RESPONDING TO EUROPE

GOVERNMENT, NHS AND STAKEHOLDER RESPONSES TO THE EU HEALTH POLICY CHALLENGE

Scott L. Greer

University of Michigan School of Public Health
The Constitution Unit, University College London

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

ISBN 1-905030-13-4

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

Telephone: 020 7631 8450
Facsimile: 020 7631 8451

E-mail: mail@nuffieldtrust.org.uk
Website: www.nuffieldtrust.org.uk

Charity Number: 209201

Designed by Nicholas Moll Design
Telephone: 020 8879 4080

Printed by The Ludo Press Ltd
Telephone: 020 8879 1881

CONTENTS

FOREWORD

This research by Dr Scott Greer, supported by the Nuffield Trust, builds on an original grant to the UCL Constitution Unit on the impact of devolution on the NHS and is part of the Trust's continuing policy theme which examines the Changing Role of the State.

The EU has an effect on most aspects of domestic policy, and increasingly clearly on health, whether through working time directives, increased freedom in the markets for services and drugs, or through precedents set through European Court judgements. Scott Greer has researched how the machinery of government in Scotland, Wales and Westminster has adapted in the face of this new challenge, and also how other stakeholders, the service providers, professionals and patients are reacting to change, and sometimes driving it.

The Trust is very pleased to continue its support of this important emerging area of policy, reflected in the changing government systems and emphasis. This is the second publication on the EU and health by Scott Greer for the Nuffield Trust, and follows last year's work on *the New EU Health Policy and the NHS Systems*. Both these papers are available on our website.

Kim Beazor
Chief Operating Officer
April 2006

INTRODUCTION

The European Union is probably the most significant challenge to health policy and management in the United Kingdom. No other single policy challenge rivals it for speed of movement, importance, or ability to touch every aspect of health services. This report discusses how the EU has come to be so important in health policy and the adaptation it has caused in the machinery of government and in the activities of major stakeholders such as the Royal Colleges, unions, and management organisations. It is based on 22 interviews as well as participation in private seminars in London, including a Nuffield Trust series, Edinburgh, and Brussels. Section 1 discusses the issues in European health politics – how they arise, and what they are. Section 2 focuses on machinery of government. It discusses the challenges in government, the way the UK handles EU affairs in general, and the developing structure for EU health policy issues. Section 3 focuses on other stakeholders – the professions, unions, and the NHS services themselves. It discusses the challenges they face and the way they are reacting. The chief flaw in the machinery of government lies in the poor devolved investment in EU health affairs, and that while many stakeholder groups are doing well in EU issues, the level and quality of their interest is highly variable.

1. ISSUES

What does it mean to talk of EU health policy? The answer is not simple, because very few questions about the EU have simple answers. EU politics are always diffuse and complex. The Union has twenty-five member states with very different institutions and politics, central institutions (Commission, Court of Justice and Parliament above all) like none other, its own complex, detailed and partial body of law, and an astonishingly complex legislative procedure that can make laws in more than two dozen different ways. Furthermore, EU policies cover markets: most things in life, including patients, professionals, staff, devices, drugs, buildings and even finance come via markets. So it should be no surprise that the project of building a unified market in the EU entails rewriting policies covering much of life and altering much legislation. Unravelling the many policies, laws and procedures that developed in the centuries during which the UK did not need to harmonise with its neighbours takes a long time and a great deal of detailed work – which merely adds to the maze of technocratic committees, specialised interests, and highly technical policies that can make EU policy work so unappealing.

But despite this complexity, there are a number of common issues that cross policy areas and connect the world of EU politics with policies that matter, such as labour regulation, staff recruitment, waiting lists and relations with the private sector. This section explains the basic ways in which issues arise, then discusses the key issues for the NHS systems in EU health policy today.

How EU issues arise

The EU has always mattered to health services, but not formally. Functioning health services have had to comply with all sort of EU safety, labour, health and other regulations. But the nonexistent legal base for an EU policy on health services, and the weak bases for public health work, meant that there was little health sector attention to the EU: at least on paper, the EU has no role in health care and only a weak one in public health. This means that there are a few policies that look like health policies and are made under health policy powers; a large number of extremely important and destabilising policies that member states never intended; and a number of policies (such as labour regulation) that have been

Europeanised for a long time but are only now being recognised, as the NHS notices Europe, as being EU policies.

Intended policies

On paper, if there is no EU competency, there is no EU policy. But there are some policy areas – above all in research and EU aid – which are of great interest to health policymakers and people in the services, and there has been an expansion of health lobbying directed at the parts of the European Commission responsible for developing research and aid policy. The EU has also been a leader in the international Framework Convention on Tobacco Control, a major public health victory in international law. But, historically, EU health policies worthy of the name have been small, outside health services, and rare. This is changing, but it is as a result of other developments – if a significant EU health services policy emerges, it will be as a response to the unintended inclusion of the health sector in other EU policies.

Intended policies: Public health

It is in public health that the EU provides the most opportunities and has the fewest drawbacks for the UK. It is also in public health that the UK health sectors have their longest standing interests, because it is in public health that European networks and an EU focus have existed for longest. Public health powers are to be found in a distinct part of the European Commission: DG "Sanco," the Directorate-General for Health and Consumer Protection. This DG, the first in EU history with "health" in its title, is a recent creation, and weak among the other DGs. Its direct health powers are over blood and human tissue. It is the sponsor of the new European Centre for Disease Prevention and Control,[1] which is a European clearing house for infectious disease information and a hub of the public health protection networks it hopes to strengthen.[2] It is said to be preparing EU health laws and quality standards, but those have not come out. Otherwise its efforts are focused on building an EU policy community through, for example, a Platform on Diet, Physical Activity and Health that has no legislative basis but seeks to encourage EU-level work on the topic.[3]

The EU does not just make policy and create agencies, though. It is much more famous for its grants. There are funds available for all sorts of projects and including health can be a significant advantage in winning funding. This applies to research, where it is a preoccupation to insert health into research funding frameworks. The public health practitioners of the UK, particularly those who operate on a more "strategic" level, are nothing if not adept at seeking out new coalitions and funding sources. It should not be much of a surprise, therefore, that there is a great deal of public health interest aimed at winning part of EU funds for health improvement and promotion. Anecdotally, shifting the Regional Directors of Public Health and their teams into the Government Offices for the Regions (GOs), part of the 2001 *Shifting the Balance of Power* reorganisation, might have

1 www.ecdc.eu.int

2 See David Rowland's report *mapping communicable disease control in the UK* (forthcoming 2006) on the increasingly important EU role in public health protection.

3 http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/platform/platform_en.htm

awakened their interest in EU affairs, given that Government Offices manage EU bids.

The problem with public health engagement in the EU is that the same forces that made the public health function so quick to engage are the same ones that limit it. It was the promise of funds, and to a lesser extent networks, that led public health practitioners to develop an interest in the EU when nobody else was listening. But public health and getting EU funds are by no means the most important component of EU policymaking, and EU funding for the UK is dropping off now that much poorer states in the south and east have joined.

Intended policies with unintended consequences: Professional mobility

Professional mobility poses challenges – and presents some opportunities – to workforce planners and, broadly, the finances of the health services. The issue of professional mobility is comparatively old. The EU institutions have been attempting to promote the mutual recognition of qualifications for decades. This process, of mutual recognition, is one in which standards are set that ensure the basic comparability of qualifications and thereby make it easier for professionals to move across borders and work in different health systems.

Between May 10 and May 14, 2005, eight hundred French surgeons took a "symbolic four-day exile from France to England...to highlight their complaints about low fees and rising insurance premiums".[4] They chose to stay in Camber Sands, Kent, not just because it was convenient and outside France (where the government can compel doctors to work). It was also to make a point about their ability to do business elsewhere in the EU – including in the UK, which, contrary to much of what its media says, is a relatively comfortable and interesting environment in which to practice medicine.

The French surgeons could threaten to stay in Kent because of EU market integration policy which removes barriers to professional mobility within the EU. This takes the form of professional qualifications harmonisation followed by freedom of movement. The basic tenet of EU law and policy is that professional qualifications should be mutually recognised (that a doctor is a doctor and a nurse is a nurse). This means that harmonisation can work in qualifications as elsewhere – just as product safety forbids member states permitting certain chemicals, professional qualifications must obey certain standards in order to be recognised. Once they are recognised, though, member states should not be able to restrain their passage around the EU. To a large extent this is obeyed in the breach. There are a variety of ways that member states can legally force migrating professionals to undergo further training, take proficiency tests, or just wait.

The political challenge from the point of view of most health professions has been to maintain their "sectoral" directives. The Commission, and the EU policy process in general, has a sort of demiurge to subsume the specific in the general. In the case of professional qualifications and mobility, this means constant efforts to replace directives focused on a single profession (nurses, doctors) with broad directives that establish the principles by which states shall regulate a broader area of life (such as professions in general). This produces ongoing efforts by the Commission to include individual professions in broader

4 Etienne Lefebvre, "French Surgeons join UK 'exile' in fees protest" *Financial Times* (UK edition), May 10 2005, p. 10. Strangely, none of the bigger-selling UK papers noted the event.

directives, and fierce lobbying by professions to retain their sectoral directives (nurses just won this fight, retaining their sectoral regulation). Professions assume that not only will general regulation not respond to their individual problems but will also destabilise their presumably acceptable existing regulatory forms.

The consequences of professional mobility for the EU, and the policy challenges it will create, are still only hazily understood.[5] At present some states – including the UK – basically view professional mobility as a solution to their own shortages of professionals. This raises questions about professional standards. Standards of professional education are not the same anywhere. Even if we assume that they are equally good, there are many subdivisions of medical professions that differ – a German and a British nurse do not necessarily have comparable skills because their jobs are different, and both doctors and nurses subdivide into different specialties from country to country. It could be possible that a doctor or nurse from another country is very well trained to do something different. Currently, the principles err on the side of laxity whereas most member states' implementation err on the side of defensiveness.

The other problem with this stance is that as far as anybody can tell there is a global shortage of medical professionals. This means that they ought to cost even more than they already do. Most EU health systems have avoided the consequences of this shortage (relative to demand) by fencing off "their" professionals and then driving hard bargains with them. The NHS systems are by far the most significant buyer of medical labour in the UK, and so they can drive a hard bargain with the professionals. They also pay many professionals quite well. So long as the UK's doctors and nurses are basically confined to the UK, that works. But when they increasingly have the option of moving somewhere else – somewhere that pays them better, or offers them more lucrative private practice options – they might well go. That will reduce the ability of any health system to drive the hard bargains that have kept their staff costs down. Even if only a few French surgeons move to the UK, that could be enough to scare the French government and social partners into paying them all more – and thereby making France a more attractive destination for Lithuanian or Polish professionals who would otherwise go to the UK. In other words, professional mobility opens up markets, and therefore is likely to introduce not just more potential differences in quality but also is likely to do what markets do when demand outstrips supply – raise prices.

Unintended policies

Member states have repeatedly made it clear that they did not intend to have EU engagement with their health sectors, which is why the engagement of the EU in health services has been via other routes than out-and-out legislation.[6] It has been through the

5 Carl-Ardy Dubois, Martin McKee, and Ellen Nolte, eds., *Human Resources for Health in Europe* (Maidenhead: Open University Press, 2006).

6 Scott L. Greer, "Uninvited Europeanization: Neofunctionalism and the EU in health policy," *Journal of European Public Policy* 13, no. 1 (2006), Martin McKee, Elias Mossialos, and Rita Baeten, eds., *The Impact of EU Law on Health Care Systems* (Brussels: Peter Lang, 2002), Elias Mossialos and Martin McKee, eds., *EU Law and the Social Character of Health Care* (Brussels: Peter Lang, 2004).

extension of the law of the internal market to health. This is possible because of the design of the European Union, which has two institutions that between them constantly probe for ways to expand the role of the EU and the depth of its internal market. These are the European Court of Justice and the European Commission.

The European Court of Justice (ECJ)[7] interprets EU law and the treaties that constitute the EU; most courts agree with it that its decisions, and EU law, override member state law. It has built an extensive and binding framework of law out of principles it has derived from the treaties. The most important is a commitment to the "four freedoms" of Europeans – freedom to move within the EU of capital, labour, services and goods.

The European Commission is a unique creature. It is the EU's executive and has the sole right to propose legislation.[8] It is a small organisation with overwhelming responsibilities (consider the difficulty of making coherent policy for Scotland or Wales, let alone the 25 very different member states of the European Union). It is also a "purposeful opportunist", purposeful in its efforts to broaden and deepen European integration, and opportunistic in finding ways to develop new clienteles, reinterpret treaty bases, or take advantage of different crises and events (such as avian influenza or unexpected ECJ decisions) to propose new policies and legislation. And it is very vertically divided; it is common for different parts of the Commission to pursue different agendas.[9]

The result is that there are many cases in the history of European integration in which a litigant found a novel use for EU law and won a case, thereby creating an EU role in a previously untouched area, and was followed in by the Commission, which would propose legislation to stabilise EU law, derive some benefits from the policy changes, and restore some amount of political control – at the price of making the area an EU competency. Sometimes the Commission proposes a law, as with the Working Time Directive, and this passes with political support but little attention from within the health sector. This is very much the case with the development of the significant EU policies in the health sector – areas such as patient mobility and regulation. Once the ECJ has opened up a new front, the only option usually available to member states is to choose one of the proposed laws the Commission will put forth as a Europe-level response to the newly created Europe-level policy problem. The only way to reduce European involvement is to pass a European law. Member states then find themselves in a Catch-22: after refusing to put health policy powers into the EU treaties, they find health policy being made under internal market auspices – but lack the health policy powers needed to easily propose health legislation.

Unintended policies: Labour regulation

The most prominent demonstration of the EU's ability to both slip loose of member state control and constrain member state health service policies came with judicial interpretation of the Working Time Directive (WTD). The WTD regulates working times across Europe,

7 The key work on EU health law is Tamara K. Hervey and Jean V McHale, *Health Law and the European Union* (Cambridge: Cambridge University Press, 2004).

8 There is an exception for certain kinds of labour law in which the power to formulate legislative proposals is delegated to a "social dialogue" process between unions and employers.

9 Laura Cram, *Policy-making in the European Union: Conceptual lenses and the integration process* (London: Routledge, 1997).

limiting the total number of hours that can be worked and ensuring rest periods for employees between shifts. Applied to heath services, it was always going to have controversial consequences – by, for example, sharply reducing the number of hours of supervised work performed by junior doctors, by interfering with hospital on-call rota that bear no resemblance to the shift work model assumed by the WTD, or simply raising labour costs by demanding more hires to cover the same hours. The ECJ, however, did a great deal to make it more controversial with two decisions that meant member states would incur more costs and more changes than they had expected. The two major cases are *Sindicato de Médicos de Asistencia Pública* (SiMAP), decided in 2000, and *Jaeger*, decided two years later.[10] *SiMAP* established that time spent asleep while on call amounts to work for purposes of the WTD. *Jaeger* decided that the WTD's provision for immediate compensatory rest after a shift therefore applied to the shift after the shift spent on call. Both amount to forcing health facilities in the direction of a shift work model.

This combination of poor preparation for a major regulation and unexpected judicial interpretations that made compliance much more costly certainly created significant problems – even if reasonable working hours are very important to younger and female professionals. The really significant issue, though, is that there might be structural change to the NHS systems as a result. Small hospitals may depend on arrangements for on-call cover that are now incompatible with the WTD; staffing up to provide constant cover would be expensive and, in many rural settings, leave each individual doctor doing few procedures to ensure quality or good training. As a result, medical education must be adapted, and the rural and local hospital that politicians are so reluctant to close becomes even more threatened. Even if the WTD is watered down, as seems likely, it has seriously altered the way health services work.

Unintended policies: Patient mobility

Patient mobility is the highest-profile issue at the moment. It exposes the vulnerability of health services to EU regulation – and the potential transition costs, and challenges to the NHS model, that lie in adapting the UK's health services to comply with the EU. Patient mobility issues are driven by decisions of the European Court of Justice, which takes seriously its commitment to the free movement of goods, services, capital and *people* within the EU. Concretely, the cases are about member states' ability to demand pre-authorisation for services in other member states. They include a pair of famous decisions, *Kohll and Decker* which ruled that patients in reimbursement-based systems had a right to seek treatment outside their borders.[11] The decision that appears set to apply it to the UK is the *Watts* case.[12] This is the case of a woman from Bedfordshire who went to France for a hip

10 C – 303/98 Sindicato de Médicos de Asistencia Pública (Simap) v Conselleria de Sanidad y Consumo de la Generalidad Valenciana.. ECR 2000 I – 07963. Judgement of the Court of 3 October 2000. C – 151/02 Landeshauptstadt Kiel v Norbert Jaeger. ECR 2003 I – 08389. Judgement of the Court of 9 September 2003.

11 Luigi Bertinato *et al.*, *Policy Brief: Cross-Border Health Care in Europe* (Brussels: European Observatory on Health Systems and Policies, 2005). is a short, up-to-date guide. Page 6 notes that the numbers of patients crossing borders is small and likely to stay that way; it is changing legal frameworks to comply with EU patient mobility law that poses the problem.

12 Case C - 372/04. At the time of writing the report of Advocate-General Geelhoed had been issued (15 December 2005) Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health, but not the final decision.

replacement and then attempted to bill her local Primary Care Trust. The PCT declined to pay on the basis that it had given her an appointment for the hip replacement. There are two issues in the case: the extent to which the decisions on mobility apply to the NHS (i.e. the extent to which it is a business, rather than a public service); and the extent to which the NHS systems' core form of rationing, the waiting list, is compliant with EU law. The ECJ appears set to rule that the NHS systems did indeed act in a market, and so should be able to price their services even if they did not choose to do it internally, and that waiting lists were infringements on the single market because they meant patients could not use other countries' health systems.

What this means is completely unclear but could be extremely threatening to the NHS systems. The logic comes not from an explicit value judgement on the merits of waiting list as a form of health care rationing, but rather as a consequence of the logic of Europeans' freedom of movement. Essentially, ran the Advocate-General's argument, the NHS had no right to tie Mrs. Watts to its incumbent providers; that constituted discrimination against providers in other EU member states. Putting her on a waiting list for a hospital in Bedfordshire did not deliver quick care but it let the PCT try to avoid funding quicker care at a faster provider elsewhere in the EU.[13] The UK's defence – limited money – was thrown out (the ECJ has reliably said it could permit restrictions on the internal market in heath in order to preserve the financial stability of systems, but has equally reliably refused to accept anything under that provision). Instead, waiting must be clinical and based on patient needs. Waiting is, of course, a financially-driven form of rationing rather than a clinically advisable or patient-friendly thing to do. If taken literally, it is difficult to understand what would justify a waiting list. The result is far more legal uncertainty and a direct attack on the basic rationing mechanism that makes possible other, desirable, attributes of the NHS. There is some patient mobility, principally from London and south-eastern England, but the real issue is the changes that will have to made to make the NHS systems conform to the demands of a non-discriminatory EU market. This might entail transition costs at best and at worst could undermine key components of the health service – such as the decision to ration limited resources by waiting rather than limited services or patient co-payments.

Patient mobility policy is not actually about patients. Patient numbers are small and concentrated in a few places. The real policy problem lies in the extent to which principles enunciated in the patient mobility cases require change in the mechanisms of demand control that underpin health planning and finance. They may well. Whether they do will be determined in the ECJ and EU legislation and the interpretations put on EU law and court cases in the UK. Implementation of the decision will be crucial, and thinking about implementation is as important as thinking about the judicial and legislative consequences.

13 This is not the first time that the ECJ has turned a value-laden decision about domestic priorities into a questionable derogation from the freedom to move and provide services. In the *Grogan* case it undermined the Republic of Ireland's prohibition on abortion – a major issue in that country – by turning the issue into a question of whether Ireland could interfere with the single market in (abortion) services provided from England. Nobody had traditionally thought about abortion debates in terms of whether Irish laws interfere with the EU single market freedoms of English (abortion) service providers. Diarmuid Rossa Phelan, "Right to Life of the Unborn v. Promotion of Trade in Services: The European Court of Justice and the Normative Shaping of the European Union," *Modern Law Review* 55, no. 5 (1992): 670 – 689..

Part of a market?

Public health, patient mobility and professional mobility are the three major issues creating difficulties for health policymakers today, and EU public health policy provides opportunities, but they are also part and parcel of a trend to treat public services in general, including health, as if they were part of a European market. It takes the form of the European Court of Justice, and its litigants, slowly nibbling away at the exemptions provided from internal market law by taking signs of "economic" activity as reason to force public sector organisations to abide by internal market regulations. This principally takes the form of developing more open and transparent contracting procedures that do not discriminate, and lending a sympathetic ear to disappointed vendors who feel that they were poorly treated by public sector organisations.[14]

The effects could be significant. The NHS in England might be getting more marketlike, with government policies trying hard to blur the distinctions between public, private and voluntary (and even bringing in providers from elsewhere in the EU) but it does not yet work anything like the other markets regulated by the EU. Commissioning would look very different if it were bound by EU public procurement rules. The leaders of both Scotland and Wales have both decided not to establish market-based systems; they are nevertheless vulnerable as a result of the progressive reduction of the extent to which the health services can ignore EU market legislation.

Policy that always affected the health sector

Finally, amidst all the attention to new developments in EU policy – whether exciting possibilities for public health or the worrying prospect of the NHS being treated like an ordinary business – it is easy to forget the degree of EU regulation that has long applied to the NHS. EU labour law applies in areas from non-discrimination to safety. Procurement is subject to EU law, as is activity with environmental consequences (such as waste). None of this is new. It is easy to forget now, and it was easy to forget it in the past. One consequence of the increased role of the EU in headline health policies has been more attention to the effects of these other, "unrelated", EU policies in areas such as environmental regulation that had always affected the health services but which received little attention from a sector convinced that the EU was irrelevant.

It is also well established that medical devices and pharmaceuticals are part of a European market, with the attendant harmonisation as well as pressures to make them more firmly part of a pan-European market. Given the high quality standards required of many medical products, and the intensely regulated nature of the pharmaceuticals "market", this requires very detailed, and sector-specific, regulation. In pharmaceuticals there is an increasing degree of pan-EU regulation, via the European Medicines Evaluation Agency and its network of member state medicines regulators. There are anomalies; there is what can best be described as stalemate in an ongoing contest between member states, defending their

14 *FENIN v. Commission* [2003] ECR II - 357. The question, as phrased by the advocate general, is whether "the fact that the activities carried on by [part of the Spanish health service] is subject to the principle of solidarity prevents it being classified as an undertaking" – if it were an undertaking, or partially so, those parts of its activities that are economic would be subject to internal market law. This is typical of a number of cases that narrow the bounds of "solidarity" exceptions to internal market law by making more and more functions those of undertakings, subject to EU law.

medicines pricing regimes, and the Commission, which tends to view such regimes as impediments to trade; the Court tends to side with member states, but has created enough anomalies (such as permitting cross-border trade that exploits price differentials) to guarantee some instability in the pharmaceuticals sector. Pharmaceuticals issues are distinct enough, the regulatory structures and EU policies sufficiently well-established, and the existing literature comprehensive enough to not need discussion here.[15]

The health politics agenda

These various streams of policy are starting to flow together and create a European legislative agenda in health. Part of the reason is that policymaking by the European Court of Justice is clearly unsatisfying. This is because the Court makes decisions case by case, and it takes many cases and many years to piece together a legal framework detailed enough to be a suitable basis for planning. It is also because it is not yet clear what principles the Court uses, or how it weighs up different values. As a result, EU member states have made it clear that they want the European Commission to propose ways to increase legal certainty; even a problematic framework is better than piecemeal judicial heath policymaking.

The response has taken a number of forms, reflecting the diversity of policy instruments in the EU and the fragmented nature of EU politics. The first was the High Level Working Group, serviced by DG Health and Consumer Protection. It is a group where representatives of member states meet to discuss common issues; it is largely powerless and while member states were initially positive about it as a forum it has been left behind by the speed of legal and political developments. Then came the extension of the Open Method of Coordination to health policy, led by DG Employment and Social Affairs. The Open Method of Coordination is a process of peer review; governments agree broad goals (such as quality, access and financial sustainability for health systems), then agree indicators, then report on their progress and give each other action plans. It is a long way removed from frontline health services.

The most important response came from DG Internal Market, a powerful DG responsible for the development of the EU internal market. DG Internal Market was already formulating a broad proposal to extend the internal market to the enormous services sector (which makes up more than two thirds of the "single" European market but which remained largely regulated by member states and was consequently, in most countries, impervious to competition from elsewhere in the EU, or at all). In a continent worried about the prospect of economic stagnation, (a particular problem in the low-productivity services sector), and a political system that had ten new entrants whose chief advantage was low-cost labour, the obvious move was to put forward legislation that better incorporates services into the EU internal market. It included two principles: freedom of establishment (extension of the right to easily open up to provide a service in another EU state) and the country of origin principle, in which service providers would be regulated by their home member state rather than the one in which they worked (so a Slovak firm

15 Elias Mossialos, Tom Walley, and Monique Mrazek, eds., *Regulating Pharmaceuticals in Europe: Striving for efficiency, equity and quality* (Maidenhead: Open University Press, 2004).

operating in Sweden would in many cases be regulated by Slovakia: a situation that will raise interesting questions about the likely quality of regulation).

The striking thing was the inclusion of health as a service subject to the directive. This was largely unexpected; the health sectors of Europe, insofar as they were paying attention to the EU, were mostly engaged in the less threatening High Level Working Group and Open Method of Coordination or were debating whether health was a "service of general interest," a vague category of service that might be partially exempt from internal market law. The Commission's case for inclusion was that it merely reflected EU law, picking up existing ECJ decisions on patient mobility and inclusion in the internal market in order to form the base for subsequent health policy; this was partially true, insofar as health's position in the Directive did seem to reflect the Court's direction of travel. The response from the health sectors of Europe was overwhelming and overwhelmingly negative (the Commission opted not to release the results, after having apparently been overwhelmed with objections). Complaints focused not on the inclusion of patient mobility but on the extent to which health systems could be disrupted by the costs of compliance and the fundamental unsuitability of much of the logic of the directive for health systems. The UK response, led internally by the Department of Health and stakeholder groups, was certainly negative, and simple: health should be out. A final compromise, decided the week before, removed health from the Services Directive as it passed the European Parliament in February; the Commission had already signalled that it was willing to countenance the removal of health, and was preparing sector-specific health legislation. A successor will not be written by the DG responsible for the internal market. It is worth noting that the defeat of the Services Directive slows the pace of developments but resolves none of the fundamental issues; the Court is still at work and other areas of EU law are still impinging on health policy.

2. ADAPTING THE MACHINERY OF GOVERNMENT

Europeanisation is inescapable. That means involvement in EU health policymaking is inescapable. Each UK government faces problems of managing detailed information flow and complex coordination problems in EU health policy. The rapid development of EU regulation of health care means that government's first priority is necessarily the preservation of its system: that is, trying to make sure that there is no gross incompatibility between its system and policy preferences and the options permitted by EU law. This places high demands on information flow; governments need to know what is happening in the EU, and what it is likely to do to the health service (which is something in most cases known only by the service and a very few officials). It also creates coordination challenges, between governments, and between departments within governments.

Common problems

The basic issue for UK governments is that of identifying EU policies that could influence – above all those that could damage – their health service, and formulating an effective "line" that they can promote. A unified, centrally enforced line is crucial to the credibility and coherence of policy and is particularly valued and policed in the UK. Differences are hammered out within government so that the UK speaks with a single voice in Brussels. This entails problems of both information (identifying what matters and understanding issues) and coordination (minimally, ensuring that different parts of the UK do not trip each other up).[16] Both are made more complicated by devolution; information must travel further to get from the EU institutions to devolved health officials, and coordination is more difficult when there are distinct systems with different priorities and agendas but only one UK voice to represent them. They consequently require even more effort when it is a devolved system at stake.

16 The best single piece on the subject is the clearly written "The national co-ordination of European policy-making: Negotiating the quagmire," by Vincent Wright, in *European Union: Power and Policy-Making*, ed. J. J. Richardson (London: Routledge, 1996), 148 - 169.

Information flow upwards

Upwards information flow is the transmission of information about the likely impact of policies to those policymakers in government who can influence the policies. This is particularly important in health because of the complexity of the issues; it appears that the Services Directive was a very poor fit with the detailed operation of the NHS in England (and would have been even more costly for the devolved health systems), but figuring out why requires expertise in commissioning, workforce, finance, planning, and other detailed issues of health service management. Outside explicit health policies such as patient and professional mobility, seemingly innocuous issues of public procurement, waste, or labour law can turn out to have consequences. Compliance with EU public procurement law slows down purchases, so many health facilities had to buy larger liquid gas storage tanks to accommodate the longer times between new purchases of gas.[17] This problem of upwards information flow is worse for the devolved health systems; the DH has essentially no role or staff in Northern Ireland, Scotland and Wales, and no matter what efforts it makes in London or Leeds, the impact assessment for a devolved system (and sometimes the issues of interest) have to be local.

Information flow downwards

Information flow downwards – the transmission of information to those who must change what they are doing in order to comply with EU law – is in principle easier. Good, useful, information flow, should do two things beyond that. One is rapidly identify issues that might be of interest – the apparently irrelevant regulation that will create a headache for estates management or waste disposal – and identify those in the service who can in turn send useful information back up. Information flowing downwards should prompt information flow upwards. The second thing good downwards information flow should do is give adequate notice. The Working Time Directive was seven years in preparation but started to receive serious attention in most of the health services a year or less before its implementation. That in turn requires that those who monitor EU legislation and legal developments understand the consequences far out – and that, when they are soliciting information from the service, they know who to contact. Again, this is more difficult to do with devolved systems; translation of likely or real EU policy to the devolved systems requires local expertise, not merely a statement of policy.

Intergovernmental coordination

Once a health department has timely and useful information about the likely effects of an event, there is another problem: the UK has four significantly different health services with different structures, priorities and leadership,[18] but it only has one voice in Brussels. This interferes with information flow; devolved health departments can be a long way removed from direct, useful information about events in Brussels. It also means that formulating a UK policy position is more difficult because it would, under present amicable

17 Fernando Silio, "Public procurement of goods and services: a legal analysis of the Spanish case" (paper presented at the European Health Forum Gastein 2001, Bad Gastein, Austria, 26 - 29 September 2001), 121 - 141. p 139.

18 Scott L. Greer, *Territorial Politics and Health Policy* (Manchester: Manchester University Press, 2004).

arrangements, have to take some account of differing devolved interests (the Welsh Assembly Government, which had decided not to focus on reducing waiting lists, had a far more pressing interest in *Watts* than the England-focused DH, which has less of a waiting list issue). It also highlights a problem that observers of devolution (and a good number of the officials involved) have noted: the dispute resolution systems within the UK are breathtakingly weak. If in the future the UK government took a position that was bad for Wales, there is no way to resolve it other than to simply impose the UK line. There is never a guarantee that the UK line will be victorious, overall or in detail, but it is still desirable that it be representative.

Interdepartmental coordination

Within Whitehall, or a devolved administration, there are also coordination problems. Issues that influence health may be led by DTI (as with the services directive and WTD), reflecting their nature as economic policies with ramifications far outside health, while environmental regulations are led by DEFRA and DfES quite naturally deals with research and education. In other words, some big issues in health policy have had lead departments that lack the expertise and health focus of the DH. This naturally complicates the process of developing a position, and can in every EU member state create conflicts; the UK government, and DTI, supported the Services Directive, so there was a great deal of work to introduce caveats in its position for health. In principle, this line is for the Government to decide. In practice, identifying conflicts and contradictions, and ironing them out, can be a demanding task – one many other EU member states do only at the last minute, after various ministries have taken contradictory positions on an issue in Brussels. The important thing is not that DTI or DEFRA make policy in the interests of health; it is that coordination ensure that decisions about the UK line or implementation of EU legislation that touch on health are not made by accident.

The UK model

The UK is much admired for its model of EU coordination, which is built out of its general civil service traditions and focuses on developing a single "line" for the whole of government.[19] It opts for firm coordination by the centre in order to cope with basic problem of EU politics, which is that working in the EU combines diplomacy (a single representation and strategy) with all the messiness and detail of domestic policy. The range and complexity of issues is such that it is difficult to strike a balance between the need for coordination – which calls for a small number of EU experts – and information flows – which call for integration with the policy machinery of multiple departments and their stakeholders.

In practice, the system is built around line departments, which contribute to the formulation of a UK position; the process of formulating a position, policed by the Cabinet Office European Secretariat, almost automatically picks up interdepartmental divergence and brings in a sequence of increasingly high-level meetings to resolve it (going, if

19 The best account is Hussein Kassim, "The United Kingdom," in *The National Co-Ordination of EU Policy: The Domestic Level*, ed. Hussein Kassim, B. Guy Peters, and Vincent Wright (Oxford: Oxford University Press, 2000), 22 - 53.

necessary, all the way through Cabinet committees to Cabinet). That is, of course, what Cabinet Office traditionally does domestically as well as in EU affairs. UKREP, run by the FCO, is the UK's permanent representation in Brussels; it presents and promotes the UK stance, handles negotiations and reports back on how politics (and that stance) are playing. Informal networks, ingrained culture of coordination, and the policing efforts of the Cabinet Office European Secretariat and UKREP (which would know if departments diverged far) keep the UK united behind its position.

UKREP represents the UK in the EU, and the Cabinet Office European Secretariat coordinates. It is line departments that "lead," bring the information flow up and down that will reduce the number of disasters and bad decisions. They face the difficult task of ensuring this information flow. This means that the EU has to be "mainstreamed" into existing line departments; the only cost-effective (and probably the only effective) way to get the right information flows is to educate the people who deal with detailed policy issues so that they can make sure the right kind of information flows up and down at the right times. This faces the initial problem of changing ingrained departmental cultures; while some departments, such as DEFRA, have been "Europeanised" for a long time, health departments have only started to see meaningful EU policy developments in the last few years. It also faces the longer-term, structural, problem that there are many competing priorities that seem more compelling than tracking EU politics and identifying its impact. It is not surprising to learn that most HR experts focused for too long on recruitment, Agenda for Change and the doctors contracts rather than the WTD.

The basic structure is described in Appendix 1. The DH's International division leads on EU affairs; this can crosscut within the International Division (as seen in, for example, tobacco control issues, which span EU and broader international responsibilities). There were, however, 23 staff (including dedicated support staff) working on EU issues at the end of 2005. Aside from the director and three working on support for the UK Presidency, twelve were working on cross-border health care, and six other on EU "business, management and communications". This is far more dedicated health expertise than Scotland or Wales can muster. In keeping with the mainstreaming model, though, much of what they do is try to integrate EU concerns into the work of officials in other parts of the department, feeding them EU information and educating them so that they start to integrate EU concerns into their work and leave the International Division to deal with more complex interdepartmental or more "diplomatic" issues.

Intergovernmental relations and the EU

It is in the interaction with devolution that the UK model is still fragile and possibly less effective, in health and in other policy areas. Information flow is poor because the devolved health systems do not invest much in identifying the consequences of EU policies or in influencing them. Intergovernmental policy coordination is unstructured, in health as in most other areas; the assumption is that the existing civil service mechanisms (committees and networks), combined with the shared interests of Labour governments, can prevent real divergence and disputes forever. Devolved health systems share many, but not all, of their interests with the English NHS so this might not always be appropriate. What strategies can devolved governments pursue? What are they doing?

The legislation governing devolution is clear:[20] EU representation is a UK government function. Northern Ireland, Scotland, and Wales have no claim on a role in UK decision-making. It is equally clear (especially in the White Paper *A Parliament for Scotland*) that the system is designed to maximise Scottish (or other devolved) in put into decision-making, with all governments expected to consult, confidentially, with each other about significant issues. Concordats enshrine this and have some legal status, but they are best read as examples of official thinking. Officials do try to coordinate and avoid surprises and probably would even if the Concordats did not tell them to. If officials cannot resolve a problem, then there is a formal structure to deal with divergence – the Joint Ministerial Committees (JMCs).

This pinpoints an assumption made throughout the devolution settlement, namely that intergovernmental relations can be handled just like interdepartmental relations. The UK unquestionably has extensive experience in interdepartmental relations. The system of official consultation, up to JMC discussions,[21] and culminating in a decision by the Government, mirrors the systems of increasingly formal discussions culminating in Cabinet decisions that cope with interdepartmental divergence within Whitehall. But the UK model, transplanted this simply, is inadequate. The reason is very simple: governments are not departments. An interdepartmental clash is a problem that a unified Cabinet government should solve. Intergovernmental divergence, or even clashes, are a normal consequence of creating governments with the policy autonomy and democratic mandate enjoyed by Scotland and Wales. A system geared to eliminate misunderstanding and unify the already-united (Cabinet ministers) has been asked to deal with divergence on questions of means and ends between democratically legitimated governments with different health system values, priorities, and structures. The formal hierarchy in EU affairs is clear: the Government and Whitehall are in charge. But all this means is that the system risks both undermining devolution (by failing to present devolved views) and creating disputes (since a devolved government that just lost a contest might decide to go public).

Options for representation: via London and via Brussels

The structure of devolution and the structure of the EU encourage the devolved governments to work with Whitehall and the UK government. The structure of devolution, as explained above, means that devolved governments have little or no standing to take a different stance from that of the UK.

---

20 For intergovermental relations in the UK see the Constitution Unit "Devolution and the Centre" quarterly monitoring reports, online at http://www.ucl.ac.uk/constitution-unit/research/devolution/devo-monitoring-programme.html Also Robert Hazell, "Intergovernmental Relations: Whitehall Rules OK?," in *The State and the Nations: The First Year of Devolution in the United Kingdom*, ed. Robert Hazell (Thoreverton: Imprint Academic, 2000), 149 – 182; Roger Masterman and James Mitchell, "Devolution and the Centre," in *The State of the Nations 2001: The Second Year of Devolution in the United Kingdom*, ed. Alan Trench (Thoreverton: Imprint Academic, 2001), 175 – 196; Alan Trench, "Intergovernmental Relations a Year On: Whitehall Still Rules OK?," in The State of the Nations 2001: The Second Year of Devolution in the United Kingdom, op.cit. p153 – 174; Alan Trench, "The More Things Change, the More the Stay the Same: Intergovernmental Relations Four Years On," in *Has Devolution Made a Difference? The State of the Nations 2004*, ed. Alan Trench (Exeter: Imprint, 2004), 165 - 191.

21 It is worth noting that the UK government need not use JMC Europe to discuss policy; it could in principle use a Cabinet committee, and it is considerate of the UK government to use the JMC. Using a Cabinet Committee instead of a JMC would have significant negative consequences for Northern Ireland, Scotland, and Wales, which would be excluded from the major channels of information and decision-making.

Equally importantly, the structure of the EU means that for devolved and regional governments across Europe the greatest resource is the support of a member state. Regional governments in Europe, realising that European integration affords them both more opportunities and poses a potential threat to their policy autonomy in Europeanised areas, have oscillated between various devices intended to increase their role in EU policymaking, including sponsorship of and participation in the largely ineffective Committee of the Regions (which represents local and regional governments), the insertion of a treaty provision allowing regional governments to replace member state governments in the Council meetings where member states vote on issues, and a range of internal mechanisms designed to better coordinate regional policies with member states' EU stances.[22]

In practical terms an intra-state strategy means that the devolved health systems rely on influencing the UK stance rather than action on the ground in Brussels. As regional governments in Spain, Germany and other EU states have expensively learned, regions have more weight with their member state governments than they do in the free-for-all of European politics. And sheltering under the DH in Whitehall gives them access to a far larger EU health policy apparatus then they otherwise have.

An intra-state strategy also fits with the low level of devolved investment in EU health policy. The Department of Health's international division goes to lengths to keep devolved systems in touch with EU affairs, both by emailing about issues as they arise and by organising periodic meetings that afford both an opportunity to report on issues and an opportunity to build networks. Likewise there is a public health network, run by the Regional Director of Public Health for the East Midlands on behalf of the Chief Medical Officer, which is trying to include representatives of Northern Ireland, Scotland and Wales as well as its existing core of two representatives from each regional public health team. These networks transmit information down, although time pressures mean that the importance of an issue is not always explained, and it is up to devolved administrations to do their own impact assessment and try to channel information upwards to influence the DH and through it the UK line and EU decisions. This is the near-exclusive strategy of Northern Ireland. In most cases, it is also the strategy of Scotland and Wales.

This is practical but there are costs. One is already apparent: without the capacity in health departments to monitor and influence EU health policy debate, information flows are constricted. We do not know much about the likely consequences of the Services Directive or *Watts* for Northern Ireland or even Scotland because there is limited effort put into making sure that information about the EU flows downward and information about Scotland flows upward. Right now emails from the International Division of the DH bear a tremendous amount of weight. The other is latent- there is no guarantee that the current good relations between UK governments will remain, and even in the current positive climate there have already been examples (primarily in education) of Whitehall refusing to share major policy decisions with devolved governments that are intimately affected. This can be as little as a question of priorities – the UK government might not choose to focus

22 Charlie Jeffery, "Continental Affairs: Bringing the EU Back In" in *Devolution and Power in the United Kingdom*, ed. Alan Trench (Manchester: Manchester University Press, (forthcoming)), Charlie Jeffery, "Devolution and the European Union: Trajectories and Futures," in *Dynamics of Devolution: The State of the Nations 2005*, ed. Alan Trench (Exeter: Imprint Academic, 2005), 179 - 200.

its limited resources on an issue of little importance to England but of great importance to a devolved system.

Resources permitting (and the number of people required is small), the most logical strategy for a devolved government is to continue and enhance coordination with London, which is the best and most effective strategy in general so far, and also develop health departments' European expertise in order to improve information flow and, possibly, use of the existing devolved EU policy structures.

The EU in devolved health departments

Interdepartmental coordination in the devolved systems, however, quite informal and minimal, with their central coordinators and EU arms only minimally engaged. This low level of information flow means that there are few interdepartmental tensions within the devolved administrations, let alone causes for intergovernmental dispute with the UK government.

Northern Ireland's Department of Health, Social Services and Public Safety (DHSSPSNI) has two officials in Belfast who count EU affairs among their workstreams. One covers health services and the other covers public health. This is a very low level of investment, and the result is that they are very reliant on the DH – not just for information, but also for organising the meetings and flow of downward information. Other players in Northern Ireland – the central departments, including those who work on EU affairs, and the NIO – are entirely unengaged with EU health policy issues. In other words, the DHSSPSNI invests the work of two officials who each are heavily burdened with other, more politically salient, and more administratively demanding, workstreams. Northern Ireland essentially delegated EU policy to the DH, making almost no effort to even channel information about Northern Ireland upwards. Northern Ireland's Brussels office is small, focused on inward investment and EU funds, but its bulletins cover health issues. The Brussels office might develop a new structure in the coming months, one that might integrate policymakers in Belfast more closely. Overall Northern Ireland's low investment in health reflects the low demand; so long as the DHSSPSNI relies on the DH for its information and influence on EU policy, Northern Ireland relies on direct rule ministers for government, and Northern Irish politicians rely on nationalisms and constitutional politics for their votes, there will not be many demands for information flow downward, let alone upward.

Scotland and Wales are both attempting to mainstream EU health issues, but their EU health advocates face two problems. One is overload: the DH has, and has always had, far greater resources as well as a meaningful International Division. One Scottish Executive Health Department (SEHD) official with a major role in EU health policy had in mid-2005 thirteen other workstreams, most of them entirely unrelated to the EU. The other is the extent to which relying on DH has worked very well. The question is whether it will continue to work as health services diverge (remember that there is no necessary reason the DH will know *anything* useful about devolved health services if the devolved health services do not tell it).

Scotland's comparative advantage is in its long history and current expertise in European affairs. Scotland has a large and longstanding investment in Europe dating back to long

before devolution, first through Scotland Europa (creation of Scottish Enterprise)[23] and directly through the Scottish Executive EU Office (SEEUO), which shares the Scotland House premises on Rond-Point Schumann, the geographic and symbolic centre of the EU quarter in Brussels. One official in the SE's Brussels office maintains a serious watching brief over EU health policies as part of a broader social policy and environment portfolio. This official communicates directly with the relevant SEHD officials, and the office as a whole is part of Finance and Central Services and therefore connected with overall Scottish Executive central policy coordination. and also responds to the inevitable demands of work in Brussels; "the work is about influencing, listening, talking to people. You can't do that from Edinburgh" remarked one Scottish Executive official.[24]

Wales benefits from longstanding European connections of its health policymakers. In the mid-1980s, when health policymakers in the UK were still largely parochial, the Welsh NHS began to develop its international links and profile through connections with the EU and the creation of a cadre of officials who engaged with EU and international circles, particularly about public health issues. The result is that Welsh public health policy, the object of so much scornful comment in London (and Cardiff), still has admirers around the world. It also means that there should be no surprise that the Welsh Assembly Government has invested in an approximately one-third Brussels staffer (in the Welsh office, also on Rond-Point Schumann), or that his work plugs into a larger network of Welsh health policymakers who are engaged with Europe. The Welsh structure still shows a bias towards public health concerns (above and beyond the public health focus in much of Welsh policy), its origins lie in public health pressure, and the network in the Welsh Assembly Government is led from the public heath function.

Machinery of Government: Conclusion

The UK DH is integrating into the UK model, with line departments responsible for impact assessment and contributing to a UK line, and with the unity of that line the main concern for all involved. There is an established mechanism for doing this; departments, the Cabinet Office European Secretariat, and UKREP, are all patrolling, looking for interdepartmental divergences and a series of increasingly important committees resolve them within Whitehall. The mainstreaming of EU health concerns in the DH is taking place, although it is slow as it requires changing an established departmental culture and the EU can look like a distraction from the other, more salient, policies that the government is creating for the English NHS.

The potential problems lie in the relationship with devolved systems, for all that the Scots and Welsh are rapidly building health into their EU concerns. Right now, the connections between health policymakers and managers, and EU developments, are low-bandwidth; not

23 Andrew Scott of Edinburgh University has a good analysis of the history and justification of Scotland Europa, available from its website: http://www.scotlandeuropa.com/PUBLIC%20SITE/Scotland%20Europa%20Papers/papers.htm

24 There can also be divergence between the issues that interest ministers and the issues of importance; the EU's mental health strategy, which is a largely toothless EU public health policy, attracts far more attention from governments than its importance merits. This is because some ministers are interested in mental health and mental health advocates, so often forgotten, have to be skilled in sniffing out opportunities to influence policies on every level.

much information about policies or politics flows through between the EU and those who understand frontline health services. They are also tailored to the interest of health departments, which if they are not paying enough attention to EU policy can introduce distortions. It is hazardous, therefore, for health policymakers to assume that the DH or even a Brussels office will always know what matters and that its emails and briefings will suffice even if it does. Further down the road, the UK's machinery of intergovernmental coordination is inadequate; as it stands at present, a dispute would entail a ladder of meetings about an EU policy divergence until the UK government pointed out that EU affairs are a reserved power – in other words, until the UK government exercised its authority to impose a solution. It is easy to see why that might produce a political crisis, as well as reduce the autonomy of a devolved system. As with everybody else in health policy and EU coordination, the rise of an EU health policy arena has posed a challenge, and all machinery of government is a work in progress.

3. STAKEHOLDERS

There are really two kinds of UK actors in Brussels: governments, and everybody else, whether NHS, union, or professional organisation. Member state governments have a structural role to play, and can range across fields from lobbying to showdowns in the European Council. They are also confined by the need to have and hold a coherent line. Everybody else is restricted to trying to influence – influence debates, influence agendas, influence policies before they see the light of day, and influence EU institutions such as the European Parliament as they make their decisions.

This poses a series of challenges for existing stakeholders in UK health policy. It is something of a given among scholars of European integration that Europeanisation of a policy area poses risks for the dominant stakeholders.[25] Health politics in the UK is usually about the contests between a few groups – the BMA, the RCN, other unions, other Royal Colleges, the NHS Confederation, and above all the Department of Health and central government departments. There are many smaller participants, but politics is usually about watching the ups and downs of each of these groups. The agenda is tightly constricted, and politics as often as not takes the form of government action and group reaction.

EU politics is nothing like that. The interaction of twenty-five political systems alone would make sure of that. The particular way the EU operates further complicates the interest group picture:[26] the agenda expands constantly (including into health), the proliferation and penetration of different lobbies and interest groups mean that nobody can reliably influence the agenda, the organisational density and complexity make it very difficult to spot consequences, trends and coalitions, procedures are complex and negotiable, and it is imperative to build large coalitions, despite the internal diversity that will make them difficult to manage.

---

25 David Coen and Charles Dannreuther, "Differentiated Europeanization: Large and Small Firms in the EU Policy Process," in *The Politics of Europeanization*, ed. Kevin Featherstone and Claudio Radaelli (Oxford: Oxford University Press, 2003), 255- 277.

26 Wright, "The national co-ordination of European policy-making: Negotiating the quagmire" op.cit.

How do stakeholders, whether interest groups or the NHS systems, have any influence at all in this environment[27]? Their main resource is not domestic political power; it is their claim to be able to represent, with useful and timely information, a significant constituency. The European Commission, charged with writing legislation, is a small organisation that does not have the resources to figure out the (often very complicated) policy issues at stake in twenty-five different countries. The effort to make policy that will be intelligible, let alone implementable and beneficial, requires listening to those who come across as experts and representatives of the interests affected[28]. A group that fails to organise and present its point in a timely manner at the crucial stage of policy formulation – which happens within the Commission – will probably suffer in the end legislation. In other words, good EU policy depends on good lobbies talking to the Commision

In addition to this reliance on lobbies for much information, the Commission is also very aware of the EU's democratic deficit. Its solution is to be open to as many interests as possible – far more open than most UK departments are. UK departments know who their stakeholders are, and who matters in politics and administration. The European Commission has a few "usual suspects", but can never be anywhere near as certain. It is correspondingly less likely to freeze groups out on the basis that they are not important. For some groups, this is an opportunity. For the existing major stakeholders, this is a threat. And they are responding. For many, this means hiring a lobbyist or joining an EU-wide association; that means a work programme keyed to the annual work programmes of the Commission, the schedules of the European Parliament and Council, the priorities of holders of the EU rotating presidency, all of which are flagged up long in advance, and to a variable extent the gossip in Brussels. What it does not yet mean is moving from that level of defensive representation to real efforts to shape debates about the future form of EU health policy.

Common problems for stakeholders

Stakeholders have some of the same problems of governments, principally with information flow and policy formulation. They also have some flexibility governments lack – there is no need to comply with a "line" – but they also have to persuade their members to support their engagement and then satisfy them. The professionals have to overcome ingrained problems – professions are so different across Europe that they have difficulty acting in unison, and most professions are so strongly tied to their governments that they enter EU politics reluctantly, badly, and late.[29] And while even the most shambolic government necessarily gets some attention in the EU, an incompetent lobby can easily get itself shut out of decision-making circles.

---

27 The single most useful work on EU lobbying is Justin Greenwood, *Interest Representation in the European Union* (Basingstoke: Palgrave Macmillan, 2003). David Coen of UCL and Jeremy Richardson of Oxford are leading a collaboration of academics and practitioners on EU lobbying.

28 An example of this is the tangle created by the European Court of Justice when it distinguished between hospital and non-hospital care in the patient mobility cases. This obliged the Commission to figure out what defines a hospital. That meant 2005 discussions with the various health groups who were known to be willing to help it out of the legal fix created by the use of what turns out to be an extremely slippery concept.

29 Greenwood, *Interest Representation in the European Union*. Op.cit p. 124.

Information flow

Stakeholders have the same problem as governments. They need to figure out what is happening at the EU level, transmit the information downward so that their members can respond, and in most cases will also want to transmit the implications back upward quickly enough that they can try to influence the policy process based on the information. This requires good information flow – whom do they approach for an impact analysis? How do they learn about an issue outside the traditional "health" agenda that will change their lives (such as waste disposal or public procurement law)?

Satisfied members

Stakeholder groups are also under pressure to satisfy members. Groups representing the NHS have to satisfy their funders – which can mean something as irrelevant to policy as bringing in EU grants – while membership organisations such as trades unions and Royal Colleges need to satisfy their members that they are using their resources wisely. For example, the NHS Confederation's members expect to be briefed about the EU issues that they are starting to note. They certainly expect that its employment arm have taken EU labour law into account when negotiating. This can occasionally produce distortions; a group that is convinced of the importance of an EU issue will have to convince its members that work in Brussels is worth it, and members might find less important issues more interesting. Groups with members who think Europe is marginal, or who join for other reasons, will often freelance – and will often do it by suggesting more EU powers and responsibilities, regardless of what the members might think if asked.

Policy formulation

There is also the problem of determining a policy stance. How broad should the remit be? What should the group say? This is tricky when it is defending existing major stakeholders. The RCN, for example, supports the WTD's full extension but was threatened by the prospect of elimination of the specific directive on nursing qualifications. It is not enough to say that a group does not want EU involvement. There is not much in EU policy that will help NHS managers, but that does not mean their representatives can dig in their heels. For example, the instability created by the Court will only end with EU legislation, and that means that useful influencing on behalf of the NHS management cadre will have to focus on reducing the disruption involved in compliance with EU law. The issue of determining stances also fits with concerns about keeping members satisfied; they will leave a group that continually expresses opinions with which they disagree.

Credibility

Lobbies have access to the Commission because good European policy depends on affected interests telling the Commission (and sometimes others) about the costs and benefits of various ideas. But to enjoy this access, lobbies have to make good use of Commission officials' time by being useful. Van Schendelen[30] summarises the findings of academics who study the EU, and most students of politics in general, when he writes that serious lobbying

30 Rinus van Schendelen, Machiavelli in Brussels: The Art of Lobbying the EU (Amsterdam: Amsterdam University Press, 2002). pp 168-179

in Brussels requires four things. It takes, first, cohesion (unity of the represented behind their representative). Second, it takes useful knowledge (politically what can be achieved and what is wanted). Third, it takes a good image ("an image of both importance and agreeableness") and fourth it requires a mixture of resources and skills (technical expertise, positions in advisory or EU groups that show the groups' advice and representative function is agreed, finance, and some ability to anticipate opportunities). Most of most legislation is agreed long before it sees the light of day; a credible group will be one that can influence it at that pre-legislative stage. The saving grace is that the level of organised health representation of any sort is still low; one or two good staffers can make an organisation a serious player.

Common options for stakeholders

What organisational forms do stakeholder groups use to solve these problems? There are broadly four things they can do, and most mix or match several or all. They are developing their own capacity to follow and influence EU affairs, in their capitals and in Brussels; joining EU associations; and relying on their members (see Appendix 1 for the activities of a few key UK groups).

EU associations

Organisations that feel at home in their capitals, whether that means Cardiff, London, or Paris, might quite sensibly decide that they lack the expertise to handle EU politics and do not want to pay the costs of developing it. For them, the expertise, existing networks, and claim to greater representativeness that EU-wide associations offer can look like a good deal. If the EU-wide association comes knocking, whether in the spirit of entrepreneurialism or because some part of the Commission pays for it to gather up opinions, then it is all the easier to join.

These EU-wide organisations tend to be quite small, associations of associations. Few individual professionals, workers, or even businesses want to directly join EU associations; they are much more likely to join multifunctional organisations like the BMA or RCN that provide all sorts of services and assume that those organisations will seek out the right level and kind of EU engagement. EU-level associations usually have up to half a dozen staff and offices in the "European Quarter" around Brussels. The associations are often able to identify, write convincing briefs on, and lobby about many more issues than a single organisation could ever do. They also serve a purpose from the point of view of the Commission. If it can solicit opinions from groups that speak for an interest, it need not aggregate opinions and knowledge from across Europe. They can hammer out the differences internally. Furthermore, the map of EU-wide interest groups gets taken as a map of the real interests; if an interest is not represented in the EU-wide associations, it is much less likely to be thought of as a real interest, while otherwise marginal groups might loom large in EU politics if they have good staff.

This means that organisations that belong to EU-wide associations typically delegate the overall demands of representation to those organisations and then focus their staff on identifying the most important issues. They solve the information flow problems, they can develop or have ready-made credibility, and if their stances are acceptable (which presumes

that their members know enough) they can provide what their organisational members ask of them in terms of representation. Thus, for example, the NHS Confederation is adding to its connection with the large European Health Management Association (EHMA) by building its EU work in parallel with HOPE, the European Hospital and Healthcare Federation, Unison is a major actor in the European Public Services Union (EPSU, an EU organisation of public sector unions), and the RCN is a major part of the Standing Committee of European Nurses. In the latter two cases, the UK organisation is one of the largest and most important members.

Appendix 2 is a list of the EU-wide groups that engage with EU health policy and their UK membership. It shows, first of all, how much more diverse EU politics is. There are dozens of groups that are marginal in UK politics, or uninterested in health, but which can play a role in shaping the opinions of EU-wide associations that influence policy. Second, it shows the hit or miss nature of much representation; it is hardly the picture of a settled policy world.

Staff

It is rare, though, that a major stakeholder will want to rely entirely on EU-wide associations. If nothing else, it needs to pay attention to the nexus between EU policy and its opportunities to influence the UK policy line, and that requires somebody who can connect the two. Having dedicated staff also mean that the organisation is free to be quite specific in its opinions; EU groups can be unwieldy, might not take an issue seriously enough, can take a long time to decide on a position, and will often choose a lowest-common denominator position. Dedicated staff can also improve information flow downwards-produce reports, monthly or in some cases weekly, and briefings to their members, which raises the profile of the office and of EU affairs. The more successful EU specialists are also constantly presenting their issues in targeted meetings with affected groups – explaining to one specialist network or another how the EU influences them and what they can do.

The British Medical Association and the major health services unions have Brussels offices with full-time officers engaged in information gathering and influencing. The Royal College of Nursing and the Royal College of Physicians also have EU staffers (the RCN's is full time), but they are London-based. Easy travel and London's importance in health policy circles reduces the importance of this locational decision, but it still matters. In deciding whether to base the staffer, the main issue is where the emphasis should lie on understanding the policy (information flow) or in focusing on EU political credibility.

The Greater London NHS has an entire team, based in the Government Office for London, that focuses on impact assessment and EU influence, is funded by the London Strategic Health Authorities and some other NHS organisations. It pays a subscription fee to the Greater London Authority's Brussels office in return for its monitoring services. The Northwest England NHS has a staffer based in Brussels, funded by a broad consortium of organisations, most of them NHS.[31] Both use the same basic model, which focuses on

31 There has been a staffer in Brussels from the West Midlands, but that post is currently vacant and being reviewed.

collecting information about impending EU policies, transmitting it downward to members, using their expertise to develop impact analyses, and then trying to influence the EU. They have no equivalents in the devolved health systems. The Department of Health, with its limited resources, different agenda, and current political commitment to interfering less in the NHS, is supportive. The issues raised, naturally, are of sustainability and duplication – constant NHS reorganisations mean that funding must be reconstructed each time, while funding by NHS regions means that much information of general application to the English NHS (or all the NHS systems) remains proprietary. While regional priorities vary (patient mobility is a bigger issue in and around London), there is no clear case that the EU policy interests of the English NHS are regionally specific. What is regionally specific, really, is the appearance of organisational entrepreneurs who are willing to make the case for investment in Europe, and staff capable of delivering on the promise and thereby sustaining their operations.

Members

Members are a group's greatest asset. They can speak with authority; they can humanise abstract issues (medical and nursing lobbyists speak of addressing issues in ways that personalise them – such as bringing nurses to speak of their responsibilities); they are often far more knowledgeable than any political staff member will be, and can therefore be far more credible. This means that a number of organisations (above all the professional organisations) rely heavily on their members, bringing them to address European Parliament members, relying on them to formulate statements sent to the Commission or Parliament, and using them in lobbying situations where their expertise and credibility matter. This has several advantages: it uses an authoritative, humanising resource that only stakeholders have; it builds interest in EU affairs among their members; it multiplies their resources considerably; and it allows their political staff to concentrate on their area of expertise, politics. It also means that small numbers can be deceptive; one political staffer can be the connection between the EU and dozens of members who bring their expertise and authority to a range of issues.

Stakeholder participation: issues

Interest groups and stakeholders, just as much as governments, have an existing template for engaging with the EU. The basic architecture of dedicated staff, membership in EU organisations, and use of members is common to most areas of EU policy and it is possible to hire people with expertise in the EU – Brussels has an enormous labour market of relatively cheap specialists in EU influence, many of them UK citizens.

A good stakeholder EU policy eases upward and downward information flow, learning about issues in time and influencing professionally and at the right stage. This means that it should have good quality information, be realistic about its strengths and weaknesses, have support from its organisation, some stability so it can build credibility, and good coordination with the rest of the organisation. It need not be large, although the current small size mean that many issues (such as environmental regulation) have received little attention from the UK health sector. EU associations, which are soon likely to be core-funded by DG Health and Consumer Protection, can also have a tendency to "go native"

(or start out native, in many cases), and promote EU policy in advance of their members if left to their own devices. This is good insofar as it advances the debate rather than remaining reactive, but it might be questionably representative.

UK stakeholders' level of interest is variable; the BMA, and RCN moved quickly and strongly on all fronts. The GMB had an existing Brussels office, and Unison an existing international division, that are taking on more health work as the issues multiply. NHS London and the Northwest NHS also invested effectively in the last few years. As health lobbies go, they are all significant. The Royal Colleges invest much less; among the England-Wales Colleges the RCP has made the only serious investment and the Scottish Royal Colleges appear to be doing nothing at all. If the RCP or BMA, with their limited resources and clear focus, do not represent a given group of doctors or medical issue, nobody does. Maybe the RCN, BMA, and unions could get more from a greater investment, but it is clear that the serious gaps are in the involvement of medical professional concerns that should be the concerns of Royal Colleges (Scottish medicine had better happen to agree with RCP-London positions on training or public health, for example, because the RCP-London offers the only EU policy activity of any Royal College).

There are a number of issues to consider for stakeholder involvement. Sustainability and duplication are issues, particularly for the NHS. Sustainability is particularly a problem for offices that are expected to pay for themselves; EU funding is not always worth it and is decreasing as funds move to poorer countries in Eastern and Southern Europe, so a focus on funds can freeze out attention to far more important issues. Duplication can be just a waste; the case that there are distinct regional (or professional speciality) priorities in EU policy remains to be made. These are concerns above all for the NHS operations in Greater London and Northwest England. For the other stakeholders, it is clear that the problem is one of the amount of attention the EU gets; this is particularly the case for the Royal Colleges, which are with one exception (the RCP-London) sitting out important EU debates on their core concerns of training, qualifications, quality, and research.

CONCLUSION

The development of EU health policy potentially destabilises all aspects of health policymaking; the Working Time Directive, patient mobility decisions, and increasing number of ECJ cases applying internal market law to the NHS systems combine with a high-profile legislative agenda and the range of existing health-relevant policies to create a serious set of challenges. These are not one-off challenges; they are challenges that demand permanent organisational adaptation to the new world of multi-level, Europeanised, devolved health politics. And nobody has yet overcome all the challenges.

The failed inclusion of health in the Services Directive, different streams of ECJ law, and the rise of EU lobbies and the DG for health and consumer protection are all early moves in a long game. As any chess player knows, it is possible to recover from first moves- but they will decide much of the course of the game nonetheless. In the case of the EU, what it means is that the next step is to recognise the difference between hiring a lobbyist and shaping a debate. The former works well to defend interests, but the next stage is to begin to try to shape policymakers' understandings of the issues and values at stake. That depends on thinking in terms of *both* health and the EU, a difficult task that government and stakeholders to varying extents already do. It also means thinking hard about implementation issues. There is likely to be considerable member state ability to influence the real effects of policies, but that is best done by understanding both health services and the EU.

Mainstreaming health in the DH

The Department of Health has two functions. It is the Department of the English NHS, which is by far its most politically important function, and it is the "federal" department of health for the whole UK, responsible for intergovernmental relations and EU or international affairs in health. This presents two different sets of problems. In relation to its role as the agent of the English health services, it faces the internal problem of educating its own officials and the NHS management cadre so as to improve the quality and quantity of information flowing up and down. In other departments this takes time and ministerial

will; while some lower-ranking departments (ancestors of DEFRA) gained prestige from association with the EU, many officials in the DH, like those in the equally recently Europeanised Home Office and DfES, are still all too likely to view the EU as a distraction. This is a challenge that occupies much of the International Division's time, and is likely to continue to do so. The other function of the DH is as the formal connection between all of the UK's health systems, and the EU. This requires both work by the DH and work by the devolved health systems. To date the devolved systems (Northern Ireland and Scotland rather more than Wales) have generally relied on the DH for health information. The DH has both represented general NHS interests (many interests, of course, are in common) and has transmitted information.

The challenge to devolution

The challenge to devolution is simple: there is only one UK voice in Europe, but there are four health systems. Policy might not affect them all equally, but the devolved systems' best chance to influence policy is to influence the UK line, with supplementary activity of their own. All have watching briefs on health in their Brussels offices, and both Scotland and Wales are increasingly paying attention. The resulting poor information flows mean that we do not know how far devolved systems suffer different consequences or have different priorities and the devolved systems are unable to try to take advantage of DH representation. If they do have distinct problems with EU legislation we will learn when it is much too late to do anything about it.

Changing this situation means two things. First, it means that the devolved health systems would be well advised to pay more attention to impact analyses of EU health policy. They are accustomed to doing this in other areas, and should include health so that they are aware of, for example, the impact of EU labour law on services to their remote and rural populations, or of EU internal market legislation and jurisprudence for their distinctive systems of organisation and finance. This would take catching up with the self-education we already see among some senior managers in the English NHS. Otherwise they might be very unpleasantly surprised in the next few years. Second, improving understanding of EU policy's interaction with devolved health systems is likely to find areas on which there is divergence. With time it becomes more likely that some issue, perhaps a health EU issue, will become the object of a major intergovernmental clash. It means that EU health affairs, like every other part of the devolution settlement, would benefit from a dispute resolution system, preferably with a statutory basis, that would allow serious, politically driven, disputes to be resolved in some other way than with the simple imposition of the UK government's position.

The challenge to the NHS

The NHS systems are enormous employers: huge concerns with connections to almost all parts of the UK economy, and charged with spending vast amounts of money in the service of an important goal – health. It is reasonable that they should invest in EU information and influence in order to defend and promote their wide range of interests, which goes beyond what health departments can and will follow, or issues outside the usual health department territory in the civil service.

The two existing NHS operations are regional, and both are working to improve information flows upwards and downwards, the better to formulate stances and influence. The Greater London operation alone has more staff time than any devolved government dedicates to EU health operations. The problems they collectively face are of efficiency – there is no clear reason why regional structures will be much more than duplicative – and of stability. Credibility in Brussels requires consistency, a track record, and quite specific skills. Incessant reorganisation always interferes with consistency; relying on the often-reorganised and much-pressurised NHS regional and local management to sustain a horizon-scanning, policy-oriented operation has worked so far, in some places, but anything of the sort is vulnerable in the constantly reorganising NHS. Three (currently two) NHS regions have led from the front, going beyond what one expects of an often supine and apolitical organisation, but any such activity in the NHS faces sustainability threats – not on its own merits, but because all such activities are threatened by tight resources, increasingly tight focus on a few policies that are rewarded, and reorganisation.

The challenge to interest groups

As is fitting, interest groups have moved far and fast, with the unions, RCN, BMA and RCP-London all engaged on health issues and the NHS Confederation developing its role and team. The interest groups can fit the EU into their existing templates and organisation and tap the existing infrastructure of representatives and pool of political expertise in Brussels. The poor state of health service engagement in the rest of the EU means that some UK interest groups bulk very large. Still, some groups have remained stubbornly London-focused, and that means the effects of EU policies will come to them as rude shocks. Even those who are engaged need to recognise the difference between hiring a lobbyist and shaping a debate, and consider whether and how they want to do the latter.

The challenge to everybody

The health services of the NHS have never faced a challenge quite like the EU: very important, developed outside the UK with no necessary connection to the NHS or its interests, lacking in democratic legitimacy, and developed with little understanding of how the NHS systems work. In the face of much EU policy, there is scope for a united UK front, one animated by commitment to the values of the NHS and to resistance to the diversion of resources into regulatory compliance rather than the health of the public. Interviewees speak wistfully of the desirability of a database that could unite everybody with EU interest and expertise. The non-existence of that database is symptomatic. Stakeholders and governments are responding along predictable lines and with predictable levels of enthusiasm. But there could well be room for more joint working and involvement in the debate. This would avoid duplication, but also preserve and promote the core values of the NHS systems in a diverse and regulatory European Union.

I would like to thank Holly Jarman and Becky Seale for help with the research for this report, and David Rowland for his research and very useful comments. My thanks also to Justin Greenwood for comments and to the anonymous interviewees who gave their time and in some cases agreed to read and comment on the paper in draft form.

REFERENCES

Bertinato, Luigi, Reinhard Busse, Nick Fahy, Helena Legido-Quigley, Martin McKee, Willy Palm, Ilaria Passarani, and Francesco Ronfini. *Policy Brief: Cross-Border Health Care in Europe*. Brussels: European Observatory on Health Systems and Policies, 2005.

Coen, David, and Charles Dannreuther. "Differentiated Europeanisation: Large and Small Firms in the EU Policy Process." In *The Politics of Europeanisation*, edited by Kevin Featherstone and Claudio Radaelli, 255-277. Oxford: Oxford University Press, 2003.

Cram, Laura. *Policy-making in the European Union: Conceptual lenses and the integration process*. London: Routledge, 1997.

Dubois, Carl-Ardy, Martin McKee, and Ellen Nolte, eds. *Human Resources for Health in Europe*. Maidenhead: Open University Press, 2006.

Greenwood, Justin. *Interest Representation in the European Union*. Basingstoke: Palgrave Macmillan, 2003.

Greer, Scott L. *Territorial Politics and Health Policy*. Manchester: Manchester University Press, 2004.

Greer, Scott L. "Uninvited Europeanization: Neofunctionalism and the EU in health policy." *Journal of European Public Policy* 13, no. 1 (2006).

Hazell, Robert. "Intergovernmental Relations: Whitehall Rules OK?" In *The State and the Nations: The First Year of Devolution in the United Kingdom*, edited by Robert Hazell, 149-182. Thorverton: Imprint Academic, 2000.

Hervey, Tamara K., and Jean V McHale. *Health Law and the European Union*. Cambridge: Cambridge University Press, 2004.

Jeffery, Charlie. "Continental Affairs: Bringing the EU Back In." In *Devolution and Power in the United Kingdom*, edited by Alan Trench. Manchester: Manchester University Press, (forthcoming).

Jeffery, Charlie. "Devolution and the European Union: Trajectories and Futures." In *Dynamics of Devolution: The State of the Nations 2005*, edited by Alan Trench, 179-200. Exeter: Imprint Academic, 2005.

Kassim, Hussein. "The United Kingdom." In *The National Co-Ordination of EU Policy: The Domestic Level*, edited by Hussein Kassim, B. Guy Peters and Vincent Wright, 22-53. Oxford: Oxford University Press, 2000.

Masterman, Roger, and James Mitchell. "Devolution and the Centre." In *The State of the Nations 2001: The Second Year of Devolution in the United Kingdom*, edited by Alan Trench, 175-196. Thorverton: Imprint Academic, 2001.

McKee, Martin, Elias Mossialos, and Rita Baeten, eds. *The Impact of EU Law on Health Care Systems*. Brussels: Peter Lang, 2002.

Mossialos, Elias, and Martin McKee, eds. *EU Law and the Social Character of Health Care*. Brussels: Peter Lang, 2004.

Mossialos, Elias, Tom Walley, and Monique Mrazek, eds. *Regulating Pharmaceuticals in Europe: Striving for efficiency, equity and quality*. Maidenhead: Open University Press, 2004.

Phelan, Diarmuid Rossa. "Right to Life of the Unborn v. Promotion of Trade in Services: The European Court of Justice and the Normative Shaping of the European Union." *Modern Law Review* 55, no. 5 (1992): 670-689.

Rowland, David. *Mapping Communicable Disease Control in the UK – between devolution and Europe* London: Nuffield Trust 2006 forthcoming.

Sheldon, Tony. "Pressure mounts over European Working Time Directive." *British Medical Journal* 328 (2004): 911.

Silio, Fernando. "Public procurement of goods and services: a legal analysis of the Spanish case." Paper presented at the European Health Forum Gastein 2001, Bad Gastein, Austria, 26-29 September 2001.

Trench, Alan. "Intergovernmental Relations a Year On: Whitehall Still Rules OK?" In *The State of the Nations 2001: The Second Year of Devolution in the United Kingdom*, edited by Alan Trench, 153-174. Thoreverton: Imprint Academic, 2001.

Trench, Alan. "The More Things Change, the More the Stay the Same: Intergovernmental Relations Four Years On." In *Has Devolution Made a Difference? The State of the Nations 2004*, edited by Alan Trench, 165-191. Exeter: Imprint, 2004.

van Schendelen, Rinus. *Machiavelli in Brussels: The Art of Lobbying the EU*. Amsterdam: Amsterdam University Press, 2002.

Wright, Vincent. "The national co-ordination of European policy-making: Negotiating the quagmire." In *European Union: Power and Policy-Making*, edited by J. J. Richardson, 148-169. London: Routledge, 1996

APPENDIX 1: UK INVESTMENT IN EU HEALTH POLICY

Table 1.1 Government resources

Organisation	Full-time Brussels health staff and dates of establishment	Part-time Brussels health staff / % / dates	UK based EU health staff / % / dates
Department of Health	n/a (works through UKREP)	n/a technical EU issues.	23 EU specialists (as of end 2005). Other staff deal fractionally with
Northern Ireland Exec	None	1 of Brussels team of six has a watching brief, one of many. fractionally.	Two health staff deal with EU along with other issues; others
Scottish Executive	None	1 of Brussels team of 11 has health among four briefs.	Many health staff with fractions spent on EU
Welsh Assembly Government	None	1 of Brussels team of 6 has part-time health responsibilities since 1995 (approx 1/3 of role)	Three health staff deal with EU questions along with other issues; others fractionally.

Table 1.2 NHS organisations

London NHS part-time	Uses GLA Brussels office n/a for monitoring.	2 100% (since April respectively) as well as	2005 and Jan 2006, three secondees.
West Midlands NHS	1 since April 2004 but ends March 2006	None	None
North-West NHS	1 since May 04	None	None

Table 1.3 Other stakeholder groups

	Specialist Brussels health staff	Part-time health staff / % / dates	Membership in EU association
RCN	None	2 since 2000.	Principally works with PCN (Standing Committee of European Nurses)
BMA	1 since 1995	None	European Union of Medical Specialists
UNISON	None		Principally works with EPSU (European Public Services Union)
GMB	None	Part of work of 100% officer and assistant; in place since 1993 and 1995, respectively	Eight EU specialist union affiliations including EPSU
RCS Edinburgh	None	None	None
RCP Edinburgh	None	None	None
RCPS Glasgow	None	None	None
RCP London	None	1 at approx. 35% time	None
RCS London	None	None	None
NHS Confederation	None	Network of six Confederation staffers, each fractionally involved	European Health Management Association, European Hospital and Healthcare Federation

Source: interviews conducted between October 2004 and February 2006; all information fact-checked by telephone as of December 2005

APPENDIX 2: UK ORGANISATIONS INVOLVED IN EU-WIDE ORGANISATIONS WITH A HEALTH INTEREST

EU-wide organisation	Goals	UK members
AER (Assoc. Eur.Regions)	Committed to democracy and solidarity, the AER aims at promoting democratisation processes and regionalisation in Europe and encouraging the application of the principles of subsidiarity and complementarity between the local, regional, national and European institutional levels	Bedfordshire Devon Dorset East Riding of Yorkshire Council Fife Gloucestershire Hampshire Somerset West Midlands West Yorkshire
AESGP (Association Europeenne des Specialites pharmaceutiques Grand Public)	Contributing to the improvement of responsible self-medication at the European level and of ensuring that the views and interest of manufacturers of non-prescription medicines and self-care products in Europe are recognised in the debate around pharmaceutical and health-related matters.	PAGB – The Proprietary Association of Great Britain
AGE (European Older People's Platform)	To promote the interest of older people at EU level, improve the co-operation between older people's organisations and with the EU institutions and to create a resource centre for older people and their organisations form across the EU	Age Concern England (National Council on Ageing) Age Concern Cymru Age Concern Northern Ireland Age Concern Scotland Help the Aged UK Better Government for Older People British Society of Gerontology Civil Service Pensioners Alliance

		Contact Consulting (observer member) Graphical Paper& Media Union-Retired Members Association National Pensioners Convention Older & Bolder at (NIACE) National Institute of Adult Continuing Education Registered Nursing Home Association Third Age Employment Network (Observer Member) NARPO (National Association of Retired Police Officer) Public Service Pensioner's Council – PSPC Veterans in Europe National Federation of Post Office & BT Pensioners Federation of Retired Members Associations of National Association of Schoolmasters Union of Women Teachers (RMA/NASUWT) Shropshire Association of Senior Citizens Forum Senior Studies Institute – University of Strathclyde (Observer member) Brighton and Hove City Teaching Primary Care Trust (observer member) PRIAE – Policy Research Institute on Ageing and Ethnicity The Royal Bank of Scotland Centre for the Older Person's Agenda, Queen Margaret University College – (Observer member) CSV / RSVP (Community Service Volunteers / Retired and Seniors Volunteers Programme)
AIM (Association Internationale de la Mutualite)	To defend and promote, at international and European level, the social values and basic principles shared by its members: access to health care as a fundamental right, solidarity and non-exclusion as essential means to ensure this access to quality health care for all, irrespective of health status or financial capacity to pay; autonomous management and non profit orientation as guiding principles for health insurance based upon the needs of citizens.	BUPA: The British United Providence Association Ltd
ASPHER	Promote the European dimension in Public Health training programmes: Develop and strengthen a unique network of training institutions to advocate their views for a new public health strategy in Europe.	Department of Public Health University of Liverpool Department of Epidemiology and Public Health University of Wales College of Medicine Cardiff School of Community Health Sciences University of Nottingham Medical School

		London School of Hygiene and Tropical Medicine
BEUC (Bureau Européen des Unions de Consommateurs)	To defend the interests of European consumers (citizens as purchasers/ users of goods/services) in the EU policy process.	Consumers' Association National Consumer Council
CHANGE	To strengthen and streamline public health strategies centred on the involvement of people and communities most affected by the HIV/AIDS epidemic, while denouncing the "bad practices" that still remain across Europe; to integrate candidate countries' NGOs (Romania, Czech Republic, Estonia, Poland) into the European network in order to confront know-how and expertise, empower the organisations and reinforce the community's response to HIV in an integrated EU; to strengthen the influence of the network's perspective on the EU health policies so as to help identify both the priorities and the new challenges in the fight against AIDS, while promoting a response from the EU to counteract the epidemic globally.	Terrence Higgins Trust
CPME – Standing Committee of European Doctors	The aim of the CP is to promote the highest standards of medical training and medical practice in order to achieve the highest quality of health care for the people of Europe. The CP is particularly concerned to promote public health, the relationship between patients and doctors and the free movement of doctors within the European Union.	British Medical Association
EAGS (European Alliance of Patients Support Groups for Genetics services)	To promote awareness of the impact of genetic disorders on families in the EU and to raise awareness of their needs for support; to create a positive climate within which genetic research and development can; to combat unfair discrimination arising from the abuse of individual genetic information.	Genetic Interest Group
EATG (European Aids Treatment Group)	To ensure that the maximum number of people with HIV/AIDS in Europe have rapid access to state-of-the-art treatment, including treatment trials and monitoring tests. To advocate for the rapid introduction of expanded access programmes for promising experimental drugs in as many	Unknown

	European countries as possible. To promote a common Standard of Care and treatment for all people living with HIV, to promote the rights of people with HIV and their advocates to participate in the design and management of drug trials.	
EBU (European Blind Union)	To represent all blind people in Europe; to promote the advancement of the interests of blind people including those with additional handicaps with the goal of achieving their equal rights as citizens and full participation in society; to provide a European forum for exchange of knowledge and experience in the field of blindness; to promote the prevention and cure of blindness; to strive for equal representation and participation of gender and age in its activities and in particular in the selection by national members of delegations to the general assembly, in elections to the Board and committees and in appointments to commissions, committees and working groups.	Royal National Institute of the Blind
ECH (European Committee for Homeopathy)	The ECH takes the position that the training criteria for practitioners of homeopathy should be harmonised at the same high level as in conventional medicine. Both a full medical, veterinary, dental or pharmacy qualification and a high-quality training. The ECH's final goal is for homeopathy to be integrated into the existing European health care system.	Faculty of Homeopathy
ECL (The Association of European Cancer Leagues)	To promote health, to improve prevention of malignant disease, to promote research and evidence-based treatment in the field of cancer and to be responsive to the needs of cancer patients, their families and carers.	Cancer BACUP The Cancer Research Campaign Imperial Cancer Research Fund Marie Curie Cancer Care Macmillan Cancer Relief TENOVUS Ulster Cancer Foundation
EDF (European Disability Forum)	To promote equal opportunities and non-discrimination of disabled people and to guarantee and protect their fundamental human rights by means of active involvement in policy development and campaigns on disability rights at the EU level.	UK Disability Forum for European Affairs (UKDFIE) Brain Injured & Families – European Confederation (BIF-EC) Cerebral Palsy – European Communities Association (CP-ECA) Dystrophic Epidermolysis Bullosa Research Association-Europe (DEBRA-EUROPE) European Network on Independent Living (ENIL)

		European League of Stuttering Associations (ELSA) European Federation of Crohn's and Ulcerative Colitis Associations – (EFCCA) European Haemophilia Consortium (EHC) European Institute for Design and Disability (EIDD) European Society for Mental Health and Deafness (ESMHD) Royal National Institute for the Blind (RNIB) Royal National Institute for Deaf People and hard of hearing people (RNID) National Development Team UK The National Deaf Children's Society (NDCS) The Forum of People with Disabilities Ireland Huntington's Disease Association The Guide Dog for the Blind Association European Parkinson Disease Association (EPDA) European Lupus Erythematosus Federation (ELEF) Eurolink Age Disabled Persons Transport Advisory Committee (DPTAC) Disability Rights Commission United Great Britain (DRC-GB) Artsline
EFA (European Federation of Allergy and Airways Disease Patients)	To represent the views and interests of people who have allergy, asthma or COPD to ensure a continuing improvement in their quality of life, and that of their carers; To promote prevention, research and education on asthma and allergy; To provide a forum for debate within Europe between individuals and national organisations; To improve the quality of allergy, asthma and COPD management through health care professionals and patient education programmes; To campaign for improvements in the quality of life of people with airways diseases; To increase awareness of allergy, asthma and COPD; To be a strong and critical partner for European Union.	Asthma UK British Allergy Foundation BAF – Allergy UK
European Federation of Internal Medicine	The European Federation of Internal Medicine is a scientific organisation founded in 1996 from the European Association of Internal Medicine.	RCP-London

	The Federation brings together the National Societies of Internal Medicine of different countries across Europe, and currently has 30 member societies. Its purpose is to re-emphasise the importance of Internal Medicine in patient care in a world of increasing specialisation.	
EFPIA (European Federation of Pharmaceutical Industries and Associations)	To promote pharmaceutical research and development in order to bring new medicines onto the market in the interest of patients and human health world-wide.	ABPI – The Association of the British Pharmaceutical Industry GlaxoSmithKline
EGA (European Generic medicines Association)	The promotion of quality medicines at affordable prices – representing the interests of the European generic medicines and active pharmaceutical ingredients industry sectors.	Unknown
EHMA (European Health Management Association)	Committed to raising standards of managerial performance in the health sector, in order to contribute to the improvement of health status in Europe, and contributing a health services dimension to health policy debates at European level.	Anaptys Ltd BUPA Cardiff and Vale NHS Trust Centre for Health Leadership Wales Cheshire & Wirral Partnership NHS Trust Controls Assurance Support Unit (CASU) Co-operation and Working Together (CAWT) De Montfort University Department of Health City University Department of Health Social Services and Public Safety, Northern Ireland Gillian Vass Greater Manchester Strategic Health Authority Guy's & St. Thomas' NHS Hospital Trust Health & Social Care Consulting Services – HSCCS Imperial College Management School Keele University King Edward's Hospital Fund for London London School of Economics & Political Science London School of Hygiene & Tropical Medicine Centre for Public Policy and Management (Manchester Business School) NHS Confederation North & West Belfast Health & Social Services Trust Northern Ireland Centre for Health Care Co-operation & Development –

		NICARE Northumbria University (School of Health, Community and Education Studies Nuffield Institute for Health Office for Public Management Picker Institute Europe Preston Primary Care Trust NHS London RHC Health Consulting Ltd Roche Products Ltd. Royal Brompton Hospital NHS Trust Royal College of Nursing of the United Kingdom The Beeches Management Centre The Health Foundation The Nuffield Trust The Scottish Office UNISON University of Birmingham (Health Services Management Centre (HSMC)) University of Central Lancashire (Lancashire School of Health and Postgraduate Medicine)University of Durham Queen's Campus (School for Health) University of Glamorgan (Welsh Institute for Health and Social Care) University of Surrey (European Institute of Health & Medical Sciences) University of York (Centre for Health Economics) Whipps Cross University Hospital NHS Trust Middlesex University Bro Morgannwg NHS Trust Mediate Health Consulting Brighton and Sussex University Hospitals NHS Trust NHS Counter Fraud Service (Laura Davies) Centre for Research in Primary and Community Care The Hillingdon Hospital NHS Trust South & East Belfast HSS Trust
EHN (European Heart Network)	To play a leading role through networking, collaboration and advocacy in the prevention and reduction of cardiovascular disease (CVD) so that it will no longer be a major cause of premature death and disability throughout Europe.	British Heart Foundation Coronary Prevention Group National Heart Forum Northern Ireland Chest Heart & Stroke Association
EHTEL ASSOCIATION (European Health Telematics)	Promoting the use of telematics solutions in healthcare.	NHS Information Policy Department of Trade and Welfare NHS Information Authority

		St Guy's & St Thomas's Hospital NESTOR Healthwatch Limited IAPO De La Rue GSK Oxford Computer Consultants McKesson HBOC Motion Media Silicon Bridge Avienda Ltd Richardson Consulting UK Ltd Ray Rogers David Garwood David Preston
EMA (European Midwives Organisation	We recognise the importance of smooth and transparent legislation and mechanisms the mutual recognition of health profession diplomas within the EU. We will therefore work to influence these legal mechanisms at both national and international levels to ensure and keep the minimum standard of training and practice stated in the former Midwives Directives.	Unknown
ENHPA (European Network of Health Promotion Agencies)	To contribute to the development of public health and health promotion in Europe through enhancing Communication between national agencies; dialogue with the EU; and facilitating implementation of EU strategies	Health Development Agency
ENSP (European Network for Smoking Prevention)	To develop a strategy for co-ordinated action among organisations active in tobacco control in Europe. The aim is to create greater coherence among smoking prevention activities and to promote comprehensive tobacco control policy at both the national and European level.	Mrs Doreen McIntyre – No Smoking Day Ms Patti White – Health Development Agency
EPHA (European Public Health Alliance)	To protect and promote the public health interests of all people living in Europe by strengthening civil dialogue.	Health Development Authority Health Promotion Agency for Northern Ireland (HPANI) Health Services Management Centre (HSMC), University of Birmingham Faculty of Public Health Medicine of the Royal Colleges of Physicians of the United Kingdom Mid-Western Health Board National Meningitis Trust Royal College of Nursing (RCN) Royal Society for the Promotion of Health Royal Society for the Prevention of Accidents (ROSPA)

		Royal College of Physicians-London Sefton Health, Department of Public Health Sandwell Health Authority UK Public Health Association (UKPHA) United Kingdom Thalassaemia Society Welsh Food Alliance European Coalition of Positive People (ECPP) European Council for Classical Homeopathy (ECCH) Reflexology in Europe Network Diabetes UK British Fluoridation Society United Kingdom British Heart Foundation – Health Promotion Research Group (BHF-HPRG) Broadcasting Support Services (BSS) Cambridge and Huntingdon Health Authority Alcohol Concern Chartered Institute of Environmental Health (CIEH) Community Practitioners' and Health Visitors' Association Faculty of Health of the University of Brighton
EPSU (European Federation of Public Service Unions)	The primary issue for EPSU is one of representativity. EPSU is an organisation, which represents 2.8 million health workers. EPSU is a recognised social partner, and participates actively in social dialogue in health, local government, national administration and public utilities.	Royal College of Nursing (RCN) Northern Ireland Public Service Alliance (NIPSA) Chartered Society of Physiotherapy (CSP) Amalgamated Engineering and Electrical Union (AEEU, EETPU Section) GMB Institution of Professionals, Managers and Specialists (IPMS) UNISON Manufacturing Science Finance Union The Association of First Division Civil Servants (AFDCS)
ESIP (European Social Insurance Partners Association)	To preserve high-profile social security for Europe, to reinforce solidarity-based social insurance systems (Social Profit Human Risk Insurance), to maintain the European Social Protection Quality.	No UK membership
ESMHD (European Society for Mental Health & Deafness)	ESMHD is a European NGO for representatives of National organisations of Deaf people, parents of Deaf children and Deaf and hearing professionals in mental health & Deafness.	Unknown
EUCOMED	To represent the Medical Technologies and Devices industry in Europe, to	ABHI 2 AIII

	generate a clear understanding of issues of importance to the industry and to ensure that such issues are raised appropriately at both European Union and national government level.	
EUPHA (National Associations of Public Health for the European Public Health	To promote public health in Europe as a voluntary association of the national public health organisations of each country.	UK Society of Social Medicine UK Faculty of Public Health Medicine
EUROCARE (Advocacy for the prevention of Alcohol Related Harm in Europe)	To create and nurture ties between organisations concerned with alcohol related harm; influence European policy-makers by advocating evidence-based and effective alcohol policy; monitor policy; advocate the prevention of alcohol related harm in European Union decision-making	British Allergy Foundation BAF – Allergy UK British Lung Foundation BLF
EUROPA DONNA (The European Breast Cancer Coalition)	To mobilise the support of European women in pressing for improved breast cancer education, appropriate screening, optimal treatment and care and increased funding for research.	Europa Donna Forum – UK
EURORDIS (European Organization for Rare Disorders)	To Promote Rare Disorders, by: Supporting the development of National Alliances of patients organisations in each member state; Stimulating coordinated research efforts at a European level, particularly in the clinical area; Promoting increased European funding for research and clinical trials.	Alstrom Syndrome UK Angelman Syndrome Support Group Ataxia-Telangiectasia Society Birth Defect Foundation Children's Liver Disease Foundation Children Living with Inherited Metabolic Diseases (CLIMB) Contact a Family Dancing Eye Syndrome Support Trust DEBRA UK (Dystrophic Epidermolysis Bullosa) Encephalitis Support Group Gauchers Association Genetic Interest Group International Costello Syndrome Support Group Jennifer Trust for Spinal Muscular Atrophy Micro & Anophtalmic Childrens Society National Fetal Anticonvulsant Syndrome Association Niemann-Pick Disease Group U.K. Prader-Willi Syndrome Association UK Primary Immunodeficiency Association Support Organisation for Trisomy 13/18 Sturge-Weber Foundation UK Tracheo Oesophageal Fistula Support Tuberous Sclerosis Association Tuberous Sclerosis Europe (EUROPEAN ASSOCIATION – U.K.) Unique – The Rare Chromosome Disorder Support Group Williams Syndrome Foundation LTD

GAMIAN-EUROPE (Global Alliance of Mental)	To raise the profile of mental illness on a national and European level, having regard to the incidence and prevalence of mental illnesses across Europe, To continue to work towards expanding the membership of GAMIAN-Europe on the basis that every organisation has something to offer and that, by sharing examples of good practice, the best outcomes can be achieved for patients and their carers at the most economical cost.	The Men's Health Forum No Panic Phobic Action Papyrus The Manic Depression Fellowship
GIRP (Groupement International de la Répartition Pharmaceutique)	The association is a communication platform and focal point between its member organisations and all players in the health care sector, providing information and co-ordinating informed opinions on all matters relevant to the efficient and safe distribution of medicines throughout Europe.	British Association of Pharmaceutical Wholesalers Alliance UniChem Plc
HAI (Health Action International)	Promotes a more rational use of medicinal drugs: all drugs marketed should meet real medical needs, have therapeutic advantages, be acceptably safe and offer value for money. HAI promotes equitable and affordable access to essential medicines and non pharmacological therapy when possible and appropriate.	Individual members.
HOPE (Hospitals of EU)	To act as a principal source of advice on hospital and health affairs to the institutions of the EU; to develop and maintain information about planning and operation of the hospital services and of the health systems within which they function; to promote exchange and twinning programmes and training within the EU and elsewhere in the world; to engage in any other activity designed to further the best interests of hospital services in the EU and of the health systems within which they function.	National Health Service
IAPO (International Alliance of Patients' Organisations)	Representing patients of all nationalities across all disease areas, and promoting patient centred healthcare around the world.	Androgen Insensitivity Syndrome Support Group Arthritis Care Breast Cancer Care British Polio Fellowship Children Living with Inherited Metabolic Diseases Depression Alliance Ehlers-Danlos Syndrome Support Group UK

		Endometriosis SHE Trust Epilepsy HERE (Help Education & Research for Epilepsy) Genetic Interest Group Headstart4Babies Herpes Viruses Association Infertility Network UK Involve Long Term Medical Conditions Alliance Multiple Sclerosis Society (UK) Myotonic Dystrophy Support Group Narcolepsy Association UK National Osteoporosis Society No Panic Patient Involvement Group Psoriatic Arthropathy Alliance Sudden Adult Death Trust Syncope Trust and Reflex Anoxic Seizures The Patients Association
IPPFEN (European Network Parenthood Federation)	To advance, defend and protect the basic human right of all people to make free and informed choices in their sexual, emotional and reproductive lives; to strive for the development and provision within Europe of a range of accessible information, education and clinical services of high quality, regarding sexuality and sexual identities, conception, contraception and safe abortion.	Fpa
IUHPE (International Union for Health Promotion and Education)	The mission of the International Union for Health Promotion and Education (IUHPE) is to promote global health and contribute to the achievement of equity in health between and within countries of the world.	Health Development Agency – England, U.K. Health Promotion Division, National Assembly for Wales
MHE-SME (Mental Health Europe-Sante Mentale Europe)	The promotion of positive mental health and the prevention of mental distress, the improvement of care and advocacy and the protection of human rights for the patients and their families and carers.	Action for Mental Health Institutional and Professional Development Centre School of Education Heriot-Watt University InterMinds Mind Partnership for Children PENUMBRA The British Psychological Society The Northern Ireland Association for Mental Health
PCN (Standing Committee of Nurses)	Strengthening PCN and the influence of nursing with the EU, with enhanced representation in Brussels at the heart of Europe; developing nurse education, particularly in the context of the EU's	RCN

	system for mutual recognition of qualifications; developing public health policy and practice in Europe and devising a programme of continuing professional development for nurses in public health; addressing nursing workforce issues across Europe	
PGEU (Pharmaceutical Group of the European Union)	To represent and promote community pharmacists as key players to help safeguarding the health of European citizens. PGEU's main objective is to ensure that this role is recognised and acknowledged also at European level.	Royal Pharmaceutical Society of Great Britain National Pharmaceutical Association Pharmaceutical Society of Northern Ireland
Red Cross / EU – Bureau Croix-Rouge / UE	To represent and promote the interests of its members as well as the policies and values of the Red Cross and Red Crescent Movement to the European Union Institutions	British Red Cross
UEHP/CEHP (Union Européenne de l'Hospitalisation Privée)	To support the participation of independent hospitals in the social hospitals service in the countries of the European Union; to generate the political and economic conditions which favour independent initiative in the health field; to study and to create the better conditions for the management and the quality assurance in the independent hospitals	Independent Hospitals Association (IHA) – BUPA
UEMS (European Union of Medical Specialists)	The promotion of harmonisation of training programmes within the various specialties throughout the EU and the encouragement and facilitation of CME, Continuing Medical Education. Agreed positions are reached by the representatives of all the European national medical associations. It encourages the authorities of the European Union and the national specialist organisations to implement its recommendations.	British Medical Association
Youth Forum Jeunesse	No mission statement provided	BYC

This table was compiled from the European Health Policy Forum's website. The EHPF, sponsored by DG Health and Consumer Protection, is a forum of EU-wide associations; these are listed in column 1. The second column is the mission statement provided by the organisation. The third column lists UK members. Entries in this third column were supplemented by direct contacts with the organisations when it was impossible to work out their UK membership from their public documentation. It is up to date as of January 2006. The EHPF website is http://europa.eu.int/comm/health/ph_overview/health_forum/health_forum_en.htm

What is striking is the diversity of EU stakeholder organisations engaged with some aspect of EU health policy and the way policy issues are defined very differently. This is a new and challenging environment for organisations accustomed to the comparatively stable environment of UK health policymaking. It will take time to establish which organisations are the most effective allies and which coalitions are possible, and this will have to happen while the borders and concerns of EU health policy are changing rapidly.