece, and Portugal – subject to EU-IMF joint adjustment programmes) "the EU can issue policy warnings and, ultimately, enforce compliance through incentives and sanctions" (Baeten and Thomson, 2012: 189). While health care was not explicitly included in the 2011 Annual Growth Survey (AGS), it did become part of the AGS for 2012. That health care systems should be subject to some form of overarching coordination at EU level had been discussed for some time (e.g., in the public health programmes of 2003–08 and 2008–13, and in the 2010 Joint Report on Health Systems published by the EC and the Economic Policy Committee). But the inclusion of health care coordination within a context of economic austerity measures was not what many had anticipated. Nonetheless, that health care would be targeted as part of the EC's new strategy on fiscal surveillance was not surprising, despite Member States' formal legal jurisdiction over health care, given that health care spending comprises an average of 10% of states' GDP, and an average of 80% of health care in the EU is funded through the public sector (Ahtonen, 2013: 1).

2.1. The new face of soft governance in European health care

The political dynamics underlying European health policy shifted abruptly after 2008, when the subprime meltdown precipitated a financial crisis which focused policy attention quite sharply away from social issues and on to economic ones. The details of this shift are complicated and cannot be analysed here. One point worth noting, however, is that due to the emphasis on financial stringency, national health policies began to be viewed as legitimate policy domain for EU-level decision-making, notwithstanding Member States' formal legal jurisdiction over health care. Given that health care spending comprises an average of 10% of states' GDP, and an average of 80% of health care in the EU is funded through the public sector (Ahtonen, 2013: 1), this was not particularly surprising.

Yet ideas are rarely static; and it is not remarkable that ideas and processes as complicated and variegated as experimental governance should shape themselves in response to a new political landscape. In the case of soft governance, two distinct trends are notable. Administratively and procedurally, older mechanisms such as the OMC have been superceded by newer instruments that retain informal processes of collective governance, but which are defined by much tighter parameters and expectations. Politically

and normatively, the principles of soft governance increasingly serve as a philosophical position where those critical of market-based assumptions and strategies can come together and articulate their objections in a more systemic and unified manner.

2.1.1. The open method of coordination (OMC)

Of all the mechanisms of soft governance, the OMC has by far received the most attention. First introduced in 1997 to facilitate the development of the European Employment Strategy, the OMC was very quickly applied to a number of other policy areas. While the detailed application of the OMC in each respective field is slightly different, the basic design is similar. The OMC is a recursive system of policy development in which very general policy objectives are agreed upon at the EU level. Then more specific goals and indicators, articulated in a formal Council resolution, are established by the Ministerial Council in the policy area involved. This process is facilitated by the European Commission. Each Member State then develops a set of national reports both explaining the current situation of the state vis-à-vis the policy area (including challenges and best practices) and outlining the specific strategies that would best allow it to fulfil the general goals established at the European level. These strategies are unique to each country, but are developed under the rubric of a coherent overarching policy.

When the health care OMC was launched in 2004, it included a component on long term care. When it became fully operationalised in 2006, it was "streamlined" into a larger OMC on Social Protection and Social Inclusion that also included "pension" and "social inclusion" streams as well. The evaluation of the health care OMC has generally been quite mixed, as most countries have been more forthcoming about reporting existing national health policies than in developing new ones (Kröger, 2011). Yet evaluation of the OMC is hobbled by a lack of consensus regarding what, precisely, an OMC is supposed to do. In February 2013 the Social Protection Committee produced its first annual report "in the context of the reinvigorated social open method of coordination" (DG-EMPT, 2013: 12). The report uses a new instrument referred to as the "Social Protection Performance Monitor." Using a dashboard of key social indicators monitored annually for statistically significant changes, the instrument serves as a solid, quantitative evidence base for a review of causes and solutions for trends identified by these indicators.

Many officials interviewed pointed out that the utility of discussion on social policy within the OMC was not unidimensional. The many new, weaker states in the EU certainly did benefit from the exposure to other states' "best practices," the process of peer review, and the access to EC expertise that they did not possess. Another official stated that the states which benefit from the OMC process are not always the ones one expects: occasionally it is the smaller states with more limited resources that can offer more creative and realistic solutions to specific policy problems that larger states, especially in the current climate, find useful. At the same time, however, the older and more powerful Member States were directly exposed to the challenges and limitations of the newer and weaker ones; and this greater comprehension of the vulnerability faced by new Member States was very useful in a broader sense in bolstering the tolerance of states with greater capacity for those with less.

2.1.2. Joint Action strategies

There is ongoing debate over the role of the OMC in current EU policy-making. While the high profile of the OMC has led some to call it the "fifth mode of policy-making in the EU" (Wallace, 2010), the OMC is no longer explicitly articulated in *Europe 2020*, the EU's current long-term planning strategy (de la Porte and Pochet, 2012). Because the OMC process has been seen as too broad and too unfocussed to achieve the immediate and quantifiable results that are the hallmarks of policy success, the use of OMCs has quietly been eclipsed within the field of health policy by the use of Joint Action strategies and Reference Networks. Joint Actions were clearly designed with an eye to the criticisms levied at the OMC process. They were established in 2008 and, in a sense, they are derived from the same theoretical format of the OMCs as they are a collaborative, voluntary, and non-binding exercise in mutual learning. The difference is that the objectives, scope, methods, and evaluative processes are much more clearly defined.

Joint Action strategies are very precise policy initiatives that are funded jointly by the European Commission and by other participating countries (normally these are Member States, but all states within the European Economic Area and European Free Trade Association are eligible). Key NGOs (such as the WHO, OECD, and EMCDDA) are also welcome to participate. Joint Actions are generally funded on a 50/50 basis, although the Commission will shoulder up to 70% of the costs in cases of "exceptional utility". The focus of Joint Action strategies is generally quite precise (health indicators, rare diseases, nanomaterials, congenital anomalies, organ donation, e-health governance, HIV, pharmacovigilance, alcohol use), although some topics are by their very nature more complex (chronic disease, cancer, health inequalities, health human resources, mental health and well-being). The stated objective of the Joint Action strategy is to identify common priorities between states, and to facilitate communication and coordination between them. Capacity gaps and best practices are noted, potential strategies of cooperation are discussed, and modes of operationalisation are developed. Unlike OMCs, the attempt is, as one interviewee noted, to see that the EU's monies are "well spent". The funding period is clearly limited (up to 36 months) and potential deliverables must be identified *ex ante*.

Any potential participant is free to submit a proposal for Joint Action funding, though many of the programmes have been initiatives led by a current Council's presidency (such as Spain's support for the health inequalities programme). Specific countries normally act as "leads" on issues in which they are particularly interested (France and the UK have been the most active in coordinating Joint Actions), and states are free to join if they believe that a particular focus is especially relevant to their jurisdiction. The focus of the Joint Actions is more on implementing existing knowledge than producing new ideas. Rather than isolated pilot projects, Joint Actions are attempts at executing best practices across jurisdictions. Effort is made to achieve economies of scale, promotion of best practices, facilitating networks, and establishing benchmarks. The results are to be quite concrete, and are expected to be permanently institutionalised.

2.1.3. Reference Networks

A much more recent addition to governance instruments in European health care is the "Reference Network." Like Joint Actions, Reference Networks are very specific, and seek to coordinate and integrate existing practices and institutions on a voluntary basis. The need for such mechanisms was largely driven by the formal recognition in 2011 that an integrated European approach to health care was essential. The framework for this coordination was the Directive on Patients' Rights on Cross-Border Healthcare. The Directive, which governs the rights of healthcare workers and patients to move across Member States, was the political response to the accumulation of decisions by the European Court of Justice stipulating limits to Member States' jurisdiction over their respective health care systems. Article 12 of the new Directive requires the European Commission to work together with Member States to establish networks of excellence across states in areas where "critical mass" becomes especially important in the treatment of

particular conditions. The obvious application of this is in the treatment of rare diseases, although it also applies to conditions requiring a high level of investment in specific equipment and technologies, or a considerable degree of expertise or multidisciplinary capacity (Palm et al., 2013). While the treatment of patients is the first objective of the European Reference Networks, other goals include medical training, expanded research capacity, the establishment of registries and databases, the support and development of patients' networks, and the articulation of best practices and benchmarks.

But it is important to remember that the Directive does not in itself establish the European Reference Networks; it merely stipulates the responsibility of the EC to support Member States in this effort. The political dynamics underlying this endeavour are substantial. The first issue is that of funding: who pays for the Reference Networks? The long-term sustainability of the networks is to rest with the Member States themselves. The states which have expressed the most interest are, unsurprisingly, the larger ones – Germany, France, the UK, Spain, Italy, and Belgium – but it is the smaller and poorer states with their limited capacity who stand to gain the most. Interviewees were unsure how the problem of access was to be resolved: some expected that the least wealthy states would be given an "associate membership" to allow them the benefits of the centralised expertise; others worried that such states would be "cut out" of the process. Another issue is that of organisation: who runs the networks? The process of organisation is to be a "bottom up" rather than "top down" process, but the demands of coordination introduce the possibility of hierarchal management of the networks. A related question is: who evaluates the progress of the networks? Evaluation across networks requires consistency, but a European level of evaluation raises the ever-present issue of erosion of the principle of subsidiarity. Finally, there are intrastate issues within federal jurisdictions (such as Germany) over the determination of expertise (does this rest with the federal state, or with the länder themselves?). Interestingly, what the Directive on Cross-Border Care (and specifically the requirement to develop Reference Networks) illustrates is that the execution of "hard" law in health care at the European level does not preclude the use of soft governance techniques but seems, rather, to require them.

2.1.4. The "High Level Process of Reflection"

The shift from OMCs to Joint Actions and Reference Networks demonstrates a move from quite broad processes to much more defined ones. But it would be a mistake to assume that this is indicative of the trajectory of soft governance as a whole. For well over a decade the EU has been establishing a "competence" (or legal jurisdiction) over health care, not only through EJC decisions on free movement and on human rights (McHale, 2010) but also though its new approach to economic governance. What this means is that it has become useful to think about health care systems from a more encompassing *European* perspective. But the perspective that is expressed depends to a large extent upon who is articulating the vision, and visions are highly politically-charged creations. As the following cases illustrate, established soft governance instruments also perform a highly political function that is quite separate from their instrumental role.

A High Level Process of Reflection is an *ad hoc* process that is established to address a particular concern; it is not a clearly regularised practice. As a "High Level" process it is generally comprised of representatives from the relevant Council (in this case, Employment, Social Policy, Health and Consumer Affairs, DG-EMPT, supported primarily by the Directorate General for Health and Consumers, DG-SANCO). The lack of administrative rigidity combined with the participation of key high-level individuals means that it is a body able to engage in substantial policy planning without being impeded by the usual bureaucratic complexities of EU policy-making; the disadvantage is that it is not a particularly transparent process. One High Level Process of Reflection was undertaken in the early 2000s as "an initial effort to map out the consequences of (especially) internal market law for health services" (Greer and Vanhercke, 2010), and in 2004 it was folded into the High Level Group on Health Services and Medical Care, which was itself formally suspended in 2009. This was partly due to the development of a European Health Strategy, commencing in 2008, to provide a coherent framework for action at the European level. But by 2011, after the implementation of the European Semester, it was becoming clear that EU health policy goals were increasingly defined by the need to cut public expenditure at the Member State level. Strategically, then, the subsequent High Level Process of Reflection was an attempt to re-think the project of European health systems in a manner that did not, like the initial responses articulated by the European Semester process, jeopardise long-term public health objectives.

In April 2011, concerned health ministers from a number of Member States convened to initiate a new High Level Process of Reflection entitled "Towards modern, responsive, and sustainable health systems". The focus of the strategy was not subtle. The Council document establishing the High Level Process of Reflection stressed the need to "ensure that health is adequately addressed in the National Reform Programmes submitted by Member States within the framework of the Europe 2020 strategy;" to "reposition the perception of health policy, making it more visible when macroeconomic issues are at stake," and to further strengthen long-term health promotion and disease prevention planning (Council of the European Union, 2011). The process was also a strategic move to allocate as much funding from the new round of Structural Fund programmes (2014–2020) as possible to the field of health care (currently only 2 per cent of the Structural Funds are used for health care).

The High Level Process of Reflection is under the purview of the Senior Level Working Party on Public Health, and is scheduled to present its final report in October 2013. Because of the "high level" nature of this policy instrument, with Ministers of Health playing a leading role, the likelihood of "buy in" by Member States is considerably higher than it would be if undertaken by mid-level bureaucrats subject to several levels of administrative approval. The problem with the High Level Process of Reflection, as interviewees noted, is that the *ad hoc* nature of the procedure means that there is often a lack of continuity and follow-up of recommendations. To address this deficiency, the 2011 Reflection Process has articulated an intent to focus on the long-term planning and stability of projects, especially after the termination of the Structural Funds which initially support them, and to develop a "practical toolbox" (including *ex ante* indicators of performance) to assist Member States in implementing the proposed policies.

As an instrument of soft governance in the field of European health policy, the High Level Process of Reflection serves two purposes. The first is the standard "soft law" objective of coordinating interests, engaging them in discussion, establishing common interests, developing possible solutions, and operationalising collaborative but discretionary policy in key areas. The second role is much more political, and serves as a forum for those favouring a pan-European approach to health care that is not premised on market principles. The current Process of Reflection does not challenge the need to make states' health care systems more responsive to the financial limitations of the economic landscape. Rather, it suggests alternate ways of doing so. Instead

of simply shifting health care expenditure to the private sector, it endorses strategies such as integrated care, volume drug purchasing, e-health systems, enhanced primary care, better use of health human resources, and the exchange of best practices. None of the solutions proposed by the final report of the High Level Process will be novel or unexpected. The point of the process, to a large extent, is simply to reinforce the point that there are other ways to think about restructuring health care in an environment of constrained fiscal capacity. As with the former High Level Process of Reflection in health care, the current process was established only when the political context produced a discursive contest over defining the nature and function of health care systems.

2.1.5. The EU Health Forum

As noted above, it had become clear by the early 2000s that the decisions of the European Court of Justice were reshaping the contours of Member States' health care systems. At this point the European Commission was beginning to articulate the need for some overarching coordination of national health systems, notwithstanding its limited formal legal competence in the area. To allay concerns that this was a shadowy form of "competence creep" that would lead to more health policy-making within the subterranean decision-making apparatuses of the Commission (especially within the context of the EU's perceived "democratic deficit"), the European Union Health Forum was established in 2001 as an umbrella organisation for the health sector "to ensure that the European Commission's health policy is transparent and responsive to public concerns" (EU Health Policy Forum, 2009: 1).

The composition of the Health Forum is balanced between health NGOs, representatives of health professionals and trade unions, health service providers and health insurance, and businesses with an interest in "health promotion, protection, and improvement." The Health Forum currently has 52 members. Procedurally, there are two components to the Health Forum. The European Union Health Policy Forum (EUHPF) meets twice a year to discuss the strategic priorities established by the Forum and the Commission at previous meetings. The Open Health Forum (OHF) comprises interested parties from the wider community, and meets once a year to discuss an agenda prepared jointly by the Commission and the EUHPF. Both groups are advisory bodies only, and all recommendations are non-binding.

How effective has the Health Forum been? Again, the attempt to evaluate such a mechanism depends largely upon how one defines its purpose. Formally, the role of the Forum is to support the implementation of the European Health Strategy, with an especial focus upon enhancing citizen engagement more broadly. A report commissioned by DG-SANCO to evaluate the 2008 Health Strategy at its midpoint noted that the Forum "fulfilled its role as a communication channel, even if too 'one-way' with information flowing principally from the Commission to members," but "did not necessarily achieve its full potential as a tool for proposing policy options and identifying emerging health issues and shaping (or giving feedback on) policy proposals and implementing measures" (PHEIAC, 2011:12). This account was largely corroborated by EC officials and NGOs interviewed by the author. Some of the larger NGOS were quite dismissive of the process, although smaller ones found the access to information about the Commission's plans to be useful. At the same time, some officials found it advantageous to float ideas to the Forum as a means of gauging their reaction to specific policy proposals. Interestingly, since the establishment of the European Semester system, the role of the Health Policy Forum has solidified more concretely into a discursive one similar to that of the High Level Process of Reflection. Like the Reflection Process, the Health Policy Forum has increasingly focused upon developing a systematic critique of the European Semester process vis-à-vis European health policy.

3. The role and nature of soft governance in European health policy

This account of the instruments of soft governance in European health policy is not exhaustive: there are other mechanisms– such as the Social Dialogue – which could potentially be added to the discussion. What can be concluded from even this limited discussion, however, is that the experimental modes of governance that gained prominence in the EU in the last decade are not obsolete. Soft approaches to governance will continue to thrive because they fulfil two very significant purposes. The first is instrumental: new governance mechanisms are useful because, in many cases, they are simply a more effective way of getting things done. They facilitate policy development in ways that a strict imposition of legal harmonisation cannot. This is especially true in the field of health care, where rapid technological change, high complexity, the need for scale economies, the quest for best practices, the focus on patient-oriented care, and the need for interjurisdictional cooperation mean that the static, rigid, and homogeneous model of traditional command-and-control systems is increasingly unable to accommodate an efficient and sustainable model of health care. Trubek et al. (2008) describe four functional advantages to softer forms of governance over more traditional ones: they are better at gathering local clinical knowledge or information on patients' cultural diversity; they are more efficient at transferring knowledge from the clinical setting to higher-level agencies; they are flexible enough to facilitate learning while encouraging further experimentation; and they are able to close the "regulatory gap" that exists when the lack of fit between goals and tools hinders optimal results.

But soft governance instruments also perform a significant discursive function in the EU. This approach sees political change to be the result of the persuasive force of narratives that challenge dominant ways of thinking about the world around us (Schmidt, 2013). But ideas do not exist independently of political interests; and political interests require vehicles through which to articulate their ideas. This can be seen in the way in which certain soft governance instruments such as the Open Method of Coordination, the High Level Process of Reflection, the Social Dialogue, and the Health Forum have been building a coherent discursive account focussing on coordinated investment in better health services across Europe (in contradistinction to indiscriminate cuts to public health care expenditure). Yet a limitation of discursive theoretical approaches is that they provide little explanatory clarity: how, precisely, are oppositional ideas developed and diffused in a particular political context? Which actors use what kind of strategies to accomplish their objectives? Discursive approaches are most useful when combined with more detailed explanations of political causality; in this case, Sabatier's theory of advocacy coalition can be usefully applied to illustrate the way in which discursive challenges can be operationalised.

It is no coincidence that the critical narratives emanating from the various fora discussed above sound remarkably consistent, as most of these processes are coordinated through the same administrative units. As Miliband (1969) described in his analysis of the state, different state institutions tend to represent different interests in society. A more sophisticated modern version of this theory is the "advocacy coalition" approach, which holds that various interests in society attempt to influence policy by joining

forces with like-minded political actors who find their home in specific state institutions (Sabatier and Jenkins-Smith, 1993). While all Directorates-General are bureaucratic state institutions and are therefore formally politically neutral, it is commonly understood that certain Directorates (such as DG-SANCO and DG-EMPT) are institutional homes for political actors and interests who support solidarity-oriented policies, while others such as DG-ECFIN (Economic and Financial Affairs), DG-MARKT (Internal Market and Services) and DG-RESEARCH (Research and Innovation) are homes for those with more of a market orientation (see, e.g., Greer and Vanhercke, 2010). The reorientation of health services to meet the legal decisions of the European Court of Justice was largely under the purview of MARKT, and the reorganisation of economic governance following the economic crisis is supported by ECFIN.

It is possible to say, then, that the competing visions for European health policy are institutionally grounded in two discrete directorates. The disjuncture in vision over the future of European health policy is most clearly illustrated by the fact that, while ECFIN has been the most dominant institution in the coordination of the European Semester (including, pointedly, health services), it does not consult with the unit – SANCO – with the most expertise in health policy. A number of interviewees held that ECFIN, the directorate responsible for drafting country-specific reform proposals in the area of health care, did not have a good understanding of what was required for sustainable health care simply because it did not understand the nature of health policy per se particularly well. But the current dominance of ECFIN over European health policy (through the European Semester) should not be overstated. In the first place, the influence of SANCO (once considered a very weak directorate) has been steadily increasing as the need to coordinate European health care has been recognised and institutionalised. In addition to simply being responsible for "public health" in a larger sense, SANCO supports relatively important health programs and strategies such as the consecutive Health Strategies, the Health Impact Assessments, the 2011 Directive on cross-border health care, and oversight of pharmaceutical policy (until recently under the purview of MARKT). In the second place, the close affiliation of SANCO to EMPT bolsters its ability to promote its health care agenda. Officials explained that there is an "inner circle" of key directorates (ECFIN, MARKT, EMPT, and TAX) that are consulted in the European Semester process. SANCO is not included, but the communication between SANCO and EMPT is quite detailed and sustained, and there is an increasingly strategic alignment of policy between the units. For example, the High Level Reflection process (supported by SANCO) is calling for greater use of European Structural Funds in health and, notably, these Structural Funds are administered by EMPT. It is difficult to determine the balance of power between ECFIN and EMPT, but some interviewees have noted that there is now increasing internal discussion in the European Semester process over the need for country-specific reform recommendations to take a longer-term approach to sustainability.

There is, in sum, a clear trajectory in the way that soft governance mechanisms are being used within the sphere of European health policy. Administratively, soft governance plays a very specific and important role in facilitating the interoperationalisation of health policy upon which an effective and sustainable European network of health care systems depends. Politically, these modes of governance also create a broader discursive space in the health policy debate which allows a constellation of interests to present a coherent alternative to the development of health care at a European level. At times these two functions overlap; at other times they do not. But there is little reason to believe that they are either irrelevant, or destined to disappear.

Acknowledgement

This article was written with the assistance of grants from the Canadian Institutes of Health Research and the European Union Centres of Excellence.

References

Ahtonen, Annika, 2013. Economic Governance: Helping European Healthcare Systems to Deliver Better Health and Wealth? European Policy Centre, Brussels.
Armstrong, Kenneth, 2011. The character of EU law and governance: from 'community method' to new modes of governance. Current Legal Problems 64, 179–214.
Baeten, Rita, Thomson, Sarah, 2012. Health care policies: European debate and national reforms. In: Natali, D., Vanhercke, B. (Eds.), Social Developments in the European Union 2011. ETUI and OSE, Brussels.
Bakvis, Herman, 2010. In the shadows of hierarchy: intergovernmental governance in Canada and the European Union. Canadian Public Administration 56 (2), 203–218.
Bell, Stephen, Hindmoor, Andrew, Mols, Frank, 2010. Persuasion as governance: a state-centric relational perspective. Public Administration 88 (3), 851–870.
Benz, Arthur, 2009. Combined modes of governance in EU policymaking. In: Tömmel, Verdun (Eds.), Innovative Governance in the European Union. Lynne Rienner, London.
Council of the European Union, 2011. Council Conclusions: Towards Modern, Responsive, and Sustainable Health Systems. Available at: http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/122395.pdf (accessed June 2013).
Dawson, Mark, 2010. Transforming into what? New governance in the EU and the 'managerial sensibility' in modern law. Wisconsin Law Review. Available at: http://wisconsinlawreview.org/wp-content/files/6-Dawson.pdf (accessed June 2013).
De la Porte, Caroline, Pochet, Philippe, 2012. Why and how (still) study the Open Method of Co-ordination (OMC)? Journal of European Social Policy 22, 336–349.
Decker, Frank, 2002. Governance beyond the nation-state: reflections on the democratic deficit of the European Union. Journal of European Public Policy 9 (2), 256–272.
DG-EMPT, 2013. Current Challenges and the Way Forward: Annual Report of the Social Protection Committee 2012. European Commission, Brussels.
Eberlein, Burkard, Kerwer, Dieter, 2004. New governance in the European Union: a theoretical perspective. Journal of Common Market Studies 42 (1), 121–142.
EU Health Policy Forum, 2009. The Health Forum's Role: a Renewed Mandate. Available at: http://ec.europa.eu/health/archive/ph_overview/health_forum/docs/euhpf_mandate_en.pdf (accessed June 2013).
Greer, Scott, Vanhercke, Bart, 2010. Governing health care through EU soft law. In: Mossialos, Elias, et al. (Eds.), Health Systems Governance in Europe: the Role of EU Law and Policy. Cambridge University Press, Cambridge.
Hancher, Leigh, Sauter, Wolf, 2012. EU Competition and Internal Market Law in the Healthcare Sector. Oxford University Press, Oxford.
Hervey, Tamara, McHale, Jean, 2004. Health Law and the European Union. Cambridge University Press, Cambridge.
Hix, Simon, 1998. The study of the European Union II: the 'new governance' agenda and its rival. Journal of European Public Policy 5 (1), 38–65.
Klein, Alana, 2008. Judging as nudging: new governance approaches for the enforcement of constitutional social and economic rights. Columbia Human Rights Law Review 39, 351.
Köhler-Koch, Beate, Rittberger, Berthold, 2006. The 'governance turn' in EU studies. Journal of Common Market Studies 44, 27–49.
Kröger, Sandra, 2011. Five Years Down the Road: an Evaluation of the Streamlining of the OMC in Social Policy Fields. OSE, Brussels. Briefing paper no. 8.
McHale, Jean, 2010. Fundamental rights and health care. In: Mossialos, Elias, et al. (Eds.), Health Systems Governance in Europe: the Role of EU Law and Policy. Cambridge University Press, Cambridge.
Miliband, Ralph, 1969. The State in Capitalist Society. Basic Books, New York.
Neergraard, Ulla, 2011. EU health care law in a constitutional light. In: de Gronden, et al. (Eds.), Health Care and EU Law. Springer-Verlag, The Hague.
Ostrom, Elinor, 1990. Governing the Commons: the Evolution of Institutions for Collective Action. Cambridge University Press, New York.
Palm, Willy, et al., 2013. Building European Reference Networks in Health Care. WHO and European Observatory on Health Systems and Policies, Copenhagen.
PHEIAC (Public Health Evaluation and Impact Assessment Consortium), 2011. Mid-term Evaluation of the EU Health Strategy 2008-2013. Available at: http://ec.europa.eu/health/strategy/docs/midtermevaluation_euhealthstrategy_2011_report_en.pdf (accessed June 2013).
Sabatier, Paul, Jenkins-Smith, Hank (Eds.), 1993. Policy Change and Learning. Westview Press, Boulder, Colorado.
Sabel, Charles, Zeitlin, Jonathan (Eds.), 2010. Experimentalist Governance in the European Union. Oxford University Press, Oxford.
Sand, Inger-Johanne, 1998. Understanding the new forms of governance: mutually interdependent, reflexive, destablised and competing institutions. European Law Journal 4/3, 271–293.
Schmidt, Vivien, 2008. Discursive institutionalism: the explanatory power of ideas and discourse. Annual Review of Political Science 11, 303–326.

Schmidt, Vivien, 2013. Speaking to the markets or to the people? A discursive institutionalist analysis of the EU's sovereign debt crisis. The British Journal of Politics and International Relations 15 (2). http://dx.doi.org/10.1111/1467-856X.12023.
Scott, Joanne, Trubek, David, 2002. European Law Journal 8 (1), 1–18.
Tömmel, Ingeborg, Verdun, Amy, 2009. Innovative governance in the European Union. In: Tömmel, Verdun (Eds.), Innovative Governance in the European Union. Lynne Rienner, London.
Trubek, Louise, et al., 2008. Health care and new governance: the quest for effective regulation. Regulation and Governance 2, 1–8.
Walker, Neil, de Búrka, Gráinne, 2007. Reconceiving law and new governance. Columbia Journal of European Law 13, 519–537.
Wallace, H., 2010. Policy-making in the European Union. Oxford University Press, Oxford.