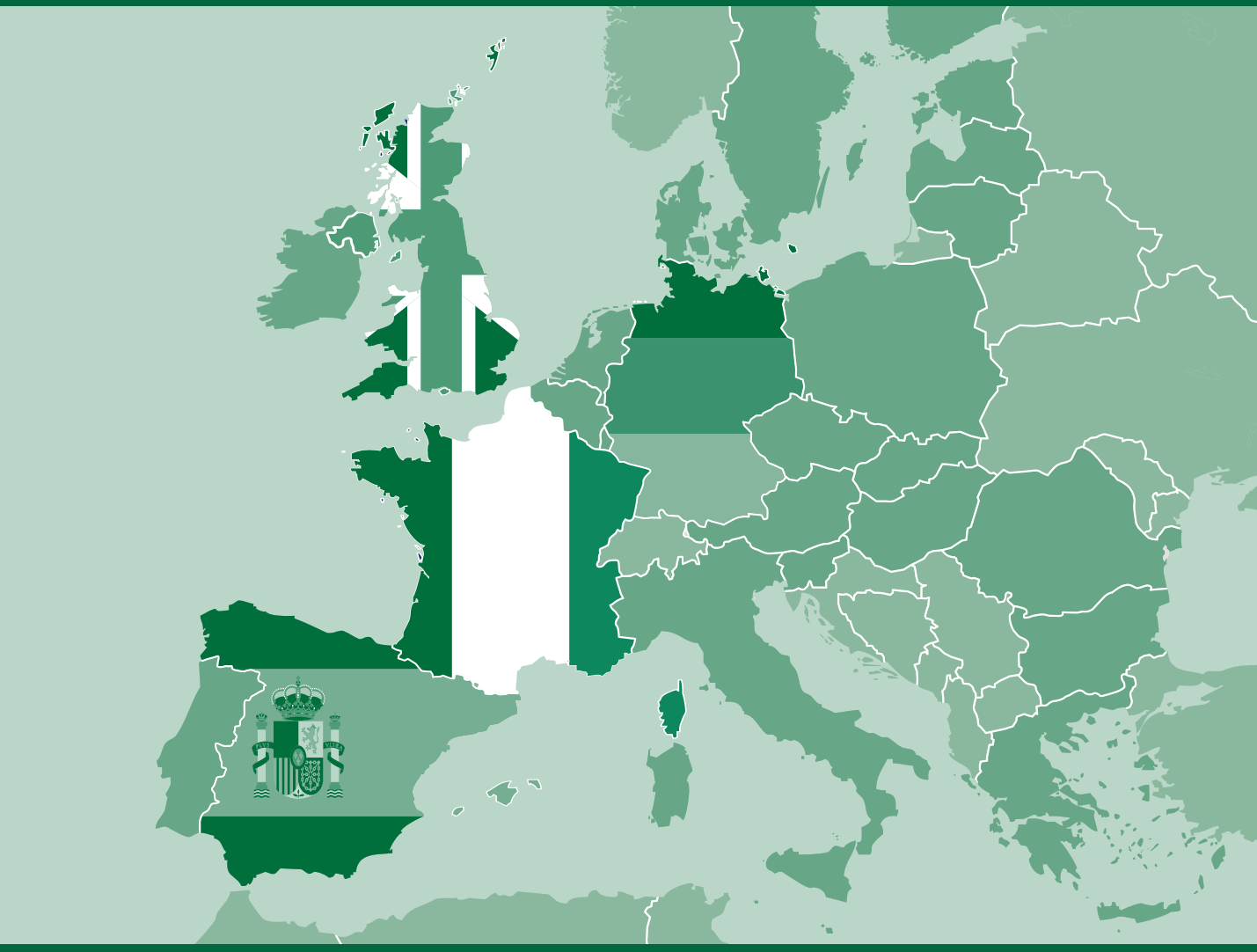
BECOMING EUROPEAN

HOW FRANCE, GERMANY, SPAIN AND THE UK ENGAGE WITH EUROPEAN UNION HEALTH POLICY

Scott L. Greer



The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

BECOMING EUROPEAN

HOW FRANCE, GERMANY, SPAIN AND THE UK ENGAGE WITH EUROPEAN UNION HEALTH POLICY

Scott L. Greer
University of Michigan School of Public Health
London School of Economics

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

The Nuffield Trust

The Nuffield Trust is a charitable trust carrying out research and policy analysis on health services. Its focus is on the reform of health services to increase the efficiency, effectiveness, equity and responsiveness of care.

Published by
The Nuffield Trust
59 New Cavendish Street
London W1G 7LP

Telephone: 020 7631 8450
Facsimile: 020 7631 8451

Email: info@nuffieldtrust.org.uk
Website: www.nuffieldtrust.org.uk

Charity number 209201

ISBN-13 978-1-905030-31-6

Typeset by Liquid Design and Communications Ltd
Website: liquid-dc.co.uk

Printed by Q3 Digital/Litho Ltd

Contents

About the author

Dr Scott L. Greer is Assistant Professor of Health Management and Policy in the University of Michigan School of Public Health, and honorary senior research fellow of Health and Social Care at the London School of Economics. A political scientist by training, his books include *Territorial Politics and Health Policy; Nationalism and Self-government: The politics of autonomy in Scotland and Catalonia; Territory, Democracy and Justice: Regionalism and federalism in Western democracies* and *Devolution and Social Citizenship in the United Kingdom*. He has written and edited several books on devolution for the Nuffield Trust, including *Devolving Policy, Diverging Values? The values of the United Kingdom's health services* and, most recently, (with Alan Trench) *Health and Intergovernmental Relations in the Devolved United Kingdom.*

Acknowledgements

I would like to thank Cesar Colino, David Hunter, Jeni Bremner and two of my official interviewees for reading and commenting in detail on the draft of this report. I would also like to thank all of the interviewees for their time.

Scott L. Greer
October 2008
slgreer@umich.edu

Foreword

Policy developments in the European Union can have a significant impact on health and healthcare in the UK. It is critical to be able to maximise the influence of the UK on EU policies. But how effective is the UK? And how could its influence be increased?

There can be few better guides through the formal and informal policy-making process in the EU than Scott Greer. This clear, succinct and highly readable report compares this process, and resulting influence, across four nations – the UK, Spain, France and Germany. While the influence of the UK is high, he notes that devolution presents a significant challenge because it is reducing the ability to develop consensus and a 'single united line' on policies across the four UK nations, which can be projected at the European Union. He ends with some cogent recommendations.

The Trust has commissioned a rich body of work on the theme of devolution over the past ten years, of which this report is part. The theme will continue next year when a study comparing the performance of the National Health Service across the four UK nations will be published.

Dr Jennifer Dixon
Director, The Nuffield Trust.

Executive summary

European Union health policies are about many things, ranging from the application of competition law to regulations permitting patient mobility and programmes promoting public health. Most of them came from adjacent policy areas and involve subjecting health services to internal market law. This obviously creates policy problems. But it also raises a major question: how much autonomy will health policy-makers have in the future? There is a real risk that health policy will be made not by health policy-makers but by EU lawyers, economics ministries, or other groups that do not understand or sympathise with the specific problems and goals of health policy. Facing this challenge, and making sure that health is the main concern of EU health policy, requires active, engaged and strategic member states; active, engaged and strategic health ministries in the states and regions; and, beyond them, an active, engaged and strategic health sector that can influence the EU.

- EU health policy matters to member states and to regions and that means influence over EU health policy should matter to member states and to regions. It does not just matter because of its ability to shape health services and policies. It also matters because it disrupts the balance of power between ministries and governments within member states – by turning the affairs of regional governments and health ministries into the affairs of member states and economics ministries.
- EU member states vary in their ability to influence EU health policy. This is because they vary in the degree of coordination and in their degree of activity. Coordination is the extent to which intergovernmental and interdepartmental disputes spill over into the EU. Activity is the extent to which they try to influence EU policy and try do to so at early stages of policy formulation; while there is better and worse coordination at the formal stage of voting, there is more variation in the equally important early stages of agenda-setting and debate.
- In each case, a member state's approach is largely explained by its domestic politics. Constitutional and political issues explain the different approaches; these include

federalism and the goals of stateless nations such as Catalonia and Scotland. The result is that they cannot always hope to simply borrow institutions from each other, even if that would make them more effective.

The country analyses find very different approaches to EU health policy-making:

- The UK and France are both active and highly coordinated systems. Both have central coordinating units (SGAE, the Secretariat-General for European Affairs and the Cabinet Office European Secretariat). Their goal it is to identify issues, specially ones where there is internal dispute, and formulate a single 'line' that their highly active Brussels representatives can then promote strategically. Both have traditionally had a clear hierarchy capable of imposing a decision and extensive information-sharing.
- Germany has coherently faced and coped with the challenges that Europeanisation poses to its regional governments (Laender). They occupy a strong legal position and must be consulted on all decisions. This reduces the ability of Germany to be active by slowing its internal consensus process; but because the German EU policy process in health relies on a few people who know and trust each other, federalism is not the main cause of fragmentation. Rather, ministerial autonomy and the absence of any central coordinating unit comparable with the SGAE or Cabinet Office European Secretariat means that German interdepartmental conflicts often spill onto the EU level.
- Spain is a story of change in which its governments increasingly began to work together in EU affairs. For decades Spain's conflict-ridden intergovernmental relations spilled over into EU policy, with the central state making and implementing EU policies that the regions could not or would not support, and the spectacle of regional 'paradiplomacy' (informal diplomacy by regional governments) that was often equally flamboyant and ineffective. In response to this dysfunction, steady efforts have been made to design more stable and technocratic systems of intergovernmental relations in EU affairs. These systems include intergovernmental councils and regional participation and decisions; these have both benefited from and contributed to a thaw in intergovernmental relations.

These different styles allow us to draw conclusions about how policy works and might be improved:

- In each case, the somewhat uncomfortable conclusion is that regions are most effective when they are 'built into' the member state. Being 'built in' means having their views formally incorporated via mechanisms that give them a measure of legal equality with the member state. The power of member states, especially big ones such as these four, is enormous, and regional governments that can influence a big member state are more

effective than governments that are restricted to lobbying their member state and the EU institutions. This conclusion is uncomfortable because it means both that regions are weak and that they suffer when they are run by a government that has political disagreements with the member state. Of the three countries facing this challenge, Germany has solved this problem to the greatest degree by building mechanisms to include regions in all aspects of its policy process, and Spain is well along the road to doing so.

- The UK faces special challenges because devolution is inexorably reducing its ability to create a single united 'line'. Northern Ireland, Scotland and Wales have their own governments with their own political legitimacy and objectives, and that means that the UK faces the task of developing intergovernmental coordination mechanisms that serve devolved and UK interests while minimising the loss of speed and effectiveness in the EU. There is a chance that the UK may repeat Spain's history of conflict-ridden intergovernmental relations before learning Spain's lessons.
- All member states benefit from information flow and central coordination when trying to influence the EU. Administrative reform might improve information-sharing and effectiveness. But the real problems are political, and if there is to be more coordination and more activity it will depend on political will. Policies that might improve coordination, in part by depoliticising it and increasing trust, would include extensive information-sharing and clarity about real and potential conflicts. They already exist in every country, but could be much stronger.
- International departments of the health ministries play a key role. None of the health ministries within the EU member states has a culture of working with the EU; even the best are relatively weak compared to other policy sectors. And every EU health ministry bears the brunt of doing the influencing and arguing in informal venues, even if there are central coordinating agencies to determine the formal line. This means that international units face the double challenge of influencing EU policy in its formative, informal stages; and educating their ministries in EU affairs so that they can be effective.
- Regional governments have good reasons to engage on the EU level, through high-level meetings as well as a wide range of networks. These often operate on a low level of information exchange when they could be opportunities for regional governments, speaking as the policy-makers for major health systems, to address the shape and direction of EU policy.
- Finally, no system is perfect, so anyone who cares about health policy and worries that their government might not be perfect should consider investing in their own ability to understand and influence EU health policy.

1. Organising EU representation: what's the goal?

What is the purpose of engagement with European Union health politics? Clearly, the answer should be: to influence it. And it needs influencing; the ways in which the EU should be a key part of any policy-maker's strategic thinking are too many to review here.[1] Suffice it to say that the EU influences health policy in many important ways, including:

- limiting the hours that professionals can work in health services
- coordinating infectious disease control
- setting standards for professional education
- applying at least some of its giant body of competition law to health services
- shaping public procurement regimes through which health services purchase equipment and services
- regulating medicines and devices
- determining the hours and shift patterns of staff, including doctors and nurses
- organising blood supplies
- playing an increasingly dominant role in communicable disease control
- creating forums for discussion of shared problems such as financial sustainability or quality

1 The publications of the European Observatory on Health Systems and Policies are crucial in understanding EU influence over health policy. Other printed sources of use include Greer, SL (2006) *Responding to Europe: Government, NHS and stakeholder responses to the EU health challenge*, The Nuffield Trust; Hunter, DJ 'Values and health policy in the European Union' in Greer, SL and Rowland, D eds (2007) *Devolving Policy, Diverging Values? The values of the United Kingdom's national health services*, The Nuffield Trust, 69–86; Mossialos, E et al eds (2008) *Health Systems Governance in Europe: The role of EU law and policy*, Cambridge University Press. For an excellent, detailed, discussion of the relationship between the EU and different member states' social and health policy-makers see Kvist, J and Saari, J eds (2007) *The Europeanisation of Social Protection*, Policy Press.

- supporting 'European reference networks' for health services
- regulating food safety and animal health.

Almost no aspect of health policy in the 27 member states of the EU is untouched by EU policies. But are health policy-makers leading EU health policies? Rarely. These policies are often driven by the European Court of Justice, the European Commission's Directorate-General for the Internal Market, and economics or finance ministries in member states. They are incorporating health into a liberalising EU framework designed to create competitive markets, and often care little and know less about the specific problems and values in the health sector.

Putting health in the lead in EU health policy takes, among other things, active, engaged and strategic member states that can rise to the challenge of establishing the importance and autonomy of the health sector. That requires active, engaged and strategic health ministries, regional governments and stakeholders. This study explains what member states have done, why, and what needs doing. It examines the ways France, Germany, Spain and the United Kingdom organise to influence European Union health policies. The European Union responds best to a coordinated, active approach to policy that spans formal and informal venues. But not all states can do that; they must balance other values and habits against adaptation to Brussels politics. This report reviews their different approaches and concludes with suggestions for policy-makers, including those of 'regional' governments[2] and issues specific to policy-makers in the UK, which is currently seeing the greatest changes.[3]

The need to influence can be, and often is, defensive. Much of EU health jurisprudence and proposed legislation would create problems for health services. Influencing EU health policy to avoid problems involves an elaborate sort of chess game in which member states have to think of arguments and policy ideas that will retain their autonomy and achieve their policy goals while responding to the incursions of EU institutions. The Open Method of Coordination (OMC), proposals to include health in a category of Services of General Interest that is shielded from the market, statements of shared values, and groups such as the High Level Group on Health Services and Medical

2 'Region' is the standard term for mid-level governments in the European Union. It is an institutional category, not a comment on nationality; whether a nation enjoys a regional government or its own state is irrelevant to its nationhood.

3 This report confines itself to describing the basic problems and mechanisms before arriving at policy recommendations. For a fuller and more contextual analysis of what the four states are doing, and why, see Greer, SL (forthcoming) *Making European Health Policies: France, Germany, Spain and the United Kingdom*, Open University Press.

Care, all fall into this category. They are high-stakes efforts to shape the EU health policy arena before the European Court of Justice shapes it.[4]

There are also positive opportunities. Public health is where many of them are to be found, and the most prominent (and important) is the European Centre for Disease Prevention and Control. Given the wide variation in the importance of public health across Europe, and the even wider variation in the skills and resources of public health services, the exchange of information and resources is useful. It should be no surprise that public health is an increasingly Europeanised field.[5] But there are opportunities for learning and useful exchange of views in health services as well; the Open Method of Coordination, the High Level Group on Health Services and Medical Care and other meetings afford such opportunities (see Appendix 1).

Heading off threats and taking opportunities in most political arenas requires a number of skills. One is identifying a goal. Another is having a useful briefing with the right information to hand; another is marshalling resources to intervene at the right time. And finally, knowing when and how to intervene. This is difficult enough for a single person or a small team. Determining goals, collecting information, and designing relevant interventions is even more difficult for states. They face both organisational and political challenges to coordination.

In organisational terms, every EU state is a giant bureaucracy with many functional subdivisions. The specialisation that allows them to do their business also creates coordination problems. An economics ministry might not know or care much about the concerns of the health ministry, and might endorse policies (such as the inclusion of health in the Services Directive, as proposed in 2005) that would shock colleagues in the health ministry. Furthermore, pursuing a coherent strategy includes tradeoffs and the use of the full range of policy tools that a state controls. This means keeping different ministries from undercutting each other – which means knowing what meetings they attend, what the agendas are, and what their representatives will say.[6] This creates scope

4 Greer, SL (2008) 'Choosing paths in European Union health policy: a political analysis of a critical juncture', *Journal of European Social Policy* 18(3); 219–231.

5 Rowland, D (2006) *Mapping Communicable Disease Control Administration in the UK: Between devolution and Europe*, The Nuffield Trust.

6 The best short text on coordination in EU policy-making is still Vincent Wright's 'The national co-ordination of European policy-making: negotiating the quagmire' in Richardson, JJ ed. (1996) *European Union: Power and policy-making*, Routledge, 148–169. Every student of the topic is indebted to Kassim, H et al eds (2001) *The National Coordination of EU Policy: The European level*, Oxford University Press and Kassim, H et al eds (2000) *The National Coordination of EU Policy*, Oxford University Press.

for different ministries and different parts of the EU machine to create contradictory policies, especially in the more subtle legal issues.

The need to particiapte in the EU also adds the problem of managing the EU divisions. Keeping ministries, central coordinators and Permanent Representations connected can be difficult. Ministries or central coordinators might ignore reports on negotiations that come in from Brussels, while some representatives in damage their credibility, and that of their member state, when they appear to be freelancing.

The problem is made worse by the fact that many of the policies with the most impact on health come from outside 'health policy', DG Sanco (the EU's Health and Consumer Protection Directorate General) and even the EPSCO (employment and social affairs) Council. They come from the Court, from the labour regulators and OMC organisers of DG (Directorate General) Employment, and from more economic actors such as DG Internal Market, DG Enterprise and even DG Trade (which has at least blocked further discussions of trade in health services at the level of the World Trade Organisation). Given poor coordination in the Commission, this means that it is up to member states to realise that economic policy might create problems for their health systems and act accordingly across venues.[7]

Coordinating strategy and information is, then, an impressive organisational burden within governments. It becomes harder still when more than one government is involved. In Spain, for example, the regions[8] (Autonomous Communities) are responsible for much health policy and have their own representation in Brussels. Impact assessment, identification of goals, and information flows must all involve more than the Spanish government if Spain is to maximise its influence and use it to best effect. Likewise, the ability of the UK government to speak for Scotland or Wales is formally enshrined in law, but its practical ability to judge the effects of a given policy in Scotland or Wales is limited. UK-devolved cooperation is necessary if the devolved administrations are not to be forgotten or work at cross-purposes in Brussels.

---

7 For more on the consequences and Europeanising effects of poor coordination in the EU institutions see Greer, SL (2008) *Power Struggle: The European Union and health care services*, Brussels: Observatoire Social Européen. For more on how member states face the problem see the same author's *Making European Health Policies: France, Germany, Spain, and the United Kingdom*.

8 'Region' is the standard EU term for mid-size governments that lie between the local level and the member state. A region is an institutional form, like a state; to say that Scotland is a region says nothing about its nationality, just as calling the UK a state does not suggest anything about its citizens' national identities.

Agreement and knowledge management, especially between different elected governments, is not just a technical exercise. It depends on political support. The political problem is that ministers and governments might not want to agree, whether because of their policy views or because they want to start a fight for political reasons. This can be between ministries, and it can be between member states and regional governments. Scotland's current government, for example, might advocate a different line in Brussels. It is a nationalist government committed to some form of independence from the UK. So while some member states can rely on a good level of cooperation with their regional governments, it is much more common for there to be rivalries and competition between them. That naturally spills over to Brussels as regional government representatives pursue different objectives from their member states.

Europe, in short, does not always empower regions. Old ideas of a 'Europe of the regions' are often just wrong: while the presence of the EU makes regional autonomy easier and more attractive, the actual operation of the institutions often reduces regional autonomy by transferring power to the EU, where regions are weak. And that means that coordination is in the interests of regions as well as member states, since regions are just as subject to EU law as the member states of which they are part.

So the organisational and political obstacles are impressive. But the advantages of having a unified, well-informed, and strategic engagement in the EU remain. That is why coordination is often called the 'Holy Grail' of public administration, and 'joined-up government' such a popular idea.[9] How, and how much, do member states try to achieve it, in the face of bureaucratic turf wars, poor information flow, political rivalries, intergovernmental competition and overloaded officials who lack the time to go looking for policy contradictions?

This report aims to answer these questions by first presenting a framework for the comparison of different member states. It then reviews the different approaches of the UK, France, Germany and Spain, and in the final section draws conclusions. It is based on a stratified sample of 92 interviews across the four countries and the wider European Union conducted since 2004 (see Appendix 2) as part of the Nuffield Trust project on the meaning of devolution and Europeanisation for health policy. (For a list of other publications see Appendix 3.)

9 Page, EC 'Joined-up government and the Civil Service', in Bogdanor, V ed. (2005) *Joined-up Government*, Oxford University Press/British Academy, 139–155.

Coordination and activity

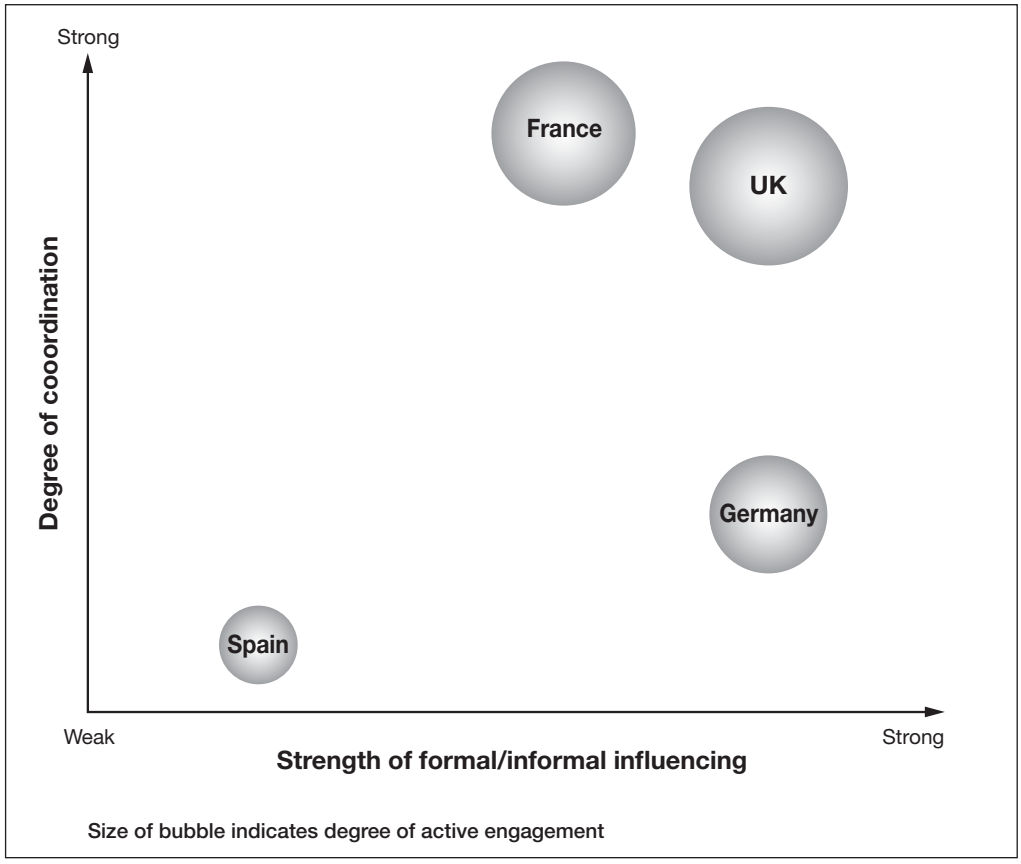
To what extent has any EU member state attained this 'Holy Grail' of coordination? And how hard have they tried? The organisational and political obstacles are impressive, but coordination and active engagement promise influence over crucial EU policy decisions for health. Analytically, we can group the member states by the amount of effort that they put into formulating a single 'line' and coordinating internally; by the amount of effort that they put into influencing the EU at any stage in is policy development; and by the extent to which they successfully influence informal as well as formal politics. In other words, how hard do they try to be unified or strategic actors in EU health policy?

The first axis is ***coordination****: the extent to which inter- and intra-government conflict is translated to the EU level*. All member states have some level of internal divergence and argument; coordination is about resolving, or masking, them for EU purposes. A highly coordinated member state has one position in all engagements with EU politics, no matter which ministry, experts, regional or other level of government is speaking, and which often persuade its interest groups to promote its 'line'. An uncoordinated member state is one in which different ministries, governments and official bodies speak with different voices and advocate different policies and priorities.

The second axis is ***activity****: the extent to which the member state collectively tries to influence EU policy*. There is a great deal of EU policy activity, from seminars and responses to consultation through lobbying to high-profile events such as Council and European Parliament votes. Member states, like any other group, can decide when and how much they want to engage; only at the time that a Council of Ministers or a European Council votes must they have an opinion (and, even then, a little adroit use of Council voting procedures can allow member states to abstain in various formal and informal ways).

The third axis is ***formal and informal influence****: the extent to which the member state influences politics in the informal stages of policy as well as formal votes*. In the EU, even more than in most countries, it is extremely difficult to figure out when a policy 'began'. There is a constant round of formal and informal meetings, proposals, ideas, 'soundings, conferences and debates, with several hundred people whose principal occupation is to engage, and thousands more who occasionally interact. These meetings shape policy, by putting pressure on the Commission and member states to adopt some ideas and no others, act more or less quickly, develop connections with experts, or listen to different groups. There is nothing as clear-cut and formal as participation in a vote in the European Council (which all member states successfully do); instead there is an energy-intensive process of policy debate, signalling and lobbying. It is here that there is most of the

Figure 1. Influencing the European health agenda



variation; Spain is a very competent member state in the Council, but it is weak in terms of influencing, and thus counted here as reactive. The UK, by contrast, is very active – its officials attend meetings, coordinate with its lobbies, and generally try to influence debates and agendas as well as work in Council and other formal channels.

A simplified summary of the position of each of the four member states reviewed is shown in Figure 1. (As will be discussed later, the UK is moving towards a position of less coordination; Figure 2 on page 51 shows both its current and potential future positions.)

This study does not fill out all the possibilities, but they exist in the EU. Typically, it is the smaller member states that are reactive and highly coordinated; countries such as

the Republic of Ireland benefit from their small size in that they can more easily share information and thinking, but they generally do not have the resources to shape many dossiers. Belgium is, judging by references in the interviews, an active and uncoordinated country; the member state and the Flemish government both engage strongly in EU politics, but do not often agree or coordinate their efforts. Italian ministries are also said to be particularly poorly coordinated.

Coordination does have costs. It calls on resources that could be used for other purposes. Civil servants on a trip to Brussels are civil servants that are not doing something else. A line official helping to prepare a response to a European Court of Justice case or a Commission consultation is not doing his or her other job. A politician talking to MEPs is paying a price for not doing something else. Coordination can also make member states inflexible by leading them to 'overthink' their positions and settle them too early, so that a useful mid-course correction becomes hard.

Ultimately the best the best EU policy engagement is unified and proactive. That is what is most likely to identify and attain desired objectives. This should be no surprise; unity and early engagement are the routes to effectiveness in many kinds of politics. In the EU, they can be particularly useful because of the many diverse fora in which member states and regions can engage and shape policy. The question is whether it is worth paying the price to attain early action and unity, or if it is even possible in a given country. Answers to that question vary greatly across the four major EU countries in this study. The next section explains how the four member states organise themselves, and why.

2. Four ways to Brussels

From Brussels, member states can look impressively stubborn in their refusal to play the game well. EU politics responds to early, broadly based, and highly coordinated engagement. Most member states do not do that. But from another perspective, each country's way of organising its Brussels representation is entirely predictable. To understand it requires a sense of its constitution, politics and administrative tradition. The explanation for the way they work is often found in the most obvious place – not the demands of engaging in EU politics, but in the nature and makeup of the member states.

This section discusses the four countries. The first section discusses the formal structure for EU affairs – in other words, the mechanisms that produce the strategy and formal positions of each member state, in Council and other situations in which the state itself must speak. The second section discusses the informal side of it – the level of activity that is often more influential and happens long before any formal policy proposal emerges.

France

France, it should be no surprise, combines a lively and intense internal politics with a drive to unity and unified policy. That description fits most of French politics. The French system of EU relations is set up to identify a single unified French position on as many issues as possible and then promote it. This means drawing up a great deal of information about issues and potential positions, and formulating a great many French positions, and doing it quickly. Should consensus not emerge, the French system is hierarchical enough to impose one.[10]

10 See Lequesne, C (1993) *Paris–Bruxelles: Comment se fait la politique européenne de la France,* Paris: Presses de Sciences Po. This superb text has been updated by Virginie Lanceron's (2007) *Du SGCI au SGAE: Evolution d'une administration au coeur de la politique européenne de la France*, Paris: L'Harmattan. President Sarkozy is currently considering a variety of reforms to French public administration and territorial policy that might alter these arrangements.

As in other areas of French administration, the process of developing a position includes a clearly demarcated technical (ministry) level and a political level of politicians and, more importantly, their advisors – the top officials around them, called the *cabinet*.

Careers can span both the political and the technical sides, but the division matters a great deal. The relationship is relatively simple: civil servants have a high level of job security, but their ability to make major decisions is sharply circumscribed by the *cabinets*.

Formal decisions: determining the French position

Against that background, it is relatively easy to describe the French system. The Ministry of Health (and Solidarity) is the line ministry with central responsibility for health services. It is the home of the technical civil servants who can assess the impact of EU policy ideas and who will often have ideas for their improvement, and it is the source of many of the experts and officials who represent France in the process of delegated EU committees called comitology (of which there is not much in health) and all the various health policy forums, such as the High Level Group, Open Method of Coordination proceedings, and the Platform on Diet, Nutrition and Physical Activity. The coordination process means that they all know the French 'line' and might have clear guidance. The ministry is also where much of the technical information about dossiers and impacts is collected and collated. This is the work of the European and International Affairs *cellule* of the Ministry.

But the Ministry itself is technical. The ministerial *cabinet*, on the other hand, is both charged with strategic, political issues and is able to draw on kinds of political power and connections that technical officials lack. So interministerial conflicts in the formulation of an EU line might get picked up at the technical level, but unless they are simple misunderstandings they are likely to be referred to the political level.

The next body in the chain linking the ministry to the EU is the Secretariat-General for European Affairs (SGAE). The SGAE is a central unit attached to the Prime Minister that is responsible for coordination – that is, collecting information about all events that might influence France and determine French goals and strategies. However surprising it might be to those accustomed to the British and French administrative traditions, the SGAE and its British counterpart, the Cabinet Office European Secretariat, are nearly unique. A powerful and relatively autonomous central coordinating agency such as the SGAE, with a claim to handle all EU policy, is the exception rather than the rule in Europe.

The powers and position of the SGAE vary with Presidents and Prime Ministers; as with any such system, there are various ways to organise its relations with the Ministry of Foreign Affairs and Prime Minister as well as major departments (all have their disadvantages and are mostly determined by personalities at the top). What is constant is that it is an elite administrative unit, a "microcosm of the French central administration", made up mostly of officials on short-term secondment from across the different ministries (mostly finance and economics) who are gaining central experience as part of rapid career progression or who were unhappy in their home ministries.[11] It distributes papers about EU developments and hosts constant meetings at which ministries agree the French position; if no agreed position emerges, it will refer the question to political levels.

The SGAE, usually led by a close adviser to the Prime Minister, is also the route to high-level political arbitration, whether informally or through its access to the Prime Minister and high levels of power. When a question becomes particularly high-level and involves the President, then bureaucracy is not a good map to the relationship. While EU health policy began with a Europe Against Cancer initiative that was initially proposed by French President Mitterrand, most health issues have not been sufficiently high-profile to engage presidents (although the current energetic inhabitant of the Elysée Palace is engaged with a wide and broadening range of issues). Finally, day-to-day coordination is ensured by the simple fact that the SGAE transmits all papers and emails to the Permanent Representation.

At the end of the chain we find the Permanent Representation in Brussels. The Permanent Representation, like all Permanent Representations, is more than a mouthpiece; its members pick up tactical and policy information that allows them to influence decisions in Paris. But their autonomy is relatively limited because France is more capable than most member states of formulating a *detailed* line and imposing it. So the common EU practice of sending representatives to Councils with only vague (or sometimes no) orders is uncommon with France. The machine does its job; there will be a dossier and a position and the Permanent Representation can focus on promoting it.

Informal influence

The high level of coordination – and high-level coordination – of the SGAE mechanism is almost entirely confined to the formal determination of the French state's position. But that is only a relatively small part of the work that a member state must do in health

11 Lanceron, *Du SGCI au SGAE*, 57–59.

policy; large and important areas of health have not yet gone to the Council at all. Instead, there is a constant round of committees, working groups, and other processes at which member states must appear and can influence EU policy developments. These meetings also overlap with the less formal meetings of working groups, seminars and conferences at which member states can shape the agenda long before it is set.

This is the world of health policy communities and networks and the small but growing EU health policy community. Here, the centre of gravity shifts down to the Ministry of Health. That is because, in a given meeting of the High Level Group or the OMC, it is ministries speaking, not the French state. The logic is that the demands on central coordinators would be overwhelming if the SGAE and Permanent Representation had to be interested in every meeting across the EU and that the value they would add would be very low because, as generalists, they would be incompetent in specialised meetings of experts in subjects such as agriculture, telecommunications or health.

Here again, France is highly coordinated and works hard at being active. The difference is that the coordination is led from within the Ministry, where the same ladder of people responsible for EU affairs leads to the Ministry's coordinating unit. That unit nurtures the EU experts and tries to interest the rest of the ministry in its work, facilitates experts' trips to Brussels when they participate, and provides the people who attend meetings of groups such as the OMC or Platform on Diet, Nutrition and Physical Activity.

The international unit, like its equivalents in other countries, faces the problem that there is a relatively weakly developed culture of European engagement in the ministry. This means that it has to work to extract useful policy ideas, let alone effort, from other parts of the ministry. This limits the value that the ministry can add; while its international unit knows more about health than generalists employed only in EU affairs, and it is better suited to learning about health matters and the situation of France, it still has to educate its ministry in the need for its existence at the same time as working out the stakes for France of a given policy idea.

The lack of a European culture is exacerbated by the French tendency not to attend many informal health events. Centralisation is also, probably, aided by the relatively weak presence of France in EU health politics debates. Compared to some countries (Germany, the Netherlands, the UK), the French are not very visible or present at informal or semi-formal EU health policy events – the endless round of conferences, talks, round tables and other meetings that shape the agenda (such as Gastein). This is especially the case with events conducted in English. The well-developed French system for outreach to people of French nationality does not work so well in policy areas such as health

where English is absolutely dominant and French nationals relatively rare, despite the crucial role of a number of French citizens at the top of DGs Sanco, and Employment and Social Affairs. The effect of common French non-participation in the broader Brussels health policy debate is to heighten the centralisation of French representation; the state is what speaks for France.

Conclusion

France demonstrates something simple but important: it is possible to develop a unified system that will have a worked-out position on almost everything and allow a high level of tactical action and strategic calculation. It might take a great deal of management and work. The Ministry of Health has a chain of people working on EU issues that reaches further down its internal hierarchy than in any other state we studied, because that is required to gather information necessary to formulate a good dossier on any issue. That is expensive by the standards of EU health policy-making, although the handful of staff costs a pittance compared to most other things in health ministries. But there is no political reason not to do it; short of the intermittent rivalry between President and Prime Minister, France has a high level of agreement that it should speak with one voice. So the problem that French organisation tries to solve is bureaucratic, not constitutional.

The other three countries are not so simple. France does not face any major constitutional obstacles to unity. It takes advantage of its unified constitution by engaging in intense internal coordination. While conceivably it is more hierarchical and fractious, or elaborate, or rigid than would be optimal, it reliably does achieve what any member state would want if it were to think of EU policy-making in isolation: a unified, active, policy. And that is useful regardless of whether the country is swimming with or against the tide of EU politics, as seen in the way France has managed to keep the concept of Services of General Economic Interest alive during years when powerful forces would have preferred to abandon it.

Germany

If France is a famously hierarchical country, Germany is its political opposite. The German constitution was designed to make German a nation governed by consensus. Consensus government meant distributing power and autonomy through many parts of the state and different governments, and requiring them to work together to achieve anything. This meant federalism, with the federal states (Laender) autonomous but tightly integrated with the federation (Bund). It also meant a high degree of ministerial autonomy. This constitutional structure reinforces longstanding German traits of ministerial autonomy and territorial fragmentation.[12]

In EU health policy-making, the key fact about territorial integration is that the Laender are involved in most policies. This comes through a simple and powerful injunction in the German constitution. While the federal government has an exclusive foreign affairs competency, Laender have a right to be consulted on any issue that touches their competencies. In health, this means all areas of public health. And while the social funds that finance German healthcare are an exclusive Bund competency, hospitals are under Laender control. As a result, most areas of health policy involve the Laender – EU reference networks, for example, or the health services directive, involve the Laender because they involve hospitals. This means that the Bundesrat, the German federal upper house in which they sit, must agree to policies that affect Laender. The federal government, elected out of the lower house (Bundestag) must live with this. Agreement can be very *pro forma*, but it must be there.

It might be telling that, in response to detailed questions about process, the German interviewees constantly discussed influence in terms of drafting reports and writing the initial statements of opinion. This probably flows naturally from a consensus-oriented system; the first draft sets the stage. By contrast, in France, it is clear that the political level of the dominant ministry is going to make the decision. Writing the first draft in France still means influence, but it is less important.

Formal decisions: determining the German position

The formal organisation of German EU policy-making is more complex than day-to-day operations. As with most member states, the International unit of the Federal Health

12 For the best guide to the interaction of German institutions with the EU see Sturm, R and Pehle, H (2006) *Das Neue Deutsche Regierungssystem: Die Europäisierung von Institutionen, Entscheidungsprozessen und Politikfeldern in der Bundesrepublik Deutschland*, 2nd ed., Wiesbaden: VS Verlag.

Ministry is the nexus between the line ministry and EU issues. Mostly based in Berlin, it communicates directly with the Permanent Representation, where the ministry has some staff posted. It has to work closely with the Laender, each of which has a person (or at least a fraction of a person) working on health in Brussels and in its own capital. A Land official goes with the federal official to almost every event, and the Laender have to agree official papers and stances via the Bundesrat and committee system. If the Laender disagree, they have their own ways of developing and voting on a position, and the allocation of who goes where is a mixture of prgamatism and political balancing with officials, the chair of the Bundesrat committee and rapporteurs on individual papers such as the proposed patient mobility directive generally balancing between the major parties. On paper this is a two-stage process in which the Laender agree a position and then negotiate a shared position with the Bund; in reality it tends to be much less formal. Done well, it involves early coordination and exchange of information that builds trust and brings out common views. Several officials interviewed for this report were keen to note that this is slow, but none could think of a time that the territorial coordination led to Germany lacking a position paper at a crucial time – in the terms of this report, they granted that Germany is not active, but it is not delinquent because of federalism.

German fragmentation comes in two kinds: intergovernmental and interdepartmental. Oddly, intergovernmental fragmentation appeared to be much less of a problem than interdepartmental fragmentation. In intergovernmental coordination, all sorts of hierachies and formal relationships dissolve in the reality of emails, meetings and a relatively egalitarian culture. It appears that this intergovernmental success comes from four sources. First, the law and power relationships underpinning the relationship are egalitarian. The Laender have to be involved. The UK civil service in London does not want to mistreat those of its members who work for the Scottish Government, but it is easy for Whitehall to forget them entirely. However, it is illegal for the Bund to forget the Laender. Second, the people constantly interact; their ministries are usually not very interested in EU affairs, and their governments are not always very interested in their health ministries, and so they can work on developing their relationships and joint working in the absence of major political tensions (unlike their Spanish counterparts). It is also easier because there are not many people engaged in Laender–Bund coordination in health in Germany, and some have had extremely long-standing relationships. So trust and informality can ease coordination. And third, this coordination takes place against a backdrop of a consensus-oriented German political culture. We could attribute this to any kind of cultural trait, but it is simpler to point out that in an institutional environment as complex and interpenetrated as Germany, nothing would get done without a high level of consensus. If the Bund engages early and respectfully with the Laender, there will be constructive debate and a consensus will start to emerge at

the important early stages. So if the Bund office is overstretched, and willing to cede the first draft to a Land, there is usually a Land with the capacity to write the first draft. Given the importance of the first draft, and explanatory memoranda, this is a sign of confidence and a high-trust environment. It also means, of course, that the bigger Laender that can afford to put more effort in – the ones that can reduce the other burdens on their officials, such as Bavaria, Baden-Wurttemberg, and North Rhine-Westphalia – have more influence. Finally, relative to other issues in Germany, EU affairs have to work reasonably well because the EU sets the agenda and the timetable. It is not a good idea to have long-running squabbles, because that would mean Germany would be unable to participate in EU decisions.

Interdepartmental coordination is a different matter. British, French and Spanish interviewees, as well as Commission officials, commented on how the frustration of dealing with Germany comes from its inability to agree lines between ministries rather than between Bund and Laender in any given policy area. The underlying principle is called *ressortprinzip* and is written into the constitution (Article 65). It means deference to the autonomy of ministers and ministries. It is underpinned by the relatively small number of generalists in the German civil services; most people in a health, or economics, ministry have been in that ministry for most of their careers.

Minsterial autonomy means that, when things go wrong, Germany can have multiple contradictory positions and not even know it. And at the end, when some coordination is required if a country is to vote in a Council and when disagreeing ministries learn what they are doing, Germany is famous for not voting ("abstention is the German vote" fumed one interviewee for this report). This comes with relatively weak central coordination. As Article 65 makes clear, the Chancellor (prime minister) can, of course, override ministers, and a call from the Chancellor's office can put an end to ministerial adventuring. But the routine coordination carried out by the French SGAE or British Cabinet Office European Secretariat is often not present, and ministries do not turn out to voluntarily contact each other that much (whether for strategic reasons, because of time pressures, because they do not know who to contact, or because they do not see the point). There is no SGAE monitoring all activity in the hope of finding divergence, and coordination is often passive.[13]

Divergence might be caught in Brussels. But Permanent Representations are busy places. The Dutch might make time to drink coffee together and review the day's agenda at "morning

13 For a description of German environmental policy coordination that fits health well, see Chapter 6 in Jordan, A and Schout, A (2006) *The Coordination of the European Union: Exploring the capacities of networked governance*, Oxford University Press.

prayers",[14] but most officials, of most countries, are too buried in the agendas of their own policy areas to investigate potential policy conflicts in depth. The German Permanent Representation is like its peers in this – fragmented by the sheer amount of work.

If ministries can 'hide', something that is much easier in Germany than in France, then sometimes they will. It can be rational for a weaker ministry (such as Health) to let issues develop in Brussels until they have a momentum of their own and cannot be blocked by a stronger ministry. There are, for example, obvious clashes between the goals of health and economics ministries, which is in all of our countries often willing to turn a blind eye to health concerns in the pursuit of revenue and economic growth. In these debates, tobacco has been a sore spot in all four countries, not just because it affects powerful interests but also because tobacco control involves a short-term loss of revenue (tobacco taxes) for a long-term gain in healthy and productive life-years. In all four countries the economics and finance ministries are more powerful than the health ministries – especially so in Germany, where the economics ministry does much of the EU policy coordination. If participating in coordinating mechanisms means letting an opposed ministry decide policy, then a little less coordination might be entirely rational. This could not happen on any significant level in the UK or France because the SGAE and the Cabinet Office European Secretariat exist to pick up such divergence (backed up by those countries' foreign ministries) and because those countries' bureaucratic cultures punish such efforts to bypass coordination. Of course, good practice in Germany is to involve other ministries early – if for nothing else, to defuse what conflict can be defused. In the same way, minsterial support matters. So once again, influencing the consensus – writing the first draft – matters in Germany's system.

Informal influence

As with any country, Germany's formal system is only part of the story. The particular officials and their talents for German and EU politics matter enormously. But the formal structures of German consensus can require time-consuming work that reduces its direct ability to shape EU policies. Simply put, the kind of strategic action that France can indulge in is hard if Germany is tied up developing its own internal consensus. It is the relative weakness, or absence of Germany at these informal engagements, that make it a relatively reactive member state.

---

14 Soetendorp, B and Andeweg, RB 'Dual loyalties: the Dutch permanent representation to the European Union' in Kassim, H et al eds (2000) *The National Co-ordination of EU Policy: The European level*, Oxford University Press, 211–228.

A state exercises informal influence when it identifies EU policy developments at an early stage, carries out impact assessments, formulates an approach if not a specific agenda, and then has its officials move across different informal and formal groups, such as Gastein and the working groups of the High Level Group. Activity means engagement, even if it is not coordinated. Furthermore, it is here that the line ministry is most capable of hiding from its formal central overseers. There is no reason for the federal health ministry to inform the Economics ministry of a developing public health agenda in Brussels, and nothing would be more logical than for it to keep quiet until the agenda was firmly set.

So the problem, in principle, is that the German federal ministry is less capable of speaking for Germany than the French ministry because the French ministry only needs to operate its internal coordination system (unless it enters an interdepartmental fight of some sort), while the German federal ministry might not be speaking for Germany's full range of governments or even the German federal government. The picture seems bleak. But there is an abundant literature pointing out that, despite its structural difficulties making unified policy, Germany has had extensive influence over the substance of EU policy.[15] This study certainly found that.

The first reason is that the simple technique of having Land officials shadow federal officials improves communication. A federal or Land representative can intervene in groups, especially lower level ones such as the working groups of the High Level Group, because he or she has a well-briefed Land counterpart who can detect problems. This might break down at the highest levels where formal coordination is required, but at the lower levels of EU meetings it appears to work well. A second part of the answer is that Germans lobby more than most countries; in a quantitative study of different countries' engagement with EU, we found that Germany and the UK are among the countries whose interest groups are particularly likely to join EU-groups while France and Spain, along with the other Mediterranean countries and the 2004 accession states, are less likely to join groups that lobby the EU. If we are to count interest groups such as NGOs (non-governmental organisations) and professions, then Germany is active even when the German state is not.[16]

But Germany – the state – is more active than it might seem from the constitutional picture. This is because of the large number of German officials who attend informal events with a

15 For a short review and excellent example see Dyson, K and Goetz, KH 'Living with Europe: power, constraint and contestation' in Dyson, K and Goetz, KH eds (2003) *Germany, Europe and the Politics of Constraint*, Oxford University Press.

16 See Greer, SL et al (2008) 'Mobilizing bias in European Union Health Policy', *European Union Politics* 9(3), 403–433.

more or less clear idea of their objectives. Every Land office in Brussels has a representative from its ministry responsible for health (or ministries, since some divide between public health, part of the environment ministry, and health services, which are associated with social services). That is a workforce of perhaps two dozen Land representatives in Brussels who follow at least the most prominent health policies. It is conventional to say that this is a waste of human resources, but it is also an impressive investment in human capital and EU skills across German government that pays off in terms of people capable of influencing EU policy. Thus, for example, the Commission sends officials to meet with the Laender representatives in Brussels. This might just be the Commission's ongoing search for information and legitimacy, which leads it to seek out many sources of information. But there are many groups that could make similar claims. Interviewees for this report suggested that it is ultimately because the Commission would rather that its agenda reflect the views of the powerful regional governments that could lead the EU's biggest member state to veto their plans.

Conclusions

The result of German fragmentation is a relatively reactive EU policy. Germany, as any interviewee said, expends much of its effort on building its own internal consensus. That is time not spent lobbying and shaping debates in Brussels. Individual Germans do a great deal of influencing, and many policy areas of the EU show marked German influence, but Germany as a member state is often missing in political action and abstains in Council votes. Coordination – even the largely amicable and productive relationship between the Bund and Laender in health – takes up time and resources that could do something else. Several German interviewees spoke rather wistfully of the quality of briefing they see on the side of France or the UK: no matter the issue, they said, the British and the French had briefings, prepared positions, arguments and facts at their fingertips. One spoke wonderingly about the British habit of keeping a file on any likely issue, updated after any development or annually if nothing was happening, and wished something like that could exist in Germany. They, at least, blamed the German need to devote resources to internal coordination.

Germany also shares the common problem of a low level of engagement with the EU in health departments. Explaining EU policy issues to other health ministry officials is hard; forwarding dozens of boring emails about EU issues can annoy other officials (and Germany was one of the countries for which interviewees spoke about the challenge of informing line officials without irritating them). The international unit of the federal health ministry must work to induce colleagues to help them with impact assessment, policy formulation, or even wish lists. This problem is worse at the Land level; there are few full-time officials working on EU health affairs. Land departments' strength and weakness is their local focus; the EU

can seem very distant, and even for things that unquestionably matter (such as state aids to hospitals or the Working Time Directive) the complexity of EU engagement and low salience might make it more rational to do something else.

Some German officials interviewed for this report when (as the saying goes) presented with lemons, made lemonade and pointed out that if the German position is decided the morning of a Council decision, that very lateness means that the German position will take into account all known information and the exact political situation at the time. This is an optimistic view; France, for example, can make last-minute changes to its positions if the *cabinets* are involved because they are a fast and hierarchical mechanism in themselves, and it pays none of the costs of the German system (though France does 'overthink' and become rigid on less salient dossiers). There are two kinds of problems. First, the decision-making process produces inflexible positions, hampering Germany's ability to negotiate: there is a trade-off between consensus and speed that cannot be eliminated by email alone. Second, the slow pace of German decision-making reduces its ability to 'sell' a point during the decsion-making process; Germany abounds in capable and influential officials who can make its argument, but the German system does not always supply them with the argument.

The Federal Republic of Germany has a long and articulate tradition of complaint about federalism, and a long and tortured history of trying to reform it. EU health policy-making, at least, shows no signs of being one of the areas of trouble, in large part because of large areas of substantive agreement and because of the good working relationships between the relatively stable cadre of people who work in the field. Germany shows how a small network of people can make the complicated relatively simple if they are bound by trust and mutual respect. But admiring that trust between regional and state government officials is not enough. They work together because they must. That is a key point about the structure of EU relations, and states more broadly. Germany has a system based on what is essentially legal equality between the Laender and the Bund, underpinned by veto power. From that basis, much cooperation is possible and takes place. So we have two poles, one of hierarchy and one of egalitarianism. France demonstrates the power and effectiveness of hierarchy as a tool to influence EU policy. Germany demonstrates the power of legal equality and consensus as tools to preserve an established constitutional balance under threat from the EU's growing competencies. The next two countries, the UK and Spain, are both in motion between these two poles, and show different ways of working out the tensions between the EU, domestic policy-making, and their constitutions.

United Kingdom

Britain and France are the two member states that traditionally seek unified EU policies of all kinds. The difference is that the UK, on a day-to-day basis, is less internally hierarchical and fractious. If France is hierarchical, Whitehall is more of a network. That is because Whitehall is still mostly a unified civil service body; despite the growth of special advisers attached to ministers, the top levels of British administration are still dominated by generalists from a single corps of officials with a strong culture of active information-sharing.[17] If anything, this should make British coordination smoother and friendlier, with the civil service smoothing out policy contradictions and political disagreements clearly set out for presentation to the right Cabinet committee. But Whitehall is changing, with less territorial unity since devolution and a slow but steady reduction in the role in health policy of classical Whitehall civil servants.

Formal decisions: determining the UK position

The Department of Health (DH) is the line ministry with two sets of responsibilities. One is for the management and policy of the National Health Service in England. This job overwhelmingly dominates the department; no other ministry in Europe has a problem as immense as directly running a health service for 55 million people. The other job is as a UK department, responsible for the work of the UK government in health. Given that public health and health services are overwhelmingly devolved to Northern Ireland, Scotland and Wales, that means little more than EU and international relations.[18] The departments responsible for health in Northern Ireland, Scotland and Wales share the preoccupation with running health services and have even fewer resources dedicated to international work (none of them have full-time health department officials dedicated to EU issues).

Reflecting this imbalance between its roles as a UK department and an English health department, the DH is organised and staffed to run English health services rather than make the UK's EU policy. In an ongoing study of the DH, a colleague and I have found

17 For the relatively low level of noncoordination in the UK, and the observation that failure to coordinate tends to be a political, not technical problem, see Page, E 'Joined-up government and the Civil Service' in Bogdanor, V ed. *Joined-up Government*, 139–155.

18 The other key responsibilities are for professional regulation and – to date – for training and pay settlements, where the devolved governments agreed to DH leadership. See Greer, SL and Trench, A (2008) *Health and Intergovernmental Relations in the Devolved United Kingdom*, The Nuffield Trust; also Lodge, G and Mitchell, J 'Whitehall and the government of England' in Hazell, R ed. (2006) *The English Question*, Manchester University Press, 96–118.

that almost none of the top officials of the DH are the traditional Whitehall officials of UK politics textbooks. Instead, they are mainly NHS managers and health professionals.[19] This changing in staffing, and the priorities it underlines, has two effects for EU policy. One is that they lack the networks of traditional civil servants that underpin information-sharing and handling interdepartmental relations. The other is a tendency to focus on departmental concerns rather than health issues which affect (or stem from) other government departments.

The International Division of the DH is the focus for EU policy. This means that it is the hub for EU affairs but also that, in keeping with the general UK approach, it tries to speed the 'mainstreaming' of EU affairs in other parts of the DH and NHS. The idea is that knowledgable officials should go to EU meetings and formulate UK positions as much as possible, with the International Division and the central coordinating bodies keeping an eye out only for complex problems or contradictions in the developing UK line. This level of trust and active information-sharing is remarkable, and partly possible because of confidence in UK traditions of very active information-sharing – copying everybody relevant into every communication.

The hub of the UK EU machine is the Cabinet Office European Secretariat. The Cabinet Office is the centre of government, and its coordinating roles mean that its officials get responses more quickly and fully than almost any others. It traditionally served the government collectively, convening the machinery of official and political committees to identify and resolve disputes between departments. The Blair governments converted it, on paper and often too in reality, into a vehicle to service the Prime Minister and deliver his agenda. This was in keeping with the view held by many – both politicians and officials – that the UK's problem was too little power at the centre.

The European Secretariat is one of the most important parts of the Cabinet Office, and carries out the traditional role of a Cabinet Office unit. Its role is to apply its traditional skills to the formulation of EU policy. These are to:

- identify emerging issues and emerging departmental 'lines'
- identify contradictions

19 See Greer, SL and Jarman, H (2007) *The Department of Health and the Civil Service: From Whitehall to Department of Delivery to where?,* Nuffield Trust; also Day, P and Klein, R (1997) *Steering But Not Rowing? The transformation of the Department of Health: a case study*, Policy Press.

- convene an escalating series of forums to resolve contradictions and prepare a UK line (starting with email or phone calls, running through official to ministerial committees, and on paper eventually ending in Cabinet, or at least a decision by the Prime Minister and the inner circle of Government).

As they are copied into essentially every piece of paper or email of importance, their routine coordinating ability is impressive. Departmental divergences tend to be the product of unresolved political divergence, and in such situations the European Secretariat will use its series of meetings to force decisions.

Then, in Brussels, there is the UKREP – the Permanent Representation. The Permanent Representation takes its line from the Cabinet Office European Secretariat, from the Foreign and Commonwealth Office (which runs it), but communicates directly with the DH and other line departments. In most routine cases, that means the European Secretariat is only generally aware of a line created in the DH and put forth by UKREP and visiting DH officials. In more political cases, there will be a decision orchestrated by the European Secretariat for UKREP to put forth. UKREP also puts a great deal of effort into lobbying, and is generally highly active. The UK is again like France: it is line ministry officials and the permanent representation that try to shape opinions in Brussels, while the coordinators in the capital mostly coordinate and develop strategies.

This is an impressive machine, one admired by most countries that deal with the UK. The problem is that the Whitehall machine has not adapted to devolution. It has not done so because British political leaders are only adapting slowly. In formal terms,[20] the devolution legislation is clear that EU matters are for the UK, and if a devolved government breaches EU law it pays the fines. That said, the legislation and the White Papers surrounding the birth of the devolved bodies are also clear that the UK should consult the devolved administrations and take their views into account.[21] Combined, this works out to an injunction that the UK should try to represent devolved opinions as well as its own.

The ambiguity worked well for the first decade of devolution. Regardless of whether they invented the model or learned, the officials responsible for the UK, Scotland and Wales in Brussels developed what might be the most successful model of regional influence – a relative score, given that it only means there was less complaint than from most other

20 Greer, SL and Trench, *A Health and Intergovernmental Relations in the Devolved United Kingdom*.
21 Jeffery, C and Palmer, R 'The European Union, devolution, and power' in Trench, A ed. (2007) *Devolution and Power in the United Kingdom*, Manchester University Press, 218–238.

ambitious regions about their member states. Scotland and Wales operated, on one hand, as lobbies: they both have large offices at the Rond-Point Schumann, the symbolic centre of the EU, and they are both active in pan-EU regional groupings. But the devolved governments also worked through the UK – being able to coordinate their own lobbying with the power and resources of a major EU member state gave them the best of both worlds. Scotland, for example, was able to gain some visibility in the launch of the 2005 EU green paper on mental health (a topic that interested its ministers at the time) by working through UKREP. Informality, meanwhile, meant that the UK could get by without ponderous German coordination mechanisms. The result was that Scotland and Wales had all the tools of regional lobbies, and privileged access to a big EU member state – a member of the small club of states that would cut deals and present them to the rest of the EU as a *fait accompli*.

There were serious accusations of problems – most cuttingly, from the head of the Scottish representation in Brussels in a report leaked in January 2007 (see below). But in health, interviewees found no problems; while we might wonder about Scottish priorities in 2005 (attending the launch of a mental health strategy rather than intervene in the debates about the Services Directive), it got part of what it wanted in that low-salience area. Interviewees in Northern Ireland and Wales, likewise, reported no serious problems. Neither Scotland nor Wales, of course, put a great deal of effort into their own risk assessment or EU health strategy; they were happy to trust the UK government.[22] Northern Ireland intermittently joined, but its political headlessness, intermittent disorganisation, divergent priorities and different relations with the EU, UK and Republic of Ireland made it rather distinctive. Overall, devolved 'customer satisfaction' with the International Division of the DH was very high.

Formulating a common UK line, then, falls to four analytically separable mechanisms. One is civil service-to-civil service contact; the International Division of the DH keeps in touch with the EU leads for the three devolved administrations. This is a very low-capacity sort of connection, because the level of devolved knowledge of and interest in EU matters can be very low. The second is through the 'territorial offices' in the UK Ministry of Justice; the Scotland Office, Wales Office and Northern Ireland Office, unlike the Scottish Government, Welsh Assembly Government and Northern Ireland Executive, can be copied into UK government correspondence and sit in relevant committees. Of

22 As a DH official said in May 2006, the EU contains, and must make policy for, very diverse states. The differences between Sweden and Romania are so vast, in his view, as to make the differences between England and Wales irrelevant for most policy. His devolved counterparts at the time agreed.

course, they are parts of the UK government, not the Scottish one, so they are better suited to mediate disputes than persuade a UK Labour government that it should implement the wishes of nationalist parties Plaid Cymru, Sinn Féin or the SNP. Third, there are formal intergovernmental venues, called Joint Ministerial Committees (JMCs). In these, ministers meet to discuss issues. Most 'functional' JMCs do not meet, but JMC Europe, on EU strategy, and a JMC-like meeting on agriculture tend to meet regularly and receive good reviews. No JMC associated with health meets regularly, but JMC Europe has discussed the European Working Time Directive and the Services Directive, both of which directly affect health. Since the start of the Brown government, the Cabinet Committee on National Security, International Relations and Development Sub-committee on Europe (NSID(EU)) has replaced JMC Europe, which brings EU affairs firmly under the UK government. Finally, there are political-level contacts not routed through the JMCs, such as contacts between special advisers and sometimes ministers. These appear to have mattered more when it was Labour special advisers and ministers sorting things out among presumptive allies. Some devolved interviewees commented that by late 2006 that they could go for months without hearing from Whitehall.

The problem with all four is that none works particularly well, whether because of general disengagement (as with civil service contacts and JMCs), because of political conflict (as with ministerial contacts), or because of fundamental contradictions (as in the position of the territorial offices: it is hard to be part of the UK government and an advocate for a devolved government run by a different party). Or, to put it differently, the mechanisms designed to formulate a common UK line work best when there is implicit agreement or implicit hierarchy behind them. Neither holds; sometimes there will not be a common UK line because its four governments do not – and do not have to – agree.

If there is no agreement, then problems come to light. There are three basic problems with the UK approach. First, the UK government is dominant. That might not sit well in case of divergence or even fit with Scotland's current self-projection. Second, the big organisations of Whitehall do not regularly integrate their work with Scotland or Wales. This could mean forgetting to ask for Scottish or Welsh views, or ignoring Scottish or Welsh priorities. A famous memo leaked in January 2007 made this case, and much electoral play for the SNP as well. In it, Michael Aron, the head of the (then-) Scottish Executive Brussels Office wrote that Scotland was often "kept out of the loop" with consequences that could be "disastrous".[23] Whitehall officials do not need to be very busy

23 Fraser, D 'Scotland "finding itself frozen out of Brussels"', *The Herald*, 22 January 2007. www.theherald.co.uk/politics/news/display.var.1137459.0.0.php, accessed 22 January 2008.

or defensive to forget about Scotland. That is a feature of organisational life, although Aron argued that the downgrading of the territorial Scotland Office to a mere part of the now-Ministry of Justice was part of the problem.

But there is a third and bigger issue. The UK applies standard interdepartmental dispute resolution mechanisms to intergovernmental disputes. But agreement cannot come about by administrative organisation alone. The unity of Whitehall depends on the unity of Westminster. A unified civil service only works when combined with collective Cabinet government because the priorities between departments are necessarily different. Collective responsibility means that high-level politicians will eventually have to agree. But there is no reason why the Scottish Government or the Welsh Assembly Government, under any leadership, should be subject to that kind of discipline. Their incentive is to fight when they care about the policy or when they want to make a political point. Westminster shares those incentives. If there is no consensus, then dispute resolution premised on consensus will not work, strategies that work best with consensus – like the existing EU strategies – will not work, and dispute resolution based on the UK government's supremacy will rub intergovernmental relations raw.

Failure to take account of the stresses and strains of devolution is, indeed, an existential threat to the Whitehall civil service itself, which seems largely unaware of the speed with which its members in Edinburgh and Cardiff, and their governments, are moving away from any interest in a unified civil service.[24] A Scottish official remarked in January 2008 that in his view most Scottish Government officials fully expect to be part of a separate Scottish civil service soon, while his colleagues in Whitehall have not even thought of such a possibility.[25]

Informal influence

The UK excels in informal influencing in Brussels and health policy is no exception. Informal influence comes from participating in events; being well briefed; understanding the national government's position on issues at an early stage; and hiring skilled officials with good connections (and perhaps also a great tolerance for long meetings). The UK does well in both developing a government focus on influencing early stages of policy formulation and maintaining connections with the broader EU policy community.

24 Greer SL, 'Whitehall' in Hazell, R ed. (forthcoming) *Constitutional Futures Revisited: Britain's Constitution to 2020,* Palgrave Macmillan.

25 Private Nuffield Trust seminar, January 2008, Edinburgh.

To maximise government influence on informal EU decisions, the best strategy is to have well-briefed officials saying the right things at the right meetings (and at the dinners the night before that strangely few countries attend). The DH, like other health departments, still lacks a European culture on the scale found in, for example, agriculture. This means convincing line officials that paying attention to the EU is a good use of time, a hard sell given that most of the DH is dedicated to the central management of the English NHS. Much of the burden here, as in France, is borne by the International Division of the DH. It has had a highly stable personnel, which makes it unusual in Whitehall, and it is dominated by civil servants rather than NHS managers, which makes it a rarity in the DH. This stability has allowed its officials to develop networks, understanding of policy and personal reputations that stand them in good stead (and lead to some of them, particularly from the UK Department of Health and the German federal health ministry, constantly referring in interviews to specific officials from other countries as models of effectiveness).

But despite that, the most effective mechanism is to have line officials, managers and experts doing the advocacy rather than the generalists of the international division. This means that the day-to-day work of the International Division often involves inducing line officials to take an interest and tutoring them. In theory, it will be able to draw back and focus on developing an overall UK line, and dealing with interdepartmental issues, while much of the day-to-day expert work is done by other parts of the department.

The UK has made a good start. Many EU networks have a high percentage of people from or based in the UK, and some of them work for the UK government. The NHS Confederation has a strong lobbying operation of its own in Brussels. The DH supports this, in keeping with the Government's agenda of separating the NHS from the DH. It reinforces the UK's visibility, and could either reinforce or counteract the UK position to the extent that a lobby can. The Health Protection Agency and its current or former staff are ubiquitous in European communicable disease circles. Some senior officials and ministers have shown sustained interest in recent years, with initiatives such as Chief Medical Officer Liam Donaldson's work on patient safety, which signals to their subordinates that the EU matters. This has not identifiably been the case in the other countries. EU health policy in the UK is far from where it might be, or where EU policy is in agriculture or trade, but the ability to plug into these networks, and the strong signals to officials that EU health policy is being taken seriously, have had an impact. The effect is that it multiplies the eyes and ears of the UK government on the ground.

Combine this relatively high level of engagement, which could be much improved but which no member state appears to have bettered, with the overrepresentation of the UK

among lobbyists and academics interested in EU health policy. The chances are good that somebody in a meeting will have a 'British' approach and set of values and assumptions even if they are not privy to the UK government line or do not agree with it. Even if the specific thinking of the government is a mystery, the basic needs and realities of the NHS are likely to influence a person working in or from Britain. This holds for the UK's devolved governments; they share NHS-model systems, with similar needs and possibilities, even if their policies are very different. Their offices have not been particularly engaged (although the Welsh office in Brussels has long taken some interest and is becoming increasingly serious about it), but as they become more engaged they contribute to the overall activity of the UK state – even if they also diminish its coordination.

Conclusions

The UK has been very well adapted to influencing EU affairs. Part of this was institutional design. A relatively non-hierarchical civil service with a tradition of generalism, strong central and departmental coordination, and a commitment to information-sharing and 'mainstreaming' EU policy all helped. It is easy to point out the considerable extent of hierarchy, non-coordination, communications breakdowns and introversion, but by the standards of this study the UK does well.

The biggest conclusion is that the UK will need to adapt its system of EU health representation as part of overall adaptation to the challenges of devolution. This is discussed in greater detail in the concluding policy recommendations. From the point of view of influence in Brussels, the UK in recent years has been as effective as any of the best member states, and in the eyes of some interviewees was the best. But if there is anything to be learned from this comparative review, it is that constitutional politics trump adaptation to EU influence, and so the UK will have to reconfigure its EU policies to fit with the impossibility of achieving a high degree of coordination in a devolved country.

Spain

Spain, we might say, combines a French attitude to public administration with a level of territorial diversity more like that of the UK, and produces the highest level of fragmentation of the four countries reviewed here.[26] The big difference between decentralised Spain and decentralised Germany is, as students of comparative federalism say, that the German Laender are 'built into' the Bund. The Bund government contains both a directly elected Bundestag and the Laender chamber Bundesrat; it makes no sense to talk of a German position without taking both into account. Because of this favoured position, the German Laenders' own lobbying efforts can be lavish (as with Bavaria's Brussels office), but need not bear the entire weight of regional aspirations.

This has not been the case with Spain. Spain decentralised a previously French-style jacobin state by carving out areas – of policy, of law, of money and of administrative resources – for the Autonomous Communities. The state remained intact but with fewer powers, responsibilities and resources. In health, this meant a lengthy process, spread over approximately 1979–2000, during which the autonomous communities took over responsibility for health services and public health such as it is. The jacobin state remains, with many centralist tendencies, but it lacks powers to do much of what it might expect to do. The other side of the coin, historically, is the mobilisation of stateless nations and some strong regions: Catalonia and the Basque Country, pre-eminently, but also Galicia and the distinctive but non-nationalist Andalucia, Madrid and Valencia (the latter three also serving as showcases for their dominant political parties). Two centuries of Spanish history have been about the state's efforts to assimilate them and their efforts to gain autonomy or independence. The democratic constitution of 1979 did much to resolve the tension with autonomy for regional governments, but the tradition of regional–central contention is still very important. Spanish intergovernmental relations have been zero-sum and contentious; Catalonia, the Basque Country and some other Autonomous Communities 'won' powers from the central state in 20 years of administrative struggle. In such a situation, it was natural for governments to behave like racing-car drivers, driving separately, trying to get ahead of each other, and sometimes cutting each other off.

The history of Spanish intergovernmental relations since 1979 has been one of coping with these tensions – initially with an emphasis on combat and disharmony, and more recently to an emphasis on 'building in' the autonomous communities. At each step the process has been highly political, with the partisan complexions of different governments

26 See Closa, C and Heywood, P (2004) *Spain and the European Union*, Palgrave Macmillan.

crucial to understanding their approach to intergovernmental relations. But it has also been the clearest case of relatively apolitical learning of the four countries reviewed here; Spanish governments have found that the challenges of coordination in health and EU politics demand a level of coordination if they are all to avoid being losers.

Formal decisions: determining the Spanish position

The process of extracting regional competencies from the state produced one of the more remarkable features of contemporary Spanish public administration: the Ministry of Health in Madrid. The Ministry used to have direct responsibility for providing health services for most of Spain. Now it runs essentially nothing. This poses a major strategic challenge for the ministry, and leads many outsiders (especially Catalans) to ask what its employees are doing all day, given that interviewees from the Autonomous Communities tend to see its usefulness as confined to a very diplomatic sort of international relations (such as tracking people with infectious diseases – a Ministry can ask another country for information that no regional government could get). Interviewees of all political stripes complemented minister Ana Pastor of the former Aznar government for trying to live up to the strategic challenge, but Pastor's term is long over and many of her initiatives proved difficult to implement. Much of the ministry's visibility now lies in its constant advertising campaigns on public health issues, and much of its health policy activity is focused on 'cohesion'. Cohesion matters mostly for Spanish domestic health policies, but it is an effort to unify and guarantee standards through a contentious and still largely undefined mix of consensual and imposed standards. It might lead to nothing at all; that will depend on the political skills and agendas in Madrid and the Autonomous Communities. This backdrop is important, because it means that the usual bad blood ('mala leche'[27]) between the central state bureaucracy and the more dynamic of the autonomous communities is exacerbated by a large and proud ministry of state that is looking for a role and has little more than its international role for a starting point.[28]

In theory, the Ministry is responsible for developing EU policy ideas and conducting impact assessment (a topic on which some interviewees thought it performed poorly). It then works with the Secretariat of State for European Affairs (SEAE), which is the

27 Literally, 'bad milk'.

28 In the course of the research for this project the author sent one regional policy-maker a book chapter about Scotland which suggested that having the same party (Labour) in office in both the UK and Scotland eased relations. Drawing on years of experience of just that situation in his region, the interviewee said he disagreed with that point! (The chapter was Helen Fawcett's 'The making of social justice policy in Scotland: devolution and social exclusion' in Trench, A ed. (2004) *Has Devolution Made a Difference? The state of the nations 2004,* Imprint Academic, 237–254.)

central coordinating unit. The SEAE, like the French SGAE, has varied in its official status (the rank of its political and civil service heads, and its relationship with the ministry of foreign affairs). Unlike the SGEA it has not been able to monopolise Spain's formal EU policies in the same way; while the Spanish central government is quite hierarchical, it has turned out to be difficult to instill a bureaucratic culture of information-sharing. It also has the problem that as part of the central state it is a long distance from the autonomous communities, which are responsible for most Spanish health policy, and the long tradition of central–regional suspicion maintains much of that distance. The result is that it is an arena for debates over EU policy rather than having a monopoly of EU policy-making.[29] The Ministry, like its peer departments, conducts lower-level EU operations more or less on its own. That means it is the key actor in the OMC, High Level Group, and other forums. As with the other countries, there is a theoretical need for the centre to monitor potential cross-departmental conflicts, but such everyday, active, coordination is rare.

In Brussels, the Spanish permanent representation fulfills the same tasks as the other permanent representations, with dossiers on health typically prepared by the Ministry of Health and routed through the SEAE. Given that Spanish coordination tends to happen at the very top, and is often done by the diplomats of the Ministry of Foreign Affairs, technical and lower priority issues often go unexamined until the last minute – if even then. This shows in relatively vague instructions for Spanish officials at lower-level events and occasional last-minute decisions by the centre.

Naturally, such an arrangement at the centre of government is a poor fit with autonomous communities that often see their own international projection as an end in itself. Even if Andalucian health policy is not very distinctive, it is important for Andalucia that its health policy have some representation in Brussels. The Basque Country and Catalonia are particularly emphatic – like Scotland, they see international activity ('projection') as an end in itself and an affirmation of their nationality.[30] And given that Spain lacks German imperatives to coordination and consensus, the Spanish regions and government are free to block and counteract each other.

The result has been poor coordination, exacerbated by the central state's own tendencies to fragmentation and tardiness. Region–state tension increased policy and implementation

29 Molina Álvarez de Cienfuegos, I 'La adaptación a la Unión Europea del poder ejecutivo Español' in Closa, C ed. (2001) *La Europeización del Sistema Político Español*, Madrid: ISTMO, 163.

30 For an interesting and informative sample see Urgell, J ed. (2003) *Donar Protagonisme a Catalunya: acció international i política de relacions exteriors catalana*, Barcelona: Pòrtic.

problems for the state, and regional governments were frustrated by their inability to influence the Spanish vote in the Council meetings that decided so many important policies. The solution[31] was a quasi-German innovation: 'sectoral councils' in which the autonomous communities and central state meet to discuss and coordinate policies (the health council is called an 'interterritorial' council. The difference is only in the name). In the councils, all the problems of an asymmetric state come up again. From the point of view of nationalist politics, it is obvious that the Basques should have a say in Spain-wide health policies. From a health system point of view, the Basque, Catalan and Valencian systems are so different as to have different issues at stake in the EU.[32] From a constitutional point of view, all the autonomous communities have health systems, so tiny La Rioja should have a say as one of the health systems of Spain. From a population point of view, some see it as preposterous[33] that La Rioja and the Basque Country have a vote such that they could join a coalition and block a decision led by the three Autonomous Communities that treat most of the Spanish population: Catalonia, the Community of Madrid and Andalucia. Beyond this mathematical problem, there is the problem that the autonomous communities and central state have many incentives to disagree, deal, and pick fights. The result is that, by general consensus, councils only work well in a few areas.[34] Two of those are healthcare and Europe – and in both cases it is because they *have* to work if Spain is to enjoy any measure of policy integration and coordinated political activity in Europe.

The councils were not just technical; the obvious trigger for their creation was the dependence of the minority Aznar government on the votes of nationalist and other small parties between 1996 and 2000. Part of their price was the creation of a mechanism that would allow them to more effectively engage in central state policies, and thus the councils were born. The Aznar governments' absolute majority in the 2000 election muddied the water substantially. The councils, and other innovations in intergovernmental

31 I focus on the Councils because interviewees named them as the main institutions. A fuller analysis of the range of mechanisms and issues can be found in Colino, C 'La integración europea y el estado autonómico: europeización, estrategias y cambio en las relaciones intergubermentales' in Closa, C ed. (2001) *La Europeización del Sistema Político Español*, Madrid: ISTMO, 225–262.

32 Adelantado, J et al 'Las políticas públicas autonómicas: capacidad de autogobierno y estado de bienestar' in Subirats, J and Gallego, R eds (2002) *Veinte Años de Autonomías en España: Leyes, políticas públicas, instituciones y opinion pública*, Madrid: CIS, 203–250.

33 As some interviewees argued. German interviewees often spoke of their irritation with both federalism and the major role for small Laender, but without the vehemence found in Spain.

34 The most optimistic author is Börzel, T (2002) *States and Regions in the European Union: Institutional adaptation in Germany and Spain*, Cambridge University Press.

relations, were cast into the shadows by the bad political relations that developed between the government and the autonomous communities between 2000 and 2004. As a result, the often poisonous debate between Madrid and the Catalan and Basque political leadership overshadowed the low-level institutionalisation of the councils. It also limited their high-level effectiveness because it meant that there were not many politicians who were willing to accept influence from other governments. The Partido Popular's style of opposition to Zapatero after 2004 did not help; its governments sometimes refused to particpate. Ostensibly this was due to complaints about how funding was being negotiated; in reality it was part of a strategy of frontal opposition to Zapatero.

Between 2000 and 2004, and even 2004 and 2008, it required an optimist to focus on the institutionalisation and ignore the *mala leche* between Madrid and some autonomous capitals. The best that could be pointed out was that the councils, when not humbly doing their job, were sometimes seen as the natural forum for arguments.

The problem that the councils faced then, and still face compared to other countries, becomes clear when we compare them to the German strategy. The councils exist partly because of policy failures from poor coordination, but mostly because strong autonomous community governments sought and fought to have them. They are institutional and legal concessions by the Madrid government, while the Bundesrat is part of the German constitution. The councils have agreed agendas and the Madrid government must inform autonomous communities of major issues. Catalan interviewees complained that the information is late, poor quality, and hard to get while Madrid interviewees complained about autonomous nosiness and carping (in other words, information sharing is passive, so the autonomous communities feel underinformed and the Madrid ministries are annoyed by requests for information and snooping). The Germans reported no such problems because of the simple system of having people paired so closely; the Bund representative cannot go anywhere significant without a Land representative accompanying him or her, and the Laender have a constitutional right to receive all the EU documents that the central state receives (formally, via the Bundesrat). It is unsurprising that, once joined, Laender and Bund officials will often try to work together productively and share the load. While the Spanish councils for health (focused on coordinating life and death issues like transplant organs) and Europe work well by Spanish standards, information, agendas and initiatives are still weapons in them, and all the players are quite capable of just racing ahead alone.

The election of the minority Zapatero government in 2004, with much of its small plurality from Catalan votes, and coming after the victory of a Socialist-led coalition in Catalonia, marked a major change in Madrid's strategy and in Spanish intergovernmental

relations. Zapatero's Socialist party, the PSOE, is the strongest statewide party; the Popular party, its main Spanish opposition, is notoriously weak in the Basque Country and Catalonia. This enabled Zapatero's broad shift in intergovernmental relations. Aznar's government, and the Popular party, often ran *against* "the nationalists" (as they refer to the Catalan, Basque and smaller nationalist parties). This had uncertain electoral rewards in the Basque Country and Catalonia, but gave them considerable opportunities to shape the Spanish political agenda. By contrast, the Socialists' obvious strategy is to develop a web of shared interests with a variety of small parties so that they will have a range of supporters in the Spanish parliament as well as an electoral base across the country. Add in the merits of defusing conflict – above all in the Basque Country – and there is a compelling case for Socialist governments to make intergovernmental relations less political and more coordinated.

The Socialist approach to intergovernmental relations involved a number of related fronts. The most public and contested was the development of new Statutes of Autonomy for various Autonomous Communities. This allowed the Socialists to negotiate and grant expanded powers for the Autonomous Communities without opening up the politically dangerous topic of constitutional reform. The statutes sometimes disappointed – Catalonia got significantly less than it requested, and fractured politically, while the Basque Country proved intractable. But they expanded Autonomous Community power and might have closed the opportunity for further reform on that 'high politics' level. The reform of the statutes of autonomy took place concurrently with a financial reform to the 'common system' that governs the finances of most Autonomous Communities; it merged the health budget with other revenue streams, and addressed Catalan complaints that they were subsidising the rest of the country.

In EU health policy formulation, the changes were less visible but shaped by their place in the new overall Socialist approach to intergovernmental relations – and the long-standing interest many Spanish thinkers had in German practices. The most dramatic change was opening up the Council itself to the Autonomous Communities. The Autonomous Communities can send delegates to four councils – including the EPSCO Council, which covers health, employment and social policy. They may speak in agreement with the Spanish position but do not head the delegation. The autonomous communities rotate this responsibility alphabetically, and all have been in the Council at least once; a few have intervened with statements on behalf of Spain. This sometimes means that heavy dossiers are being carried by small autonomous communities; the small office, and public administration, of La Rioja is a far cry from the resources of a Catalonia, Basque Country or Andalucia. It would be quite reasonable for them to shift to a different

system in which the Autonomous Communities delegate different responsibilities to individual governments for longer periods of time (as in Germany, and indeed Italy).

This ability to speak in the Council is dramatic by the standards of EU policy-making (even if most citizens would probably find the Council rather dull), and autonomous community governments' press offices will sometimes make a big play of it. There are less dramatic forms of participation, including autonomous community participation in comitology. But there are problems. Large delegations from any country play into the general, EU-wide, pressure on delegation size (it is not just a practical problem that it has become hard to fit everybody into the Council meeting room). But what matters most, of course, is the position. In that sense, the representatives in comitology (largely outside health due to the weakness of comitology in health) are more important because of their well-documented autonomy. The policy is what matters, and a regional government of any country that is representing a position it dislikes is nothing more than an unusual sort of diplomat.

The policies in health and social policy are subject to the increasingly coordinated policy process developed by the Zapatero government. In it, there is an extensive agenda of issues that the councils discuss, with a substantial flow of paper between them and a much higher level of information exchange than took place under Aznar.[35] The Councils should, in principle, agree positions by majority vote, but in practice they work best when there is agreement, or a majority of autonomous communities with a shared position that they can negotiate with the central government. The central government's freedom is mostly a function of the level of autonomous community diversity, or disengagement. Given the relatively low salience of EU health policy in Spain, and the broad ideological congruence between governments on issues such as the Services Directive, there has not been too much tension here.

The result is that Spain has improved its formal EU coordination with a mixture of symbolic autonomous community participation and real, administrative-level, coordination of policy-making. This is partly a sensible adaptation to the exigencies of EU health policy-making, but it is embedded in the broader changes in Spanish territorial politics since 1996. The Socialists, and many autonomous community politicians, want to make Spanish politics better integrated and less combative, and they have supported a

35 Conferencia para asuntos relacionados con las Comunidades Europeas (2006) *'Guia de Buenas Practicas' Para la Aplicación del Acuerdo Sobre el Sistema de Representacion Autonómica en las Formaciónes del Consejo de la Union Europea*, Madrid: Ministerio de Administraciones Públicas.

process of institutionalisation and coordination that was sluggish in the conflict-ridden Aznar years. Whether this would change under a future government is unclear; Zapatero's Socialists won the largest number of seats in the Spanish parliament and formed the government again in 2008, so that is a question for 2012 or beyond.

Informal influence

Spain might be getting better coordinated, but it is not very active in EU health policy, or in many other areas. The EU, like most political systems, responds to energy, and Spain has directed relatively little energy into shaping its health policy system. This means that the Spanish government is often invisible in informal EU policy debates; just as there is a pronounced Mediterranean weakness in EU health lobbying,[36] the Mediterranean states are often invisible in EU health debates. When they appear, it is often via their connections in the Commission, which is in a sense the last resort of member states that have failed to influence the agenda. This appears to have been the case with the delays to the proposed directive on patient mobility, which several interviewees said was held up by the intervention of the Spanish commissioner.

It is here that decentralisation helps Spain by keeping it off the floor on the axis of informal activity. The activities of the autonomous communities, and their determination to be represented as a matter of principle, mean that they can participate in the informal debates that take place before legislation is published. Given that their formal involvement is relatively recent, they had no option but to develop 'soft' power and influencing strategies if they were to be heard in Brussels. When the Council door was closed, or the Spanish interterritorial councils weak, it was rational to focus on influencing the Commission and broader Brussels debates. This they did, and many autonomous communities developed networks and expertise that competed with, or outshone, the central state. This is a collective resource for Spain that makes it more active than its coordination systems and weak Ministry might lead the observer to expect.

Spanish policy shows that a determined and well-organised effort on salient issues (such as EU funding) can work very well, but it is not necessarily shaping the debate. Its informal and (still) formal fragmentation means that in Brussels the Spanish often work at cross-purposes. It probably reinforces the noted Spanish tendency to reactiveness; in any list of major EU countries, Spain is ahead of Italy and Poland but behind the others in its ability to identify and engage with emerging policy issues. Spain looks relatively good

36 Greer, SL et al (2008) 'Mobilizing bias in European Union Health Policy', *European Union Politics* 9(3).

compared to them because Spain is very good at pursuing a few policy objectives, not many of which touch on health. They are, typically, structural funds, fisheries, certain agricultural subsidies (often still picking apart deals sealed just before Spanish accession), and permission to delay implementation of EU laws. But that is often a result of, first, the intensity of Spanish interests in fish, regional development, and such; and second, of Spain's focus on those topics. The effectiveness does not spill outside the areas of constant political attention – and is still mostly at high-level negotiation stages, not earlier stages of policy influence when governments, such as those of the UK and France, can exert softer forms of power if they know what they want. It is for that reason that the autonomous communities' interest in their own projection and role, and the influence several of them have built up, serves Spain's collective interest well. Without the autonomous communities, a Spanish voice would often be quiet or missing.

Conclusions

Spain's is a happy story from some points of view, because it teaches us about concrete techniques and political approaches that can improve even very bad intergovernmental relations. There is more that can be done; the interterritorial/sectoral councils are still not built on a platform of formal equality between governments, and observers in some autonomous communities are keen to point out the formal and informal ways that the central government can shape the outcomes. Likewise, there is more scope for political change in Spain than in Germany or France. A dramatic election result in the central government, or a number of autonomous communities, could still put the newly constructed system of intergovernmental relations under pressure. Electoral calendars mean that will not happen for several years, during which the mechanisms of policy coordination and integration will continue to develop and become more entrenched. Even if there is conflict, the new councils are increasingly likely to become the arenas, and that would be a victory for transparency and the technical level of debates. The problem of course is that, compared to the other member states in this report, Spain's positions are less sophisticated, less influential on the agenda, and more likely to be proposed (imposed) by high political levels at the last minute.

But the growing institutionalisation of EU relations also means that the virtue of Spain's autonomous community activity is showing. The networks and soft skills, and activity, of the more prominent autonomous communities (Andalucia, the Basque Country, Catalonia and Valencia) help Spain in the informal politics and make it a more active country in EU health politics than it otherwise would be.

3. The future of EU health representation: recommendations

The most important lesson of the four cases is that constitutions matter. The explanation of the different member states' EU-level organisation in health is their general political and administrative makeup. Spain's organisation on the EU level depends on its organisation domestically. Germany is reactive because it is focused on its internal consensus, to the benefit of the Laender but to the periodic embarrassment of its representatives in the Council. France is internally contentious and highly political, much like the country, but the face the world sees is as glittering and organised as any of its architectural *grand projects*.

A member state's EU coordination is at its fastest and most unified when underpinned by hierarchy (as in France), and it is slowest but most consensual when underpinned by legal equality (as in Germany). France and Germany spend much time and effort on coordination, but get different payoffs. France gets a unified position and is free to strategize for the long term, while Germany gets internal consensus and votes last in the Council. Spain and the UK sit uncomfortably between the two, with efforts to create a unified, hierarchical form of coordination in conflict with demands that the regional governments join as equals with member states in determining their positions.

The UK spends less time on coordination than France, principally because it trusts its officials more and has more internal bureaucratic unity, but gets about the same payoff as France (possibly more, depending on how we evaluate its officials' constant policy advocacy in forums across Europe where the French are almost always absent). Spain often gets the worst of all worlds – no consensus, a good amount of time wasted in imperfect coordination, and implementation problems. Germany is a model for countries preoccupied with keeping their regional diversity (and its real problems in health are

between departments, not territorial levels); Spain's experience depicts a likely future for countries in which governments are more concerned about maintaining their room for autonomous action than about influencing each other.

But that merely points us back to the original problem for those who would improve EU coordination: the real benefits of the Spanish system are in avoiding a constitutional crisis in Spain and letting the various voices be heard, even if they are discordant and would be more powerful in unison. The real benefit of the German system is in preventing the massive disempowerment of the Laender and constitutional change by stealth. And the UK is going to demonstrate over the next few years that EU policy-making depends on the domestic constitution more than any design for effective EU engagement.

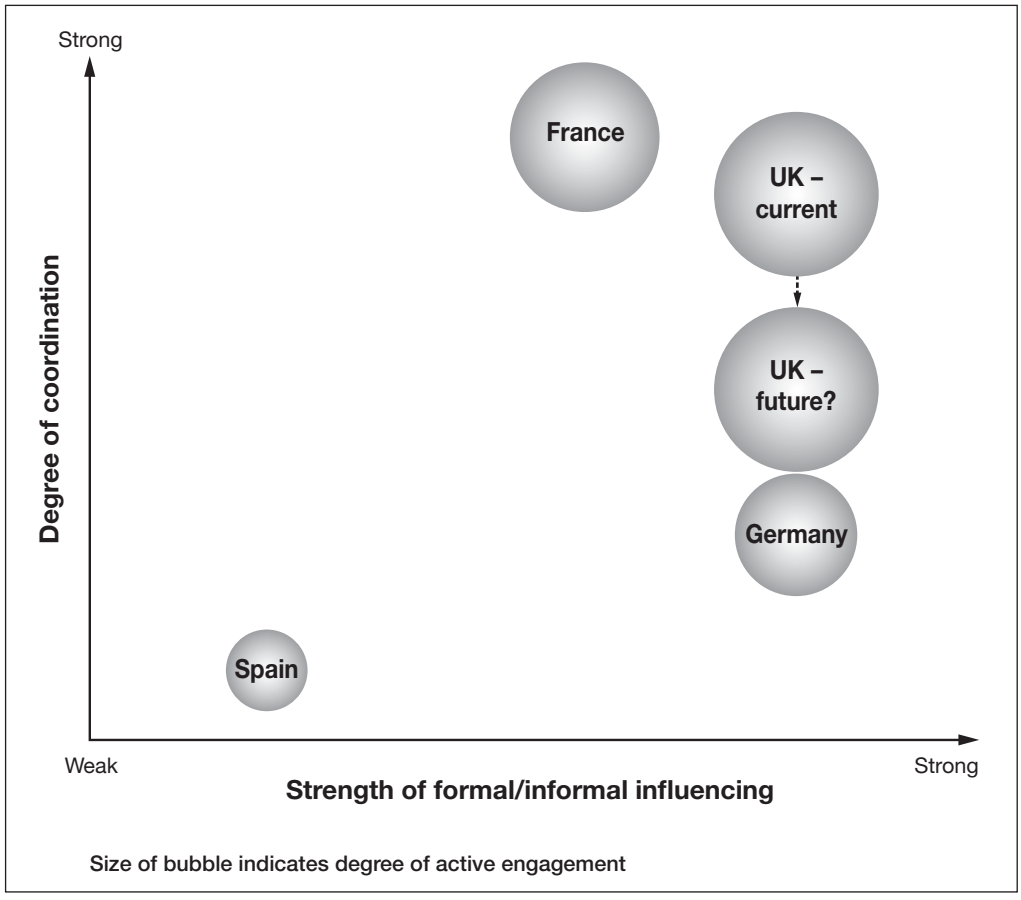
This highlights a basic problem for the legitimacy of the EU. Assume that the distribution of health policy responsibilities in each country reflects a democratic, legitimate conclusion – that the Laender in Germany should dominate hospital planning; that NHS Scotland or NHS Wales should have its policies made in Scotland and Wales; that the Spanish feel that the central state, rather than the regional governments, should be the coordinator of health policies. The EU upsets those balances and, in health policy, does so without any democratic legitimacy. NHS Scotland and the city-state of Hamburg are equally being constrained by EU level rules that, insofar as any part of the UK or Germany can influence them, are best influenced by the UK or German governments. Futhermore, among the best channels of influence for Scotland or Hamburg is close partnership with the member state – further diminishing their distinctive voices. The EU, and to a lesser extent, the member states therefore gain powers over health policy that the architects of their constitutions awarded to the regions. The EU, in other words, destabilises constitutions and in health policy usually does so in ways that are bad for regional governments. Opportunities to join in EU-funded exchange programmes such as INTERREG are very small compensation for that.

Not-so-United Kingdom: adapting to devolution

There is one clear case of change. The UK is the country that is changing from one position to another: from the unified/active position it shares with France, to a more fragmented and active one. This is for the simple reason that its devolution settlement is less stable and more rapidly evolving than any other member state's. It is, in some senses, where Spain was in the early 1990s.

European counterparts admired the Whitehall machine for its unity and coordination, but devolution, as explained above, is inexorably weakening that. So the UK will become more fragmented (see Figure 2). But while coordination is weakening, it is unthinkable

Figure 2. Influencing the European health agenda: the future



that the British would lose their affection for EU lobbying and engagement. Britain's governments will stay active and engaged, but the number of active and engaged British governments will increase. Even if the pervasive Euroscepticism of the British political classes and the official preoccupation with 'delivery'[37] might be diminishing Whitehall's willingness to nourish its EU machine with its brightest officials, the Scottish and Welsh governments continue to invest heavily.

Will this make the United Kingdom a more or less effective player? It depends on what we mean by the 'UK'. Just as Germans are influential without Germany being coordinated or active, the UK can collectively continue to influence the EU. Scotland and Wales, in their enthusiasm, might even make up for some of the decline in Whitehall interest. But the UK government, publicly undercut by the devolved governments, will not look as good. And the devolved governments are quite likely to find themselves in an odd position, one Spanish regions know well: visible, dashing, and often irrelevant. That is because the best a region on its own can hope to be is a big lobby. Lobbies and Brussels faux-embassies can do a lot. But working in tandem with a member state – exercising influence in the real embassy as well as the regional lobby – does much more.[38]

The best option is to be like Bavaria, with a palatial 'embassy' across from the European Parliament and huge weight in the domestic politics of the EU's biggest member state. Catalonia, despite an equally impressive and more active (though less architecturally interesting) 'embassy', is a loser compared to Bavaria. That is not because of its work in Brussels but because of its place in Spanish politics.

Northern Ireland, Scotland and Wales look likely to end up in Catalonia's place: much admired by students of regional 'paradiplomacy' but sensibly viewed by others as mere lobbies. One obvious alternative scenario for them (assuming secession does not happen) is the German one. The UK can never again be its old self, so it might try learning from Germany.[39] The people who should be advocating it are regional governments that would

37 *The Economist* complained: "For years, Whitehall has sent its most smoothly devious officials to serve at the British representation to the EU, or on secondment to EU institutions… but for how much longer?... The problem, say some officials, is that Whitehall departments actively discourage their brightest and best from putting in time in Brussels, disdaining the skills they might pick up there." 'Charlemagne' 'Britain's costly disdain: a salutary tale of lost interest and influence in Europe's corridors of power', *The Economist,* 3 November 2007, 65.

38 Jeffery, C 'Continental affairs: bringing the EU back in' in Trench, A ed. (forthcoming) *Devolution and Power in the United Kingdom*, Manchester University Press.

39 While several German interviewees recommended consensus in general, they were reluctant to recommend imitating German institutional forms.

like to have a say in what member states do, and shield their autonomy. The central state can remain secure in its possession of the Council seat and the knowledge that if it does not cooperate the region will usually be the one that suffers. So Northern Ireland, Scotland and Wales should be trying to establish a more stable and formal – German – system.

The best scholars of the topic tend to argue that this calls for formalisation.[40] So does this analysis. Formalisation of UK intergovernmental relations – in EU affairs and in general – would be likely to mean:

- statutes setting out the obligations of governments in EU affairs, in detail with some sort of enforcement
- statutory systems for dispute resolution that at least make it transparent when and why the UK government is choosing not to respond to a devolved concern
- a UK commitment to extensive information sharing along the lines of the German obligation to offer a copy of every EU document received to the Laender. It would be better to have devolved governments receive too much information than be ignored
- strong commitment to the JMC Europe and consensual agendas
- devolved participation in EU soft governance mechanisms such as the Open Method of Coordination, and a UK commitment not to unilaterally sign up for any standards or goals without consultation.

The advantages would be:

- increasing the likelihood that the UK government position would reflect distinctive devolved activities
- improving differential impact assessments – an increasingly important point as health systems diverge
- improving information flows to reduce the chances of implementation failure.

This is a UK version of the approach taken in Spain. Health has relatively amicable relations and small problems compared to some other policy sectors. It would be a good place to start to develop the informal signs of intergovernmental respect that limit conflict. This is a point that is especially important for the devolved administrations, since, as Alan Trench notes, the UK government "can proceed as its wishes largely without regard to the devolved administrations, but the devolved administrations cannot reciprocate".[41]

---

40 See especially the chapters by Alan Trench and Charlie Jeffrey in Trench, A. ed. (2007) *Devolution and Power in the United Kingdom,* Manchester University Press.

41 Trench, A 'Conclusion: devolution and the territorial distribution of power' in Trench, A ed. (2007) *Devolution and Power in the United Kingdom,* Manchester University Press, 276.

Regions: building in versus striking out

The UK, Spain and Germany are very different countries, but they share an attribute – decentralisation – and a problem – the European Union. The EU, in its simplest form, is an organisation that has representation for states (through the Council) and voters (through the European Parliament (EP)). It does not have meaningful representation for regional governments; the institution intended to provide them with meaningful representation, the Committee of the Regions, is ineffective – or at least not effective enough to satisfy the needs of big, powerful regions.

This is a problem as the EU comes to influence policies across all areas of government, including health policy. The extreme case is agricultural policy, devolved to regional governments in the UK, Spain and Germany but almost entirely made at the EU level – where the member states have the power. Decentralisation of responsibility for agriculture within a member state is a 'dead letter', because real power has already been centralised in Brussels. Health is unlikely to become so completely Europeanised, but it already runs that risk of regional disempowerment. Member states and EP members decided the fate of the Services Directive draft that would have included health, but regional governments would have had to cope with its consequences.

There are a variety of solutions. Broadly, one kind is the German solution (also adopted by Belgium and Austria), in which the regional governments are built into the member state. They have defined powers over what the member state does, and rights to the information it has. A relationship of rough formal equality and investment in staff resources back them up. They are still free to lobby and operate as any other group in Brussels, but they share in the considerable power of the German state. This is because of the extent to which they engage with the central state on the basis of legal equality.

The other broad kind is the old Spanish model, which is not quite zero-sum but does export intergovernmental competition to EU policy. There is not much coordination, and not much spirit of coordination (although it does vary; the nadir was under the second Aznar government). The Spanish state suffers from this fragmentation insofar as its regional governments might be saying very different things from its official position. But regional governments suffer most when they are not able to influence the state. Catalonia and Bavaria both have very visible participation in the EU, but the difference is immense: Catalonia has often been basically a big lobby. Bavaria is both a lobby and a key player in German policy-making. The Spanish reforms have the support of even the most combative autonomous community (the Basque Country) precisely because any symbolic loss associated with participating in coordination is cancelled out by its benefits.

Procedural improvements: developing European cultures

If the significant differences between countries are due to their constitutional and administrative legacies, then there is not much to learn at first blush (it does suggest that the French would be wise to slow or stop the few, tentative, efforts to connect their regional governments with their regional hospital agencies (ARHs) because it would expand the number of independent political actors involved in policy for little gain).

Administratively, we might say that all four member states are adequate. Their administrative structures for dealing with the EU are suited to the demands placed on them – the French are most elaborate, the British just as centralised but slightly less labour-intensive, the Germans consensual and, on paper, duplicative, and the Spanish fragmented. The coordination failures in each case do not happen because of administrative issues; they happen because of political issues such as turf wars between departments and intergovernmental conflict. Spanish fragmentation and reactiveness is the fruit of conflictual intergovernmental relations and a relatively low priority placed on influencing EU health policy.

The real question, then, is what combination of legal and administrative changes will help to solve political problems? Realism demands rather low expectations; politics will not go away. But there are a few lessons in the comparative studies:

- Active information is more useful than passive information. This seems like a simple point, but information sharing has powerful enemies – political rivalries and bureaucratic realities. Only a strong, legal commitment backed up by a culture of sharing is likely to make sure that information is shared. This can be done by routing as much information as possible through a central unit such as the SGAE, or it can be done by good practice, as when Germans start to develop their consensus early, or by building on norms of sharing, as with the Whitehall civil service (which might not look coordinated to inhabitants of the UK, but which is a paragon of coordination to most outsiders). The basic principle is that useful coordination is enhanced if as much information is possible is available. And it is always easier to delete an email than it is to seek out information about a dossier or issue.
- Shared knowledge management is also valuable. The problem with organising coordination through a single 'strong' central unit is that it reduces the potential effectiveness of officials outside the centre. It is a particular problem with the most valuable kinds of political knowledge – how to approach a given official, or how to interpret a document, or exactly what is happening with regard to a given dossier. The German Laender and Bund, forced to cooperate by their consensus system, are particularly open to sharing useful information of this kind with each other.

- This leads to another point: the value of broadly-based engagement. If nothing else, the large number of officials who have glancing experience with EU health policy increases the capacities and skills of the German governments. Broadly-based engagement with the EU institutions can look like a waste of time, but builds a level of expertise and understanding of EU politics that strengthens the member state's ability to influence. Highly European policy areas such as agriculture and trade understand this; health ministries would be advised to learn it as well.
- Cooperation can build trust, so intergovernmental and interdepartmental joint forums are useful. Spain has a long history of bad central–regional relationships, but has to some extent overcome them through the sectoral councils (the account here would be far more negative if it had been written in, for example, 1999 or 2001). It is possible to criticise the councils on many grounds, but the combination of a meaningful agenda (EU policy, for the EU council) and some genuine equality means that even the most sceptical governments participate. This is a foundation for a level of trust, even with a weaker legal base than found in Germany.
- Depoliticisation can come from trust and mutual transparency. The UK official quoted in the report had a point: the differences between systems within a country are usually smaller than the differences between countries. An EU that must make policy for Bulgaria and Belgium will not make many policies that are catastrophic for Valencia but leave Catalonia untouched. This means that a level of depoliticisation is possible: even if Scotland were to secede from the UK, it would still share an NHS model of financing and professional cultures with the residual UK. Those shared interests are likely to persist, and that reduces the incentive to score political points. But it requires political will to recognise shared interests and depoliticise them.
- Legal equality builds trust. German intergovernmental relations are often justiciable, meaning that if one government violates its responsibilities to coordinate with or inform other governments, its decisions can be reversed in court. That is precisely why there is very little litigation on the subject in Germany. Law declaring that regions have a right to certain kinds of information and participation – found, to some extent, in Spain as well – reduces the asymmetry and creates a firmer foundation on which to establish useful forums and build trust and permit active information-sharing.

Developing a regional voice

Regional efforts in Europe could be better directed. There is a strong, natural, and usually unproductive tendency for regional governments to organise meetings where representatives of different regions present their best practice on a range of issues. It grows out of genuine interest – and EU funding for such gatherings (through, for example, INTERREG). It does, indeed, allow for regional projection. It fits with the day-to-day preoccupations of regional health ministries – whose strength, and weakness, is that they are focused on actually managing health systems. Sometimes it allows a region to play a catalytic role in a policy area (as with a major conference hosted by the government of Andalucia on e-health in 2006). But there could hardly be a better formula to bore and alienate the most effective policy-makers.

The result is a great deal of misdirected effort: various political streams flow together to produce regional projection and EU engagement, but much of the result in health is, at best, educational and, at worst, surreally pointless. It does not usually influence major EU policies. It would be much more effective for regional governments that want to organise events to focus their attention on shaping EU health policy debates. A regional perspective on, for example, the role of health in EU competition law would carry weight with the EU institutions, and influence an issue that will shape the strategic environment in which regional health ministers will have to operate in the future. Regional governments in Spain, the UK and Germany all make serious claims to be among Europe's most important political units, and their size, powers and responsibilities back them up. It would suit them to use their health summits to shape the European policy area in which they must operate. Influential is as influential does.

Making independent voices heard

The final lesson is that member states are not the be-all and end-all. They are the most powerful representatives of any health system, and among the most powerful actors in Brussels, but it is dangerous for managers, professionals or any other interested parties to rely entirely on them for representation.

First, this analysis should have shown that even the most effective states have failings and weaknesses. France is not as strong in informal influence as it could be because of its relatively weak culture of European engagement in health. That puts too much burden on the state to be effective. Germans are easy to encounter in EU health policy, but Germany puts much of its effort into developing consensus internally rather than at tables in Brussels. Spain is often just absent at crucial moments. So it is dangerous to

assume that the member state will get everything it wants. The EU is a democracy of member states, and every state sometimes gets outvoted.

Second, even if everything works properly, member states might not make a decision that satisfies health policy-makers. All of the member states are relatively competent, but their analyses of risks and priorities are political. The whole purpose of coordination is to rank priorities and impose broader concerns. This might not produce what health policy experts want; the overall trade-offs made by governments, in analytical capacity as well as policy, might not suit health policy-makers. Coordination might just lead to a tighter grip on health policy by the finance and economics ministries, something most regional or state health ministries would regard as a problem.

Developing independent analysis and action especially matter because this area of policy is still so unformed. Engagement in argument about EU policy influences that policy. Does the EU law on state aids or competition apply? There is, as yet, no settled answer. But there is a debate, and many more groups than member state governments might want to engage in order to influence the conclusion. And they might not feel represented by any given state's decisions. So it pays for anybody interested in health policy and health systems to develop at least some engagement on their own. Right now, the northwest quadrant of Europe dominates EU health lobbying, which suggests that those systems are influencing the informal policy process more than accession or Mediterranean systems. Policy-makers in the EU and in the under-represented states might worry about those consequences. 'Statism' means reliance on a state (or regional government) that can, as in the case of Spain, fail to deliver. If the UK state fails to influence policies, there are lobbies with broadly similar interests that will be at work. That is not the case with Spain or France. And, as ever, superiority here is relative. By health standards, German and UK lobbies are powerful; by EU overall standards they are small, few and under-resourced.

This report has found some imperfections, and what it admires is always relative. All EU representation has imperfections, and the one that can never be avoided is the eventual imperfect decision-making process of a democracy. That is why governments and health services alike should not just rely on their government to represent them, and instead invest in their own capacity to understand and learn about the EU – the better to influence it.

Bibliography

Adelantado, J et al 'Las políticas públicas autonómicas: capacidad de autogobierno y estado de bienestar' in Subirats, J and Gallego, R eds. (2002) *Veinte Años de Autonomías en España: Leyes, políticas públicas, instituciones y opinion pública*, Madrid: CIS, 203–250.

Börzel, T (2002) *States and Regions in the European Union: Institutional adaptation in Germany and Spain,* Cambridge University Press.

'Charlemagne' 'Britain's costly disdain: a salutary tale of lost interest and influence in Europe's corridors of power', *The Economist,* 3 November 2007, 65.

Closa, C and Heywood, P (2004) *Spain and the European Union*, Palgrave Macmillan.

Colino, C 'La integración europea y el estado autonómico: europeización, estrategias y cambio en las relaciones intergubermentales' in Closa, C ed. (2001) *La Europeización del Sistema Político Español*, Madrid: ISTMO, 225–262.

Conferencia para asuntos relacionados con las Comunidades Europeas (2006) '*Guía de Buenas Prácticas' Para la Aplicación del Acuedo Sobre el Sistema de Representación Autonómica en las Formaciones del Consejo de la Unión European*, Madrid: Ministerio de Administraciones Públicas.

Day, P and Klein, R (1997) *Steering But Not Rowing? The transformation of the Department of Health: a case study*, Policy Press.

Dyson, K and Goetz, KH 'Living with Europe: power, constraint and contestation', in Dyson, K and Goetz, KH eds. (2003) *Germany, Europe and the Politics of Constraint*, Oxford University Press.

Fawcett, H 'The making of social justice policy in Scotland: devolution and social exclusion' in Trench, A ed. (2004) *Has Devolution Made a Difference? The state of the nations 2004,* Imprint Academic, 237–254.

Fraser, D 'Scotland "finding itself frozen out of Brussels"', *The Herald*, 22 January 2007.

Gallego, R and others (2003) *Estado de Bienestar i Comunidades Autónomas*, Madrid: Tecnos.

Greer, SL (2006) *Responding to Europe: Government, NHS and stakeholder responses to the EU health challenge,* The Nuffield Trust.

Greer, SL (2008) 'Choosing paths in European Union health policy: a political analysis of a critical juncture', *Journal of European Social Policy* 18(3), 219–231.

Greer, SL (2008) *Power Struggle: The European Union and health care services*, Brussels Observatoire Social Européen.

Greer, SL (forthcoming) *Making European Union Health Policies: France, Germany, Spain and the United Kingdom*, Open University Press.

Greer, SL 'Whitehall' in Hazell, R ed. (forthcoming) *Constitutional Futures Revisited: Britain's Constitution to 2020,* Palgrave Macmillan.

Greer, SL and Jarman, H (2007) *The Department of Health and the Civil Service: From Whitehall to Department of Delivery to where?,* The Nuffield Trust.

Greer, SL and Trench, A (2008) *Health and Intergovernmental Relations in the Devolved United Kingdom,* The Nuffield Trust.

Greer, SL et al (2008) 'Mobilizing bias in European Union Health Policy', *European Union Politics* 9(3), 403–433.

Hunter, DJ 'Values and health policy in the European Union' in Greer, SL and Rowland, D eds (2007) *Devolving Policy, Diverging Values? The values of the United Kingdom's national health services*, The Nuffield Trust, 69–86.

Jeffery, C 'Continental affairs: bringing the EU back in' in Trench, A ed. (forthcoming) *Devolution and Power in the United Kingdom*, Manchester University Press.

Jeffery, C and Palmer, R 'The European Union, devolution, and power' in Trench, A ed. (2007) *Devolution and Power in the United Kingdom*, Manchester University Press 218–238.

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

Kassim, H et al eds (2000) *The National Co-ordination of EU Policy,* Oxford University Press.

Kassim, H et al eds (2001) *The National Co-ordination of EU Policy: The European level,* Oxford University Press.

Kvist, J and Saari, J eds (2007) *The Europeanisation of Social Protection*, Policy Press.

Lanceron, V (2007) *Du SGCI au SGAE: Evolution d'une administration au coeur de la politique européenne de la France*, Paris: L'Harmattan.

Lequesne, C (1993) *Paris–Bruxelles: Comment se fait la politique européenne de la France*, Paris: Presses de Sciences Po.

Lodge, G and Mitchell, J 'Whitehall and the government of England' in Hazell, R ed. (2006) *The English Question*, Manchester University Press, 96–118.

Molina Álvarez de Cienfuegos, I 'La adaptación a la Unión Europea del poder ejecutivo Español' in Closa, C ed. (2001) *La Europeización del Sistema Político Español*, Madrid: ISTMO, 162–197.

Mossialos, E and et al eds (2008) *Health Systems Governance in Europe: The role of EU law and policy,* Cambridge University Press.

Page, EC 'Joined-up government and the Civil Service' in Bogdanor, V ed. (2005) *Joined-up Government*, Oxford University Press/British Academy, 139–155.

Rowland, D (2006) *Mapping Communicable Disease Control Administration in the UK: Between devolution and Europe*, The Nuffield Trust.

Soetendorp, B and Andeweg, RB 'Dual loyalties: the Dutch permanent representation to the European Union' in Kassim, H et al eds (2000) *The National Co-ordination of EU Policy: The European level*, Oxford University Press, 211–228.

Sturm, R and Pehle, H (2006) *Das Neue Deutsche Regierungssystem: Die Europäisierung von Institutionen, Entscheidungs-prozessen und Politikfeldern in der Bundesrepublik Deutschland*, 2nd ed., Wiesbaden: VS Verlag.

Trench, A 'Conclusion: devolution and the territorial distribution of power' in Trench, A ed. (2007) *Devolution and Power in the United Kingdom,* Manchester University Press, 269–288.

Urgell, J ed. (2003) *Donar Protagonisme a Catalunya: acció international i política de relacions exteriors catalana*, Barcelona: Pòrtic.

Wright, V 'The national co-ordination of European policy-making: negotiating the quagmire' in Richardson, JJ ed. (1996) *European Union: Power and policy-making*, Routledge, 148–169.

Appendix 1

Interviewees 2005–2008

	Health department (international or EU unit) / DG Sanco	Permanent representation/ officials of DGs Employment and Internal Market	Regional government	Lobbyist	Academic	Total
France	1	1	n/a	0	3	**5**
Germany	10	1	3	1	6	**21**
Spain	5	1	7	0	7	**20**
UK	5	2	8	7	1	**23**
EU	4	6	n/a	11	2	**23**
Total	**25**	**11**	**18**	**19**	**19**	**92**

Appendix 2

Influencing EU health policy: a guide to the principal forums for influence

The EU is a porous organisation, better understood as a web with many nodal points than as a hierarchy. This means there are many ways to influence it, and it is never entirely clear what venues and what kinds of influencing activity will work best. The safest thing to do is to participate in all of them.

The multiplicity of venues is the basis for the argument that coordination matters: if a member state operates with a clear strategy across all these venues, it maximises its influence. But it also explains how member states such as Germany can be fragmented and still influential; even if the German state is absent or poorly coordinated, Germans participate in these forums.

The **European Council** is the ultimate legislative body of the EU. Here, member states vote for or against policies put forth by the Commission. The votes can demand unanimity (as with social security law) or qualified majority votes (as with internal market law). But the Council will often try to establish a consensus, and member states will construct complex deals – a game best played by the ones whose central politicians best understand the full range of issues under discussion. The Council is very powerful, and is where member states, and member states alone, operate. They operate through "Permanent Representations', which negotiate with each other and represent their member states in the Council.

The **Committee of the Regions** was created in the Maastricht Treaty to provide regional governments with a voice in Europe. It is a consultative body that must give opinions on

some issues and can comment on any proposed EU legislation. It shares the diversity of Europe's local and regional governments, ranging from mayors to heads of giant regions, and this has reduced its power. Important regional governments such as the Laender do not see it as worthwhile to spend their time creating a consensus in the Committee when there are more effective instruments. Tailor-made to represent regional governments, the most important ones generally do not ask it to do so.

The **European Parliament (EP)** steadily gains in power. It is directly elected, and it is possible to identify the representatives from each region and member state. The more sophisticated regional governments and member states routinely engage with 'their' MEPs, since regional and state interests often cross party lines. Most EU health policy has not been legislation (as with the ECJ decisions on patient mobility), or has been legislation whose health consequences were not understood (as with the Working Time Directive). So the Parliament is a relatively new entrant in EU health politics. Only the more sophisticated lobbies and member states have connected their EU health policy debates with the art of influencing MEPs. That influence is particularly important now, given that the Commission's proposed Directive on Patient Mobility is in the EP.

The **European Commission** is the executive branch of the EU. It has the unique right to propose legislation and is responsible for implementation, for administering grants, and for servicing the many committees and forums through which the EU often has its influence. As the executive, many tasks are delegated to it, and it can also do many things that the Council does not notice. The Council's influence is like a searchlight: it is powerful where it is pointed, but much else goes unnoticed. The Commission can be lobbied, and it often is, but it has also structured EU representation into different bodies that advise it and allow it to influence developing policy consensuses.

The **Open Method of Coordination (OMC)** is the pre-eminent form of 'soft governance' in the EU. Much discussed, it is ambiguous: for some it is a device to extend the power of the EU into new areas (such as health policy) and for others it is a device to constrain the EU by putting member states back in charge. For some it is a device to open up EU policy-making by including, among others, regional governments; for others it merely turns them all into satellites of the Commission. And for many member state officials, it is a diversion from watching the Commission closely. The truth is somewhere in the middle. The OMC alone is simple enough: member states agree shared objectives and indicators. Then they present their standing relative to the indicators, and action plans to remedy their deficiencies. The Commission services the OMC process and writes much of the output. It is a Commission-led peer review process with no legal force behind it, and has expanded across policy fields and parts of governments since it began. Each country

engages according to its normal formula. The Germans write a country report jointly between Laender and Bund. The UK DH asks its devolved administrations to write their sections. The Spanish Ministry writes its report with consultation with regions. The French ministry just writes its part of the report, as coordinated with other ministries.

DG Sanco consultative bodies are mostly created to improve the Commission's engagement with the Directorate-General for health:

- The **High Level Group on Health Services and Medical Care** is the group set up in 2004 after the close of the High Level Reflection Process (the first serious attempt by health policy-makers to get to grips with developing EU law). Serviced by DG Sanco, it brings together representatives of the member states to discuss major issues. They meet in working groups on specific topics and also write a collective annual report; the main working groups are on:
  - cross-border healthcare purchasing and provision
  - health professionals; networks of reference; health technology assessment e-health and information
  - health impact assessment and health systems
  - patient safety.

  Strangely, DG Sanco called fewer and fewer working group meetings during 2007, and has been negiligent about posting minutes of the meetings that did happen to its otherwise comprehensive website. This is presumably because the structure of the Group permits the member states to write its conclusions, such as the annual report, and thereby reduces DG Sanco's steering capacity. When the legislation on health services in the internal market was delayed in late 2007 and 2008, DG Sanco began to revive the Group, with a strong schedule of meetings.
- The **European Health Forum**. This is the mechanism for civil society dialogue, with an inner forum of a few elite groups and an outer forum in which many can participate. It is for interest groups, so governments coordinated with interest groups will have some influence via them.
- **The Platform on Diet, Nutrition and Physical Activity** brings together groups with seemingly opposed interests – big companies, governments, and non-governmental oganisations (NGOs). Regional governments can participate in the discussions and make their own commitments to action.
- There is currently **new legislation on health services and patient mobility**, proposed by the Commission, that will change some of these forums. It is not yet clear when or in what form the legislation will pass.

Appendix 3

The Nuffield Trust devolution project: list of main publications

Greer, SL (2008) *Becoming European: How France, Germany, Spain and the UK engage with European Union health policy.*

Greer, SL and Trench, A (2008) *Health and Intergovernmental Relations in the Devolved United Kingdom.*

Jervis, P (2008) *Devolution and Health*.

Greer, SL and Rowland, D eds (2007) *Devolving Policy, Diverging Values? The values of the United Kingdom's national heath services.*

Greer, SL (2006) *Responding to Europe: Government, NHS and stakeholder responses to the EU health challenge*.

Rowland, D (2006) *Mapping Communicable Disease Control Administration in the UK: Between devolution and Europe.*

Jervis, P and Plowden, W (2003) *The Impact of Political Devolution on The UK's Health Services: Final report of a project to monitor the impact of devolution on the United Kingdom's health services 1999–2002.*

Woods, K and Carter, D (2003) *Scotland's Health and Health Services.* TSO.

Greer, SL (2001) *Divergence and Devolution*.

Jervis, P and Plowden, W (2001) *Devolution and Health: Second annual report of a project to monitor the impact of devolution on the United Kingdom's health services*.

Jervis, P and Plowden, W (2000) *Devolution and Health: First annual report of a project to monitor the impact of devolution on the United Kingdom's health services*.

Monaghan, S, Davidson, J and Bainton, D (1999) *Freeing the Dragon: New opportunities to improve the health of the Welsh people*.

Hazell, R and Jervis, P (1998) *Devolution and Health*.

Unless otherwise stated, all publications are published by the Nuffield Trust. Recent publications are available at www.nuffieldtrust.org.uk.

A major Nuffield Trust report comparing health system performance across the four UK nations is due for publication in 2009.

BECOMING EUROPEAN

HOW FRANCE, GERMANY, SPAIN AND THE UK ENGAGE WITH EUROPEAN UNION HEALTH POLICY

The UK is not alone in trying to work out how to organise the complex relationships between devolved governments, member states and the European Union in the complex field of health policy. In different ways France, Germany, and Spain are also grappling with these problems. This report, based on extensive interviews with senior policy-makers in the four member states, analyses the political and administrative organisation of their EU engagement from three perspectives: coordination of approach, type of activity, and formal and informal influencing. It looks at the consequences for each member state of its given policy and the lessons that the UK can learn from these, in the context of its own political devolution.

Becoming European is the latest report in the Nuffield Trust devolution project. It will be of interest to policy-makers, researchers and students in the fields of health policy, EU policy and UK devolution.

The Nuffield Trust
59 New Cavendish Street, London W1G 7LP
Email: info@nuffieldtrust.org.uk
www.nuffieldtrust.org.uk

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES