

MIGRATION OF PATIENTS AND MIGRATION OF POWER: POLITICS AND POLICY CONSEQUENCES OF PATIENT MOBILITY IN EUROPE

SCOTT L. GREER*

INTRODUCTION

This paper advances the argument that patient mobility policy is not about patients, rather, it is about power. Patient mobility is about power because it initiates two types of movements in the distribution of power, both of which are more consequential than the actual movement of patients: shifts in power between governments and shifts in power between different interest groups.

First, patient mobility policy is about the shifts in power between governments which is also known as “authority migration.”¹ The fact that patient mobility fits into a larger European Union (EU) regulatory framework driven by EU institutions² means that it comes with a transfer of power to the EU, loss of Member State autonomy, and disruption of relationships between governments within Member States. Second, the developing EU patient mobility regime is also a shift in power between different policy advocates and interest groups with their different/substantive preferences. This depends upon the different advocates’ ability to exploit new power relationships. As a result, the development of EU patient mobility law is a power struggle. The stakes are determined by the choices respective governments make, how they constrain each other’s autonomy, and what substantive policy objectives will win as a result of the shifting intergovernmental relations sparked by the extension of EU competencies.

* Scott L. Greer, PhD, Assistant Professor of Health Management and Policy at the University of Michigan School of Public Health. Senior Research Fellow at LSE Health, London School of Economics, UK.

¹ Elisabeth R. Gerber & Ken Kollman, *Introduction – Authority Migration: Defining an Emerging Research Agenda*, 37 PS: POL. SCI. & POL. (Issue 03) 397, 397 (2004). See also KAREN ORREN & STEPHEN SKOWRONEK, *THE SEARCH FOR AMERICAN POLITICAL DEVELOPMENT* (2004).

² Definitions of institutions and theoretical debates are plentiful. For purposes of this article, “institutions” means coherent organizations with legal bases acting in politics: the European Court of Justice and the European Commission above all.

The approach found in this article focuses on policy issues, if nothing else, because a political scientist's ability to contribute to legal knowledge in the wake of the other papers at this symposium is limited.³ The policy perspective is a distinct one that focuses on policymakers' views of the sources, contexts, and consequences of EU policies. Compared to a more legal approach, a focus on policy has three outcomes: first, focusing on policy reduces the role of law. Courts are but a part of policymaking; second, it combines legal and policy issues; and third, it focuses on the organization of health policymaking in understanding the law and its consequences.

It is first necessary to focus on how policy changes emphases. The European Court of Justice's (ECJ) repeated assurances that it respects the centrality of Member States in the organization and the finance of health care was derided by Member State officials that were interviewed by the author.⁴ On the other hand, Member State officials also, more or less freely, admitted to ignoring particular points of European Union (EU) law that is contrary to them when they feel that a legal challenge to non-compliant policies is unlikely. We see this when asked if they have changed policies to comply with EU law in areas such as patient mobility, competition, and public procurement; the answer is often a simple "no."

Second, a focus on policy combines legal and policy issues because it seeks out the effects of the interaction between the law and existing policy. For example, as some United Kingdom (UK) interviewees suggested, the principal effect of *Yvonne Watts v. Bedford Primary Care Trust, Secretary of State for Health*⁵ was to increase the power of consultants (specialist doctors) whose "clinical judgment" had gained credibility at the expense of managers charged with rationing scarce health resources. The change in the balance of power within the UK's National Health Service (NHS) might be compatible with the ECJ's holding,⁶ but

³ HEALTH SYSTEMS GOVERNANCE IN EUROPE: THE ROLE OF EU LAW AND POLICY (Elias Mossialos, Govin Permanand, Rite Baeten & Tamara K. Hervey eds.) (forthcoming 2009). See HEALTH GOVERNANCE IN EUROPE: ISSUES, CHALLENGES AND THEORIES (Monika Steffen ed., 2005).

⁴ References to interviews are from this set. They are described below and in SCOTT L. GREER, BECOMING EUROPEAN: HOW FRANCE, GERMANY, SPAIN AND THE UK ENGAGE WITH EUROPEAN UNION HEALTH POLICY (2008), available at <http://www.nuffieldtrust.org.uk/ecomms/files/Becoming-European-191108.pdf>.

⁵ Case C-372/04, *Yvonne Watts v. Bedford Primary Care Trust, Secretary of State for Health*, 2006 E.C.R. I-4325.

⁶ *Id.*

it is highly unlikely that the Court knew enough to expect it or put serious effort into working out such possible consequences.

Third, a focus on policy also means that the organization, both formal and informal, of health policymaking becomes crucial to understanding the law and its consequences. The meaning of decisions that undermine pre-authorization requirements and their force are different in the UK and France because the former system maintains much tighter control over patient pathways.⁷ Member States' organizations, cultures, and contacts with the EU matter greatly here because they shape real and practical responses and engagement with the EU policy process.

The goal of this article is to identify the consequences associated with the development of the part of EU health policy carried out under the rubric of patient mobility. It can be seen not just as a chapter in the ongoing expansion of the EU's power to regulate Member States, but also one with noticeable costs and effects on policy. The data contained in this article is based on ninety-two interviews conducted in waves at approximately six-month intervals since 2004, with officials and lobbyists from four Member States (France, Germany, Spain, and the UK) and the European Union as well as a quantitative study of European Union health lobbying. This approach gives a particular bias that might complement other studies; it focuses on the Member States' top policymakers more than, for instance, the people on the ground who make patient mobility policy and make it work more or less well.⁸

Part I of this paper will introduce two key concepts from the study of EU politics that influence the shape of EU health policy: the policy advocates and the regulatory state. It argues that it is possible to identify systematic biases in EU health policies by paying attention to the kinds of policy advocates who work in EU health politics, and to the available, largely regulatory, EU policy tools. Part II carries this notion forward by arguing that the two principal institutions involved in EU health policymaking, the European Court of Justice and the European Commission, both have a strong tendency to privilege pro-market regulatory policies that expand EU competencies. Part III examines the likely consequences of this political structure, arguing that it produces systematic distortions in favor of regulations justified by the internal market, without much ability to conduct realistic cost-benefit analyses. Part IV

⁷ GREER, *supra* note 4, at 31.

⁸ Octavi Quintana i Trias, *Foreword* to PATIENT MOBILITY IN THE EUROPEAN UNION: LEARNING FROM EXPERIENCE at ix (Magdalene Rosenmöller, Martin McKee & Rita Baeten eds., 2006), available at http://www.euro.who.int/Document/Obs/Patient_Mobility.pdf.

of this article then identifies the kinds of costs that we can expect this policymaking to impose on health systems: compliance costs and foregone opportunities to make policies. Part V argues that Member States put up with EU health law because the structure of the EU makes it almost impossible for them to change such law. The article concludes by stressing that patient mobility law is about the power of the EU rather than about patients, and recommends that future law and policy might be improved by greater cost-benefit evaluation, flexibility, and legal certainty in health law.

I. THE POLITICS OF HEALTH IN EUROPE

At a basic level, the politics of patient mobility and the effects of patient mobility jurisprudence can be understood best by keeping two simple facts in mind: policy advocates are not usually interested in constitutional politics while the EU institutions' limited range of policy tools shapes what they can do. Both facts come from classic analyses of policymaking and the EU and neither of them are particularly controversial but can be easily forgotten.

The first fact to be aware of is that policy advocates drive policies and that behind most snap decisions there is somebody or many "somebodies" who have been pressing for the policy in question for some time. Typically, policy advocates' loyalties are to a substantive outcome as much or more than to a particular institutional form.⁹ This makes policy advocates strategic actors in intergovernmental relations, regardless of whether they are good or bad at it. Policy advocates seek substantive ends, be they ideologies, particular pet policies, or solutions to their particular problems. They tailor their approach to questions of territorial politics to reflect their substantive interests. A private insurance industry association might ask its Brussels office to support expansions of internal market laws and a public health association might invest in its own Brussels office and networks to help it win grants; but those are almost always tactical decisions about which forums will be most responsive to the different organizations' concerns. Neither the insurers nor the public health activists are likely to be paying for services to subsidiarity or European integration.

⁹ See generally JOHN W. KINGDON, *AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES* (2d ed. 1995); See Hank C. Jenkins-Smith & Paul A. Sabatier, *Evaluating the Advocacy Coalition Framework*, 14 J. OF PUB. POL'Y 175, 179 (1994).

The second fact concerning the politics of patient mobility is that EU institutions, like any set of institutions, have defined and observable capacities, characteristic capabilities, constraints, policy tools, and preferences. The EU institutions' cultures and interests adapt to focus on what works best for them and their participants will filter out irrelevant options.¹⁰ In other words, a political process and its outcome will be shaped by the particular organizations involved; courts will not have the same effect as legislatures.

By fusing the two aforementioned facts, the result is a small, even banal, yet sturdy model of politics. Advocates will lobby the European Commission (EC) or file suits on points of EU law based on the policy ideas that they think the EU is most likely to pick up and the EU institutions will select the issues and points of law that promise to combine substantive accomplishment with an expansion of their role. Perhaps the EU institutions will overstep their competencies and others' tolerations or perhaps the substantive justification for the policy will turn out to be inadequate. That is simply the kind of risk that comes with involvement in EU politics.

Thus, substantive policy will reflect institutional capabilities. The European institutions—and EU policymaking overall—will pick up the policy ideas that they *can* use (and obviously not ones that they cannot use). Therefore, some policy advocates will develop elective affinities with the EU. The process of filtering that takes place in the relationship means that advocates who come to the EU institutions will seek what the EU institutions deliver best—fitting their expectations to their target's capabilities. Others, such as trades unions, will draw back after disappointment or conclude that a great deal of what they can do in the EU is defensive because it generally cannot develop the kind of broad based labor law they once sought.¹¹ The result is that the expansion of EU competencies will often come with substantive justifications and support from lobbies. The nature of the EU institutions, however, will shape the policies that succeed.

What are the policies that those institutions tend to produce? The key element to remember in analyzing the EU institutions and its elective affinities is that the principal role of the EU institutions is regulatory. Regulatory politics are distinctive because the regulator can often

¹⁰ See FRITZ W. SCHARPF, *GAMES REAL ACTORS PLAY: ACTOR-CENTERED INSTITUTIONALISM IN POLICY RESEARCH* (1997).

¹¹ See AILISH JOHNSON, *EUROPEAN WELFARE STATES AND SUPRANATIONAL GOVERNANCE OF SOCIAL POLICY* 94-96 (Palgrave Macmillan 2005).

control the level of its exposure and involvement.¹² Unlike policies that require budgets, resources, or hiring large workforces, regulators can simply go quiet when they lose interest or political support and reappear later. Regulatory power does not necessarily mean a commitment to act. In turn, extending regulatory competencies is relatively low cost.¹³ The ECJ and the EC, in their respective ways, can draw back from the more extreme conclusions they might reach but leave behind principles that permit them to revisit the issue. When EU institutions retreat, it is not necessarily clear if they have retreated permanently or as a tactical retreat. Thus, the manner in which an EU competency, such as a competency in health services, is established matters as much as its actual content. The authority to regulate remains even after the politics have moved on. This explains some of the characteristic mechanisms that courts use to expand their influence. One is to declare that the court does have jurisdiction and then side with the politically stronger force (as in the American case, *Marbury v. Madison*,¹⁴ or the Spanish decision 76/1983 striking down the Law for the Harmonization of the Autonomous Process).¹⁵ This allows the court to expand its jurisdiction while leaving the most powerful political forces satisfied. Another mechanism is to develop new lines of reasoning and competencies in cases where the actual policy consequences are small. In the same way, the ECJ patient mobility decisions initially enunciated major principles in substantively unimportant cases—spectacles and orthodontia in Luxembourg, the topics of *Kohll v. Union des Caisses de Maladie*¹⁶ and *Decker v. Caissede Maladie des Employés Privés*,¹⁷ make up a comically small issue, even if the underlying legal issues were not. This kind of role power without administrative responsibility is attractive to elite bureaucrats in most settings and there is no clear reason to assume that EU officials do not also share the preference for it.¹⁸

The secondary kind of EU power is its ability to direct interest to itself through networks, soft governance mechanisms of many sorts, and

¹² See generally Theodore J. Lowi, *Review Article: American Business, Public Policy, Case Studies, and Political Theory*, *WORLD POL.*, July 1964, at 677 and GIANDOMENICO MAJONE, *REGULATING EUROPE* (1996).

¹³ MAJONE, *supra* note 12.

¹⁴ 5 U.S. 137 (1803).

¹⁵ STC, Aug. 5, 1983 (S.T.C., No. 76).

¹⁶ Case C-158/96, *Kohll v. Union des Caisses de Maladie*, 1998 E.C.R. I-1931.

¹⁷ *Decker v. Caissede Maladie des Employés Privés*, 1998 E.C.R. I-1831.

¹⁸ PATRICK DUNLEAVY, *DEMOCRACY, BUREAUCRACY AND PUBLIC CHOICE: ECONOMIC EXPLANATIONS IN POLITICAL SCIENCE* (Prentice Hall ed., 1992) (1991).

grants.¹⁹ None of these factors need have any consequences and there is a rich seam of skepticism about all of them. However, they oftentimes do have consequences. Applying for grants requires networks and participation in EU funded networks can create personal connections and shared interests as well as larger policy or professional results. Expanding EU networks by definition engages more people with the EU, deepening and broadening its information sources and perhaps its elite support.²⁰ In addition, networks also shape policy, albeit unpredictably.²¹

II. STRATEGIC REGIONALISM: “SHOOTING WHERE THE DUCKS ARE”²²

It seems that there is an admirable degree of consensus in EU health politics. There are no public statements, to the author’s knowledge, that suggests that any actor in the EU is motivated by the desire to make health services worse, or even impose costs on them. This should not surprise anyone. Bad policies (by any definition of “bad”) will be presented either as good ones without proper estimates of the size and incidents of their costs or, most frequently, by ignoring opportunity costs.

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

For purposes of simplicity, this paper will only address the two leading institutions of the EU: the European Court of Justice and the European Commission. They have been the main actors in the story of patient mobility law; indeed, it is difficult to imagine any of the present discussion taking place if it were not for *Raymond Kohll v. Union des*

¹⁹ See Wolfram Lamping, *European Integration and Health Policy*, in HEALTH GOVERNANCE IN EUROPE 18, 22-28 (Monika Steffen ed., 2005). See also CRIS SHORE, BUILDING EUROPE: THE CULTURAL POLITICS OF EUROPEAN INTEGRATION (2000).

²⁰ David Coen, *Empirical and Theoretical Studies in EU Lobbying*, 14:3 J. OF EUR. PUB. POL. 333, 338 (April 2007).

²¹ Scott L. Greer & Bart Vanhercke, *New Forms of EU Governance Applicable to Healthcare*, 18 EU L., POL., AND NAT’L HEALTH SYSTEMS.

²² Jeremy J. Richardson, *Interest Group Behavior in Britain*, in PRESSURE GROUPS 86, 89 (Jeremy J. Richardson ed., 1993).

Caisses de Maladie,²³ *Decker v. Caisse de Maladie des Employés Privés*,²⁴ and subsequent events such as the Services Directive debates.

A. THE EUROPEAN COURT OF JUSTICE

There is a great deal of sensitive work in the role of top courts; an increasing share of it is dedicated to the role of EU law in the EU.²⁵ Thus, it is necessary to qualify any generalizations. The generalizations are relatively simple: the ECJ is a very successful international court which has been able to establish ascendancy over Member States through the doctrines of “direct effect” and “supremacy,” and consequently has become the center of a thriving EU law community that is tied remarkably closely to the EU institutions themselves.²⁶ Furthermore, the ECJ has reshaped many areas of law over a number of decades, even at times when formal integration through legislation was almost at a halt.²⁷ Thus, it is not difficult to see why affronted policymakers in the author’s interviews sometimes speak of it as having a sort of will to power.²⁸

The qualifications stated above are important. It cannot be said that there is a necessary will to power in the ECJ because it is clearly able to demarcate its competencies when it wants to avoid becoming embroiled in endless regulatory oversight. Nor can we say it is insulated from politics. The best arguments here are the statistical ones, which find the ECJ, over the span of many decisions that have (1) agreed with a majority of the Member States and the Commission, (2) that it is indifferent to the preferences of the European Parliament, and (3) that it rarely pays attention to isolated Member States’ policy choices.²⁹ Like most top courts, the ECJ does not normally make decisions that leave it politically

²³ Case C-158/96, *Kohll v. Union des Caisses de Maladie*, 1998 E.C.R. I-1931.

²⁴ Case C-120/95, *Decker v. Caissede Maladie des Employés Privés*, 1998 E.C.R. I-1831.

²⁵ See Karen J. Alter, *Who Are the “Masters of the Treaty”?: European Governments and the European Court of Justice*, 52 INT’L ORG. 121 (1998); Walter Mattli & Anne-Marrie Slaughter, *Revisiting the European Court of Justice*, 52 INT’L ORG. 177 (1998); ALEC STONE SWEET, *GOVERNING WITH JUDGES: CONSTITUTIONAL POLITICS IN EUROPE* (2000); and Alec Stone Sweet, *Judicial Authority and Market Integration in Europe*, in *INSTITUTIONS & PUBLIC LAW 99* (Tom Ginsburg & Robert A. Kagan eds., 2005).

²⁶ Harm Schepel & Rein Wesseling, *The Legal Community: Judges, Lawyers, Officials and Clerks in the Writing of Europe*, 3 EUR. L. J. 165, 178 (1997).

²⁷ Anne-Marie Burley & Walter Mattli, *Europe Before the Court: A Political Theory of Legal Integration*, 47 INT’L ORG. 41, 46 (1993).

²⁸ A theme running throughout my interviews. See generally Greer, *supra* note 4.

²⁹ JOSEPH JUPILLE, *PROCEDURAL POLITICS: ISSUES, INFLUENCE, AND INSTITUTIONAL CHOICE IN THE EUROPEAN UNION* (2004); MIGUEL POIARES MADURO, *WE THE COURT: THE EUROPEAN COURT OF JUSTICE AND THE EUROPEAN ECONOMIC CONSTITUTION* 175 (1998).

exposed without support and it has been known to retreat from such decisions when it does.³⁰ Likewise, as with other top courts, the actual policy consequences of the ECJ's decisions can be relatively small.³¹

This, however, merely reduces the role of the ECJ to a pair of probabilistic statements. First, it is most likely to engage when it can make a legally strong decision. Second, a combination of teleology and a focus on the internal market is what policymakers look for when trying to predict its legally strong decisions. There are a variety of reasons, from workload to political backlash, as to why the ECJ would limit itself from venturing into new policy areas. That, however, does not rule out feelers. Arguably, in cases such as *Watts*³² and *FENIN v. Commission*,³³ comparing the radical reports of the Advocates-General with the ECJ's eventually moderate decisions, one might see examples of the Court extending its feelers—considering a more radical opinion offered by its Advocate General and then retracting them.³⁴

The key point is that the ECJ is not just responsible for EU law (which is still less than an entire legal code, even though its extent is impressive), it is also clearly prone to build on a small number of key principles in EU law, such as the four freedoms of movement: capital, goods, services, and people. These are strong points of law for those who would file or refer a case. They also have policy consequences toward policies compatible with nondiscrimination, freedom of movement, and integration. Those are the Court's usual priorities and they are likely to become key priorities of any policy area in which the Court is involved.

³⁰ See GEORG VANBERG, *THE POLITICS OF CONSTITUTIONAL REVIEW IN GERMANY* 25 (2005); CHARLES EPP, *THE RIGHTS REVOLUTION: LAWYERS, ACTIVISTS, AND SUPREME COURTS IN COMPARATIVE PERSPECTIVE* 17-18 (1998).

³¹ LISA CONANT, *JUSTICE CONTAINED: LAW AND POLITICS IN THE EUROPEAN UNION* 154 (2002); See MITCHELL SMITH, *STATES OF LIBERALIZATION: REDEFINING THE PUBLIC SECTOR IN INTEGRATED EUROPE* 23-24, 26-27 (2005).

³² Case C-372/04, *Yvonne Watts v. Bedford Primary Care Trust*, 2006 E.C.R. I-4235.

³³ See Case C-205/03, *Federación Española de Empresas de Tecnología Sanitaria (FENIN)*, formerly *Federación Nacional de Empresas, Instrumentación Científica, Médica, Técnica y Dental*, available at <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:62003J0205:EN:HTML> (Nov. 10, 2005) (Op. Advocate General Poiras Maduro); Case C-372/04, *The Queen v. Bedford Primary Care Trust and Sec'y of State for Health*, 2006 E.C.R. I-4331 (Dec. 15, 2005) (Op. Advocate General Geelhoed).

³⁴ Interviews, Member State Officials from France, Germany, Spain, and the United Kingdom (2005, 2007).

B. THE EUROPEAN COMMISSION

One of the first serious articles in political science about EU social policy coined a completely apt description of the European Commission as a “purposeful opportunist.”³⁵ Purposeful because the EC very rarely tries to reduce its own potential role (even if, like any rational, autonomous organization, it is willing to forego involvement on a case-by-case basis). Opportunistic because it will react quickly to substantive policy ideas (such as “centers of reference”) and opportunities (as seen, most strikingly, with the inclusion of health in Article 23 of the Services Directive as originally proposed with the justification that it merely codified patient mobility law).³⁶

The European Commission is famously open to lobbies from around the Continent.³⁷ For a purposeful opportunist, this pays off. The lobbies supply information, which eases policymaking and implementation and also keeps the Commission up to date with opportunities for it to make policy for Europeans. However, if they want the policy regardless of the government, as many policy advocates do, then they are essentially forming an alliance, however temporary and tactical, with the Commission when they help it develop policy. The fact that lobbies have a pronounced insider/outsider dimension with the Commission which is tightly connected to a “constructive” inner circle that regularly provides it with useful feedback, merely increases the odds that the advice the Commission gets supplies it with substantive policies it could usefully carry out.³⁸ This is *engrenage*, the process of “gearing” policy experts, officials, and lobbies into the European Union.³⁹

Some writers have suggested that the enormous amount of lobbying in Brussels provides a democratic legitimacy for the EU that it would otherwise lack.⁴⁰ Apart from the questionable face validity of

³⁵ Laura Cram, *Calling the Tune Without Paying the Piper? Social Policy Regulation: The Role of the Commission in European Community Social Policy*, 21 POL’Y & POL. 135, 143 (April 1993).

³⁶ *Commission Proposal for a Directive of the European Parliament and of the Council on Services in the Internal Market*, at 14, COM (2004) 2 final (Mar. 5, 2004).

³⁷ LOBBYING THE EUROPEAN UNION: INSTITUTIONS, ACTORS AND POLICY (David Coen & Jeremy Richardson eds.) (forthcoming July 2009).

³⁸ See Holly Jarman, *The Other Side of the Coin: Knowledge, NGOs and EU Trade Policy*, 28 POL. 26, 28 (2008).

³⁹ SHORE, *supra* note 19, at 147.

⁴⁰ Richard Bellamy & Dario Castiglione, *Normative Theory and the EU: Legitimising the Euro-Polity and its Regime*, in AFTER NATIONAL DEMOCRACY: RIGHTS, LAW AND POWER IN AMERICA AND THE NEW EUROPE 9, 33-34 (Lars Trägårdh ed., 2004); CIVIL SOCIETY AND LEGITIMATE EUROPEAN GOVERNANCE 278-79 (Stijn Smismans ed., 2006).

such an argument, given what is known about lobbies, the selection mechanisms suggest that the most influential organizations are chosen by the Commission and that they tailor their suggestions to its capacities and opportunism.⁴¹ Furthermore, the Commission rewards the groups with the most resources and is biased toward Northwest and German-speaking countries, which reinforces inequalities.⁴² Such realities do not lend to very good policymaking or much of a democratic commendation.

The Commission, furthermore, is a very entrepreneurial organization and dedicates resources to policy entrepreneurship. It is a frequently repeated but misleading point that the Commission has fewer employees than many of Europe's local governments.⁴³ The Commission, unlike local governments, does not provide any labor intensive services. Once one accounts for the fact that the Commission does not employ road builders, social workers, nurses, or police and instead compares it to the policymaking resources of the Member States, it looks more impressive. Assuming that half of the Commission staff makes policy, that is still a 16,000 person machine for the production of policy ideas.⁴⁴ Few Member States enjoy such a resource. The extensive use of comitology, networks, *engrenage*, and agencies in the Commission, as in most other governments, further increases its capacity for policymaking.

But where are all those people? On any given issue there are rarely more than three or four people at work. Some important issues, such as Services of General Interest, have a full-time staff of one.⁴⁵ The explanation for this is an extremely broad engagement with a variety of policy areas as well as a reflection of the genuine workload in areas such as the Common Agricultural Policy. The Commission is rationally spread thin; this allows it to be a "purposeful opportunist" looking for a role in areas of European life (and somebody can usually supply a substantive justification). The Commission can add resources if need be, or use various kinds of working groups to expand its expertise. Given that

⁴¹ JUSTIN GREENWOOD, INTEREST REPRESENTATION IN THE EUROPEAN UNION 23 (2d ed. 2007) (2003); 3 Sonia Mazey & Jeremy Richardson, *Promiscuous Policymaking: The European Policy Style?*, in THE STATE OF THE EUROPEAN UNION: BUILDING A EUROPEAN POLITY? 345 (Carolyn Rhodes & Sonia Mazey eds., 1995); Andreas Broscheid & David Coen, *Insider and Outsider Lobbying of the European Commission: An Informational Model of Forum Politics*, 4 EUR. UNION POL. 165, 180-81 (2003); Jarman, *supra* note 38.

⁴² Scott Greer, Elize Massard da Fonseca & Christopher Adolph, *Mobilizing Bias in Europe: Lobbies, Democracy and EU Health Policy-Making*, 9 EUR. UNION POL. 403, 428 (2008).

⁴³ EDWARD PAGE, PEOPLE WHO RUN EUROPE 22 (1997).

⁴⁴ European Commission Civil Service, Who We Are, http://ec.europa.eu/civil_service/about/who/index_en.htm (last visited Mar. 11, 2009).

⁴⁵ Interviews with Officials in the European Comm'n, (2004, 2006, 2007).

what it produces is a right to participate in policy areas, with or without an explicit competency, relatively weak personnel resources in any one area is an acceptable tradeoff. One staff officer is capable of assisting in the development of safe blood regulation in Europe and it is difficult to object on policy grounds to safe blood. Likewise, only one or two Commission employees are required to start a forum or advisory committee and engage a broader range of people in admirable tasks at the EU level, such as reduction of obesity.⁴⁶

The other principal characteristic of the EU, to use Cram's phrasing again, is that it is a "multi-organization," which roughly means that it is internally fragmented.⁴⁷ Internal coordination of the European Commission is relatively weak, with a central coordinating unit that many Member States put to shame and a collegial structure that provides little political basis for directed coordination.⁴⁸ At the same time, enlargement has multiplied commissioners as well as portfolios (and, therefore, the number of EU level politicians seeking to make a mark by doing something substantive). The various Directorate-Generals (DG) each have, more or less formally, jurisdiction over a given treaty base.⁴⁹ The hierarchy among them, and to some extent their distinctive cultures, can be inferred from their treaty bases. For example, DG Trade and DG Competition are extremely powerful and autonomous because their treaty bases give the Commission impressive power and autonomy. DG Agriculture and DG Fisheries are powerful but less autonomous because they are confined to clearly delineated policy areas where they are dominant, and DG Internal Market is powerful but under constant political challenge because it "occupies" the powerful and contentious rights to initiate legislation and enforcement actions for the huge body of internal market law.⁵⁰

The nature of the Commission and the agenda of the President can shape legislative proposals and some enforcement actions with marked effects (such as a reduction in the power of DG Employment and Social Affairs and DG Environment under the Commission Presidency

⁴⁶ See GREENWOOD, *supra* note 41.

⁴⁷ LAURA CRAM, POLICY-MAKING IN THE EUROPEAN UNION: CONCEPTUAL LENSES AND THE INTEGRATION PROCESS 162 (1997).

⁴⁸ See THE EUROPEAN COMMISSION (David Spence with Geoffrey Edwards eds., 3rd ed. 2006).

⁴⁹ See generally, Martin Rhodes, *A Regulatory Conundrum: Industrial Relations and the Social Dimension*, in EUROPEAN SOCIAL POLICY: BETWEEN FRAGMENTATION AND INTEGRATION 78-128 (Stephan Leibfried & Paul Pierson, eds., 1995).

⁵⁰ GREER, *supra* note 4, at 63.

of J. M. Barroso).⁵¹ Central coordination, however, is weak. The consequences are evident in the slow return of items that do not interest Barroso (such as environment, now inserted into the Lisbon Agenda).⁵² Negative consequences are also seen in the failure of transversal policies, such as environmental policy integration in the Commission and even more obviously in health impact assessment.⁵³ Barroso could not prevent the Commission from developing new environmental policy, but neither has any environmental Commissioner been able to apply these policies to the rest of the Commission.

Each DG, therefore, comes with different treaty bases (despite the theory of collective responsibility at the level of the College of Commissioners), a different culture, different interest groups (including the groups it funds), and, as a result, a different policy agenda suggested mostly by distinctive groups of policy advocates. To take a small example, non-governmental organizations (NGOs) umbrellas funded by other DGs participate in forums run by DG Health and Consumer Protection (Sanco)—but they have a very low rate of participation, much lower than one would find if it were simply a random effect.⁵⁴ The explanation is that DG Sanco does not welcome NGOs funded by other DGs such as the elderly platform AGE: The European Older People's Platform (funded by DG Employment and Social Affairs), and while DG Employment and Social Affairs might like to influence DG Sanco, its interests are mostly in developing its own information sources and policy ideas in its chosen community.

Leadership in patient mobility has moved from DG Employment and Social Affairs (when it was social security) to DG Sanco (after the formation of the High Level Group) to DG Markt (during the Services Directive debate, despite a challenge led by DG Employment, Social Affairs, and France, which viewed it as a Service of General Interest), and now to DG Sanco.⁵⁵ Discussion of whether a given DG “wanted” responsibility for health is slightly beside the point; what matters is that they traded it off. Such a choice changed the policy proposals because each DG has different structural interests. DG Markt is the self-

⁵¹ David Spence, *The President, the College and the Cabinets*, in *THE EUROPEAN COMMISSION* ch. 1 (David Spence ed., 2006).

⁵² Communication to the Spring European Council from President Barroso, *Working Together for Growth and Jobs: A New Start for the Lisbon Strategy*, at 7, COM (2005) 24 final (Feb. 2, 2005).

⁵³ ANDREW JORDAN & ADRIAAN SCHOUT, *THE COORDINATION OF THE EUROPEAN UNION: EXPLORING THE CAPACITIES OF NETWORKED GOVERNANCE* 113 (2006).

⁵⁴ Greer, et. al, *supra* note 42.

⁵⁵ GREER, *supra* note 4, at 66.

appointed guardian of the internal market; DG Employment and Social Affairs of the “European Social Model,” and DG Sanco is a weak, young DG, scarcely moved to Brussels that has its best relationships with the health sector.⁵⁶

Just as the Commission has a regulatory bent and a penchant for *engrenage*, which could probably be derived just from reading the treaties and the EU budget, it has a tendency to fragment based on the reinforcing connection between DG treaty bases, cultures, and interest group constellations. This fragmentation, while collectively maximizing opportunities for opportunists, also creates uncertainty as to the consequences of legislation for substantive policy and patterns of authority.⁵⁷

III. WHAT IS AT STAKE?

Focusing on institutions—in this case, the EU institutions—amounts to holding substantive policy steady (there is always a large supply of policies available for consuming governments if they want it), and looking instead to the institutions to see what sort of policies they will enact. Viewing EU policy in this manner tells us two things; first, the ECJ and the EC will opt for regulatory policies that fit within their institutional capabilities and preferences, rather than some broader form of policymaking. The Commission will also engage in networks and soft governance of various kinds to complement regulation or substitute where regulatory action or legislation is not an option. However, it shapes the policy consequences.

Second, it tells us that opting for regulatory policies that fit with the Court and Commission’s institutional capabilities rules out a fundamental cost-benefit analysis. They are unlikely to cost their policies (and ECJ decisions often are policies). Moreover, they are unlikely to conduct a cost-benefit analysis that compares, for example, the costs of compliance with patient mobility law against the costs of investment in improved cancer care or anti-obesity policy. EU institutions are also especially unlikely to cost compliance with EU law against other policy goals such as education or transportation. In their respective ways, the Court and Commission are regulatory organizations and could rightly

⁵⁶ *Id.*

⁵⁷ Scott Greer, *Choosing Paths in European Union Health Services Policy: A Political Analysis of a Critical Juncture*, 18 J. EUR. SOC. POL’Y 219 (2008).

add that if Member States do not like the substantive policy then they are free to change the treaties.

This means that their institutional forms give them clear policy preferences and limit their obligation to make tradeoffs between conflicting goals. The basis of their activity builds in a hierarchy of priorities toward the key precepts of EU law for the Court and toward the most enterprising policy entrepreneurs for the Commission. Increasing the cost of health services is not an immediate problem because the EU does not pay for them.⁵⁸ Equity concerns are not very important. It takes a creative mind to argue that patient mobility is anything other than a boon to the wealthy and articulate. Solidarity is not much of a problem because EU law on the subject is soft-spoken compared to the talkative jurisprudence of the four freedoms.⁵⁹ What, then, are the likely policy effects?

IV. POLICIES AND PRINCIPLES

In principle, EU patient mobility law is relatively harmless. All it does is cast severe doubt where it usually casts doubt—on Member State level laws and policies that restrict the movement of goods, services, capital, and people. In principle, this could be answered with the same kinds of policy changes seen in many other EU areas, namely development of patient mobility policies that are proportional to the EU interest, transparent, and not obviously designed to prevent cross-border mobility. Furthermore, patient mobility decisions are hedged with repeated assertions that the ECJ respects the primacy of Member States in the organization and finance of health care (“They’d better,” snapped a Member State health ministry official, “they certainly don’t pay for the health services”).⁶⁰

A. POLICIES

The question policymakers might naturally ask is whether the costs of conducting this operation are worth the benefits. Those costs

⁵⁸ See generally Edward Page, *The European Union and the Bureaucratic Mode of Production*, in FROM THE NATION STATE TO EUROPE? ESSAYS IN HONOUR OF JACK HAYWARD 139-157 (Anand Menon & Vincent Wright eds., 2001).

⁵⁹ See Timothy Stoltzfus Jost, Diane Dawson & André den Exter, *The Role of Competition in Health Care: A Western European Perspective*, 31 J. HEALTH POL., POL'Y & L. 687, 696 (2006).

⁶⁰ Interview with Health Ministry Official. (Mar. 2006). (On file with author).

and benefits would have to be calculated in terms of tax revenue, health priority setting, and the balance of domestic actors such as insurance funds and doctors in the priority setting.

The cost is compliance. Compliance has direct costs (some of them now sunk): forms, regulations, and procedures must be changed in order to avoid discrimination and comply with jurisprudence. Though this was a time-consuming effort for bureaucracies it was not intolerable. German interviewees commented that the technical challenge of responding to *Kohll*, *Decker*, and subsequent decisions was less than they expected.⁶¹ Compliance with internal market law in general, or public procurement, state aids, and competition law could also impose simple costs of compliance by obliging bureaucracies to work differently even in areas where the EU touch is relatively light.

The second kind of compliance cost is more substantial. It presents itself in the form of changed priorities and the range of policies that are no longer possible. For example, rationing by waiting lists escaped the *Watts* decision when the Court did not specify the concept of “unacceptable” waiting times. Nevertheless, that form of rationing remains suspect. Rationing by waiting underpins a number of other efficient and equitable procedures, and as England has demonstrated over the last ten years, reduction in waiting times can be very expensive and energy intensive.⁶² That is not to say it is or is not a good thing (ridiculing UK waiting times appears to play a role in these debates as a blanket justification for EU competency creep). Thus, compliance costs include entire categories of policies with little obvious connection to the promotion of European integration or the legal substance of European citizenship and the direct costs of having priorities set by a new and not particularly democratic actor with little expertise.

The third kind of compliance cost is the “legal uncertainty” that aggravates scholars and Member States alike. Much has been said about this. The essential point is that health planning, or policymaking, is very difficult when the role of the EU, the course of future decisions, future challenges, and the policy implications of decisions are all opaque. Involving the Commission, which can propose legislation, might not be the entire cause of the post-1998 policy free-for-all, but the fragmented, purposeful opportunist introduced a range of policy options as diverse as the

⁶¹ Especially Ministry of Health, July 2007; Health funds and medical associations, June 2008. (On file with author).

⁶² Gwyn Bevan & Christopher Hood, *Have Targets Improved Performance in the English NHS?*, 332 BRIT. MED. J., 419, 420-21 (2006).

High Level Group, the Open Method of Coordination (OMC), the Services Directive, the family of Services of General Interest, and now health legislation.⁶³ It is easier for Member States, professionals, managers, providers, disease groups, and others to lobby and influence these debates. Nevertheless, there is still a profound uncertainty until there is a framework authoritative enough to deter the Court and its litigants for the time being.

Exaggerated and unpredictable, compliance costs are a feature of regulatory politics for the relatively obvious reason that the regulator does not bear the costs of compliance.⁶⁴ The regulator is free to develop and impose a principle without regard to the consequences for other principles.⁶⁵ The accountability of the regulator to the regulated is what prevents total distortion of priorities. That accountability, of course, varies. The EU institutions are a fair distance from patients and taxpayers, and accountability is principally through the states in the Council.

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

B. PRINCIPLES

Policy and principles are intertwined because the deadweight costs of compliance with patient mobility law directly affect the capacity of Member States to deliver entitlements to their citizens that they guarantee in principle, i.e., citizenship rights. Christopher Newdick's paper in this Symposium⁶⁶ makes the point well: social citizenship has great logical problems, but is relatively easy to identify in policy terms and the trend of EU law is not good for it.⁶⁷ In a similar vein, competition law's

⁶³ On file with author.

⁶⁴ Yves Meny, *National Squares and European Circle: The Challenge of Adjustment*, in *FROM THE NATION STATE TO EUROPE? ESSAYS IN HONOUR OF JACK HAYWARD* 36 (Anand Menon and Vincent Wright eds., 2001).

⁶⁵ *Id.*

⁶⁶ Refer to this current symposium issue.

⁶⁷ T. H. MARSHALL, *CITIZENSHIP AND SOCIAL CLASS*, (London ed., 1950) (1992).

“infiltration” of social security law, much of which subsumes health, is an alarming illustration of one branch of EU law undermining both policy and principle.⁶⁸ There are a variety of redistributive mechanisms within states that might, on the face of it, be wholly compatible with a modern European welfare state but that are not compatible with the particular implementation of nondiscrimination. There are other mechanisms that are somewhat discriminatory, and can seem so in the Court’s teleological way, but hardly seem worth abolishing.⁶⁹

The capacity to deliver entitlements, i.e., to make citizenship rights tangible, depends upon the ability of health systems to deliver what is asked of them in light of the costs. Imposing compliance costs and a detailed regulatory framework does not advance social citizenship.⁷⁰ This should not come as a surprise; the effects of regulation on efficiency are difficult to predict and negative integration is a poor fit with social citizenship. Principles are affected because the costs of compliance associated with new priorities and regulatory structures, foreclosed options, and uncertainty translate into a reduction in the resources, time, and money that can be spent on making principles of social citizenship into tangible realities. The lack of closure in welfare states that comes from patient mobility reduces the ability of Member States to make social citizenship real both by taxing and setting priorities.⁷¹

V. POWER

Thus, EU patient mobility law is one of several moves to submit health to internal market law and thereby submit states to EU regulation. This has deadweight costs that are difficult to measure but are probably significant; little in EU law suggests that the costs will be appropriately

⁶⁸ STEFANO GIUBBONI, *SOCIAL RIGHTS AND MARKET FREEDOM IN THE EUROPEAN CONSTITUTION: A LABOUR LAW PERSPECTIVE* 61 (Rita Inston trans., 2006) (2003).

⁶⁹ As with Austria’s limitation on admission of medical students from other EU states enjoying its free medical education, which fell victim to the ECJ despite lack of any compelling policy argument against it. Case C-147/03, *Commission of the E.C. v. Austria*, 2005 E.C.R. The result was a deadweight loss from the point of view of both policy and principles. *Id.* There is no visible policy benefit but now Austria must charge for education; limit admissions despite a shortage; or subsidize German students. *Id.* It was also a rather weak decision, given that Article 12 prohibits discrimination “within the scope of this treaty” and the Treaty is silent on the subject.

⁷⁰ Scott L. Greer, *Ever Closer Union: Devolution, the European Union, and Social Citizenship Rights*, in *DEVOLUTION AND SOCIAL CITIZENSHIP RIGHTS IN THE UNITED KINGDOM* (Scott L. Greer, ed.) (forthcoming 2009).

⁷¹ MAURIZIO FERRERA, *THE BOUNDARIES OF WELFARE: EUROPEAN INTEGRATION AND THE NEW SPATIAL POLITICS OF SOCIAL PROTECTION* 126-29 (2005).

considered. Moreover, the policy justifications for the EU decision can seem extraordinarily weak.⁷² The obvious question is: Why do Member States put up with this?

The first kind of answer depends on reducing the importance of the EU's democratic deficit. In a species of *tu quoque* (you, too) argument, these authors argue that the EU does not look so bad when we compare it to states' decision making processes in the same policy areas. Giandomenico Majone argues that this is the case in an otherwise perplexing book.⁷³ Majone contends that the EU has traditionally focused on policy areas that are subject to "non-majoritarian" (read: undemocratic) decision making in most countries, such as trade policy.⁷⁴ In the grand scheme of things, he says, the degree of delegation to the European Commission in trade or competition is not that much different from the degree of delegated power of the United States Trade Representative or the British Competition Commission. Even the European Central Bank, which is effectively insulated from democratic accountability, is a member of a category of institutions—central banks—that rarely have direct democratic accountability.⁷⁵ This argument fits with the other particularly prominent opponent of EU democracy, Andrew Moravcsik. Moravcsik argues not only that the EU never was democratic, but also that it never should be democratic; it is and will stay an agent of Member States and therefore enjoys their legitimation.⁷⁶

These authors' arguments only suggest that the European Union institutions are looking for trouble. Health is a politically important issue in all Member States and at any given time it tops the agenda in a few of them. Public or elite support for an EU role is essentially lacking.⁷⁷ It is

⁷² Consider the debates about the inclusion of health in the Services Directive as proposed by the Commission. *Commission Proposal for a Directive of the European Parliament and of the Council on Services in the Internal Market*, at 14, COM (2004) 2 final (Mar. 5, 2004). There is no case in the recitals (preliminary material that explains intent) for the inclusion of health, save generalities about the structure of service sectors in the EU in general. In interviews, Commission officials tended to argue that they were merely codifying case-law—which is a reasonable argument, but hardly a claim for the benefits of the policy for Europeans.

⁷³ See GIANDOMENICO MAJONE, *DILEMMAS OF EUROPEAN INTEGRATION: THE AMBIGUITIES AND PITFALLS OF INTEGRATION BY STEALTH* (2005).

⁷⁴ See generally *id.* at 195-201. See also Andreas Follesdal and Simon Hix, *Why There is a Democratic Deficit in the EU: A Response to Majone and Moravcsik*, 44 J. COMMON MKT. STUD. 533, 534 (2006).

⁷⁵ *Id.*; Andrew Moravcsik, *In Defence of the 'Democratic Deficit': Reassessing Legitimacy in the European Union*, 40 J. COMMON MKT. STUD. 603, 617-22 (2002).

⁷⁶ Moravcsik, *supra* note 75.

⁷⁷ That is not to say that the public opposes EU involvement if it is keyed to an attractive substantive policy. But that is not much of a qualifier. If we were to suggest sending 100 Euros to eve-

difficult to find any politically significant supporters of the EU's patient mobility regime, although supporters are slowly arising as EU policy creates niches for new kinds of health care providers. Furthermore, there is a significant difference between an organization that a Member State has insulated from democracy for one purpose and a generally insulated organization that is almost impossible to keep within its appointed slot, as is the case with the Commission and Court.

Another explanation for Member State acceptance of the patient mobility regime is much more likely to be correct; mainly, that Member States' costs of withdrawal are unbearable.⁷⁸ For most, the cost is unimaginable as well. If the EU is, in large part, EU law, then EU members have no way around formal compliance. So they must bear the EU's less attractive policies to gain the benefits of the more attractive ones. Moreover, Member States do not agree on the attractive and unattractive policies.

Furthermore, even the Member States' costs to change the relationship between the EU institutions would be excessive. Despite some murmurings from the UK under John Major (former Prime Minister of the UK), it is difficult to find leading politicians who propose reducing the power of the Court (such measures could come in a variety of ways, such as a simple Council vote to let a single Member State off for an infraction that they judge acceptable, as Fritz Scharpf suggests).⁷⁹ Rewriting the Treaties to change something as fundamental as the role of the ECJ might pass a cost-benefit test in policy terms, but it is highly unlikely to pass a cost-benefit test in political terms.

The argument that Member States would not withdraw or even rewrite the treaties because of the costs points to a third persuasive argument. Costs are borne by different people in different places. The EU, no matter how well or poorly it delivers any policy, wins at least some loyalty of the policy advocates who work with it. Even if they are disenchanted with the payoff from EU participation, there is no obvious reason to oppose it when it might deliver benefits that they seek (or even a source of personal expertise useful to them in their careers). This ap-

rybody in the EU, or curing cancer, there would be some support regardless of the government we suggested should do it.

⁷⁸ Alter, *supra* note 25.

⁷⁹ Fritz W. Scharpf, *Reflections on Multilevel Legitimacy*, 20 EUSA REV. 2, 9 (2007), available at <https://www.ucis.pitt.edu/special/eusa475/sites/www.ucis.pitt.edu.special.eusa475/files/summer2007.pdf>.

pears to be the attitude of medical professional organizations.⁸⁰ Their power base is classically at the Member State level, and Brussels offices are insurance against untoward EU activity. But like any good lobbyists, they also engage in EU politics and seek positive proposals to build their credibility as useful members of the EU policy community. This is *engagement* at work. Even if a Member State might reasonably conclude that EU health policy is bad for its health care system, the odds are that many of its own experts and officials would wish to defend particular EU policies that are useful for them.

CONCLUSION

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

A. FOR POLICY: IT'S NOT ABOUT THE PATIENTS

It takes only a few words to draw out one implication: the issues at stake are not about the patients, they are about regulation. The actual number of patients moving around the EU is significant, unknown, and likely to stay that way despite the valiant efforts of the Europe For Patients project and its research into the complexity of the issue and of patient movements.⁸¹ However, Member State officials rarely cite the actual mobility of patients and their bills as an issue. In 2005, one regional government policymaker was surprised to be told that his Member State was paying for his region's patients treated abroad. What is worrisome is the regulatory adjustment required to cope with patient mobility. Those costs probably outweigh the actual costs associated with patients (although in the EU context it will probably never be known just what

⁸⁰ Interviews with EU-level medical and nursing associations, Member State Associations, (2006, 2008).

⁸¹ Irene A. Glinos & Rita Baeten, *A Literature Review of Cross-Border Patient Mobility in the European Union*, EUR. FOR PATIENTS 83 (2006), http://www.ose.be/files/health/WP12_lit_review_final.pdf.

those costs are). In addition, it is far more difficult to gauge the policy consequences of the ECJ and its decisions than it is to count the number of Germans submitting claims for treatment in Spain. Therefore, the only remaining questions of interest are (1) who currently brings patient mobility cases? and (2) who will start to bring them in the future? Private health care groups that might benefit from liberalization have kept a low profile, usually working through commercial consultancies in Brussels and rarely engaging in litigation, in the Republic of Ireland cases such as *Asklepios Kliniken v. Commission*⁸² in Germany or *BUPA and Others v. Commission*⁸³ have already seen. In these particular cases private providers are resisting what they see as state aids to their competition.

B. FOR THE EU, ON PRESENT TRENDS

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

The EU, as a regulatory organization with an entrepreneurial Commission and a powerful top court, caters extremely well to advocates of either liberalizing substantive policy, such as Messrs. Kohll and Decker and Mrs. Watts and to relatively niche policy advocates whose principal aims are grants and support for networks. The EU does not cater well to the bulk of Member State health systems, which deliver health services, pay costs, and have a far more complex task of priority setting than any part of the EU or the EU as a whole (recall the insignificance of the EU budget and revenue, especially in health).⁸⁴ These are the groups—providers, social funds, management associations, and major professions—that have the best connections with Member State health ministries. Nevertheless, having Member States for allies, or being Member States, is a strong position in Brussels. What can Member

⁸² Case T-167/04, *Asklepios Kliniken GmbH v. Comm'n*, 2007 E.C.R. 31 (July 11, 2007) (E.U.E.C.J.).

⁸³ Case T-289/03, *BUPA and Others v. Comm'n*, 2008 E.U.E.C.J. (Feb. 12, 2008).

⁸⁴ See GREER, *supra* note 4.

States, allied with the leaders of their incumbent health service organizations, do?

Member states have a number of tactical options but only one obvious strategy to preserve not just their autonomy in health policy but also their ability to make more complex tradeoffs than EU law would permit. The obvious strategy is to broadcast the limits of their tolerance by developing their own EU-level norms and priorities.⁸⁵ The same statistics that show the ECJ being hard on Member States that diverge suggest that there is a political restraint on the Court's activity, and it is both logical and the view of many interviewees that a united front of Member States on health policy questions would deter the Court and advocates of particular liberalizing substantive policies.⁸⁶ There are a number of such mechanisms: the High Level Group, which DG Sanco muffled in 2007 and then brought back to life when the draft health directive froze; the OMC, which promises to create an influential pan-European policy network with deep roots into many Member State ministries; political influence through, for example, Commissioners' *cabinets*; and simple declarations, such as the Employment and Social Affairs Council

(EPSCO) Council's declaration adopted on June 2, 2006,⁸⁷ which declares a set of shared principles that include Member State responsibility for health care. Domestically, noncompliance, or contained compliance, can also work but only if it is matched by an accommodating court system and lobbies.⁸⁸ Contained compliance did not work in health because it meant the Court could develop a fairly substantial jurisprudence without much resistance.

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

⁸⁵ Greer & Vanhercke, *supra* note 21.

⁸⁶ Interviews with Member state officials, Spain, France, Germany, Netherlands, and the United Kingdom (2005-2008).

⁸⁷ Council Common Position, 2006 O.J. (C 10173) (EC).

⁸⁸ CONANT, *supra* note 31, at 33-34.

C. FOR THE EU, ON A DIFFERENT TRAJECTORY

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

The EU is regulatory. The EU will never become a full-service democratic government because it lacks a demos or much of a budget, so it will always be much better at delivering civil rights (as noted in T.H. Marshall’s terms, discussed in Christopher Newdick’s contribution to this symposium) rather than social or political rights. Nor can the EU be expelled from health. There is negligible historic evidence of the EU retreating from a policy area once it has established its competency. Furthermore, it has clearly established a competency in health care. Thus, the goal should instead be to try to preserve and expand what is good. Much of that, triggered as it might have been by patient mobility, is now orthogonal to the issue; the OMC has its own life, for example.

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

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

would be helpful from a policy point of view and help to reinsert principles that are incompatible with the thrust of EU law or that depend on administrative procedures that are suspect under EU law.

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

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

These three principles, especially if connected to a basic appreciation for the principle of subsidiarity, would point to a crude version of the "transformative directive" that Hervey and Trubek have proposed.⁸⁹ It might be read as a very different route to the same destination. To some extent, the currently proposed Directive on Health Services would be an improvement relative to the current situation.⁹⁰ That is because it would create vehicles for Member States' declarations of shared views. In other words, it would increase the chances that the Member States would formulate shared positions. Those shared positions, in turn, would be their best strategy for maintaining control over health policy because they might deter the Court. The price paid would be a major role for the Commission in structuring EU health care policy. This price would be high, but it would at least reduce legal uncertainty and would entrench institutional mechanisms through which the Member States could formulate a consensus that might deter the Court from adventurism. The Directive's fate is unclear at the time of this writing, but any application of

⁸⁹ Tamara K. Hervey & Louise Trubek, *Freedom to Provide Health Care Services Within the EU: An Opportunity for "Hybrid Governance"*, 13 COLUM. J. EUR. L. 623, 636 (2007).

⁹⁰ *Proposal for a Directive of the European Parliament and of the Council on the Application of Patients' Rights in Cross-Border Healthcare*, COM (2008) 414 final (July 2, 2008).

the three principles found in this article would rule out what is currently in place. The current policymaking system is a set of tactical alliances between interests, often eccentric ones, and purposeful opportunists in Brussels and Luxembourg. The costs of that policy-making regime, counted in administration, principles, or procedural democracy, are certainly likely to be high.