Inside the Social Open Method of Coordination: The hard politics of ‘soft’ governance
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CHAPTER 8

The OMC and beyond: ‘soft-to-hard-to-soft’ governance of health care in the EU

Bart Vanhercke and Lena Wegener


8.1 Introduction

Since its launch during the Lisbon European Council of 2000 as a ‘new’ policy instrument that would allow to make progress in sensitive policy areas such as social protection and social inclusion, the Open Method of Coordination, has received a great (some would argue: excessive) deal of attention, both from scholars and policy makers. The OMC has indeed been widely debated in the research community. Note that once the initial praise for the OMC (both by politicians and scientists) started to wane, the process was subjected to intense scrutiny and found wanting in mainstream academic literature. In particular the ‘social inclusion’ and ‘pensions’ OMC have been studied rather well, both in terms of emergence and impact. However, we are still flying blind with regard to the most recent strand of the Social OMC, which is concerned with health and long-term care and received only limited scholarly attention. This stands in contrast to the impact of European legislation in the field of health, which has been

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1 This chapter benefited from my contributions to two chapters which I co-authored with Tammy Hervey (Hervey and Vanhercke, 2010) and Scott Greer (Greer and Vanhercke, 2010). This earlier work was enriched with an assessment of the impact of the Health Care OMC at the domestic level (section 8.3), while I further developed the evidence of the ‘soft-to-hard-to-soft’ governance thesis (including through the example of the EU’s Health Technology Assessment) in section 8.4.2. I also added a section explaining the limited impact of the OMC in this policy field (8.5).

2 The authors are grateful to the participants of the expert seminar on ‘Social Protection and Social Inclusion in the EU: Interactions between Law and Policy’, February 10th-11th, 2011 (Antwerp University) for their comments. Special thanks go to Jo De Cock, David Natali and the editors of this volume for their lucid suggestions for revision. We are particularly grateful to Rita Baeten for the exchange of ideas about ‘soft-to-hard-to-soft’ governance, which contributed to reconciling my ‘new governance’ with a ‘legalisation’ perspective. The usual disclaimer applies.

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3 For recent overviews, see Kröger (2009), Marlier and Natali (2010 and Heidenreich and Zeitlin (2008).

4 For a more detailed discussion, see Hamel and Vanhercke (2008).

5 To be more precise: ‘social inclusion’, ‘pensions’ and ‘health and long-term care’ constitute the three strands of the ‘streamlined’ Social Protection and Social Inclusion OMC.
extensively covered\textsuperscript{6}, but is (for obvious reasons) largely disconnected from the research focusing on new governance\textsuperscript{7} in health.

This chapter has a twin ambition. First of all, it aims at understanding the significance of ‘soft’ EU cooperation in health policy through this particular strand of the Social OMC. Secondly, it wants to understand whether and how interaction is developing between EU law and policy in the area of health care. The argument is made that in this area of social protection we are moving from mere ‘interaction’ to a ‘hybridization’ of governance tools. Indeed, in between EU policy (new governance) and EU legislation, hybrid instruments are emerging that combine elements from ‘hard’ and ‘soft’ law. In this view, we begin by briefly describing the emergence of the OMC in health care, the main features of its toolbox (objectives, reporting obligations, indicators, Peer Reviews), and the policy learning that is intended (section 8.2). Based on recent empirical research in Belgium, section 8.3 then raises the question whether this OMC strand has had any ‘impact’ (effects ‘on the ground’) at all on policies and policy making-processes at the domestic level. The debate about the relevance of ‘soft’ governance in health care is then broadened to the impact of the OMC at EU level as well as to new governance processes other than the OMC (section 8.4). Within this section, particular attention is paid to the OMC’s interaction with other EU instruments such as the legal framework underpinning the European Social Fund (ESF). Section 8.5 then tries to provide an explanation for the limited tangible effects of this OMC, by referring to intense actor rivalry and the lack of stakeholder involvement in the EU health care arena. The final section draws tentative conclusions as regards the ‘soft-to-hard-to-soft’ governance of health care in the EU.

8.2 The Open Method of Coordination in health care: emergence and key features

8.2.1 Emergence: the Commission’s purposive optimism versus foot-dragging Member States

The story of the emergence of the health care OMC has been told elsewhere\textsuperscript{8}, but the essence is the following: the European Commission has been pushing the Member States, from the beginning of the 1990s, to start some kind of EU cooperation on health care, while many Member States were dragging their feet, afraid as they were that this would imply losing grip over this important policy area. As a result, attempts to start an OMC in health care failed in 2002 and again in 2004\textsuperscript{9}. Amazing as it may seem – given the increasing awareness that Europe was entering national health care systems by the back door of the internal market – until 2004, national governments continued to be strongly averse to formalizing the debate about health

\textsuperscript{6} See Mossialos \textit{et al.} (2010).
\textsuperscript{7} New governance has been defined as a ‘range of processes and practices that have a normative or regulatory dimension, but do not operate primarily or at all through the conventional mechanisms of command-and-control-type legal institutions’ (de Búrca and Scott, 2006: 2).
\textsuperscript{8} For a detailed account, see Hervey and Vanhercke 2010).
\textsuperscript{9} See Greer and Vanhercke (2010).
care at the EU level (submitting their consent to launch a ‘soft’ form of cooperation to a number of rather strict conditions). In the end, the idea of having an OMC in this field became attractive to Member States when they realized that the alternative was health policy made by the European Court of Justice, Directorate General (DG) MARKT of the European Commission and possibly the Economic and Financial Affairs (ECOFIN) Council formation.

Hesitations loomed large even after the formal start of the process (and they are still present today). At every step of the institutionalization of this process the importance of ‘respecting the subsidiarity principle’ and ‘taking into account national differences’ was recalled: both of them key principles without which EU cooperation in health was a no-go. In other words: the establishment of a new governance mechanism in this area has been intensely ‘political’: it has been shaped both by deliberative norms and through hard-boiled power games between national and EU actors (and within DGs of the European Commission). Even after the health care OMC was finally launched in 2004, it was only equipped with an incomplete institutional architecture: the health care OMC started off with provisional common objectives, no common set of indicators, ‘preliminary reports’ (instead of full-blown ‘Action Plans’) etc. It was not until 2006, when the European Commission creatively managed to include the issue of ‘health care and long term care’ in the new ‘streamlined’ Social OMC that this strand became really operational.

8.2.2 The defining features of an incomplete method

What does this process look like, then? During the past decade, the Social OMC has in practice been managed by the Social Protection Committee (SPC), a group of high-level officials that was established in 2000, as well as by its Sub-Group on Indicators (ISG) (created in February 2001). The SPC is an advisory body to the Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council of the European Union and is composed of two delegates from each Member State and the Commission. The latter provides the secretariat, and thereby has a key role. Together these actors put in place an OMC toolbox containing: the common objectives (which constitute the political mandate and thus the framework), a reporting system (through national strategic reports and joint reports), (preliminary) indicators and Peer Reviews. We will discuss how these tools were made operational between the launch of the Social OMC and its ‘reinvigoration’ in 2011; the implications of the latter go beyond the scope of this chapter.

**Common objectives: ambiguous words**

Being aware that they all – at least to some extent – face similar problems with respect to health and long-term care policies, the Member States first of all committed themselves to a number of common objectives (i.e. political priorities). In fact, they subscribed to two sets of priorities (see the full list of objectives in Box 8.1 below):

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10 Council of the European Union (2004: 9): OMC in health care should not impose an excessive administrative burden; health ministries should be directly involved in the OMC process; overlaps with the follow-up of the high level reflection on patient mobility should be avoided; coherence of views should be ensured within the single EU Council formation of ministers of health and social policy; the joint working with the Economic Policy Committee should continue.
• three ‘overarching objectives’, which apply to the three strands of the streamlined Social OMC. For example, with the third overarching objective, Member States commit themselves to promote ‘good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring’ of their social inclusion, pensions, and health care and long-term care policies;

• three objectives that refer specifically to the area of health and long-term care and which combine high quality and financial sustainability of health systems with access for all.

The common objectives have often been criticized for their openness and ambiguity. Thus, Büchs notes that the Social OMC’s objectives and guidelines contain different and sometimes conflicting elements, some of which are more likely to be interpreted in ways that promote the strengthening of the welfare state whilst others are more likely to support retrenchment (Büchs, 2009). Greer and Vanhercke point out that the ‘ambiguous words’ of these common objectives in the health care strand are in fact useful when there is no fundamental agreement on health care policies in the EU: as they are broad enough to be accepted by all Member States, they allow to expand the EU policy agenda, more particularly by providing legitimacy and new discourses. There would have been even more efforts to block the common objectives (in health) if it had been absolutely clear what they were supposed to do (Greer and Vanhercke, 2010). And yet the ‘normative’ orientation of these health care objectives is quite evident for Flear: they not only extend market rationality and facilitate governing at a distance by inducements to self-management, they also promote moves away from equity and solidarity (Flear, 2009). Writing about the same OMC strand, Hervey strongly rejects the claim that the health care OMC would be promoting neoliberal policies (Hervey, 2008), while others finds strong confirmation of pertinence of overarching objectives of the health care strand of the OMC (European Commission, 2008a).
Box 8.1 Common objectives in the Social OMC (re-affirmed by the Council of the European Union in May 2011)

A. Overarching objectives covering the three strands of the Open Method of Coordination for social protection and social inclusion (including health)

Promote:
(a) social cohesion, equality between men and women and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies;
(b) effective and mutual interaction between the Europe 2020 objectives of smart, sustainable and inclusive growth, taking full account of the relevant social provisions of the Lisbon Treaty; and
(c) good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring of policy.

B. Common objectives with regard to health care and long-term care

Member States should provide accessible, high-quality and sustainable health care and long-term care by ensuring:
(a) access for all to adequate health and long-term care; that the need for care does not lead to poverty and financial dependency; and that inequities in access to care and in health outcomes are addressed;
(b) quality in health and long-term care, and the adaptation of care, including developing preventive care, to the changing needs and preferences of society and individuals, notably by developing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients; and
(c) that adequate and high-quality health and long-term care remains affordable and financially sustainable by promoting a rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination between care systems and public and private institutions. Long-term sustainability and quality require the promotion of healthy and active life styles and good human resources for the care sector.


Reports to Brussels and (not so) soft recommendations

Every two to three years, Member States explain the progress made towards these common objectives. They do this in so-called national strategic reports11 (NSRs) which contain a section on health and long-term care. Once the Commission (DG Social Affairs) has received all the national strategic reports (which present in many countries a ‘container of measures taken’ or a ‘report to Brussels’, rather than being a forward-looking or strategic document), it analyses and assesses Member States’ progress towards the common objectives with the help of national and European indicators. The assessment is then published in a joint report on social protection and social inclusion, which is adopted by the Commission and the Council and submitted, every year, to the (Spring) European Council.

11 Formally speaking ‘National report on strategies for social protection and social inclusion’.
It is worth noting that an agreement on this joint report can normally only be reached after hard negotiations, and ultimately political compromises, between Member States and the Commission. Particularly controversial points are, for instance, the relationship between the state and the market as health care provider, and the adequate level of resources ‘necessary’ for health care funding. This again illustrates how Member States resist EU involvement in ‘their’ health care systems, while also demonstrating that governance is taken seriously (as opposed to being regarded as irrelevant) by Member States. In their analysis of health care policies in the context of the Lisbon Agenda, de Ruijter and Hervey similarly find that ‘governments of the Member States do not necessarily view the OMC-social in health care policy as a “soft” mechanism, posing little challenge to national competence (...) On the contrary, the wording of OMC-social documentation is often politically contested, as if it were a “hard” legally binding text’ (de Ruijter and Hervey, 2012).

Interestingly, the European Commission provides, as part of the joint report, a soft kind of ‘recommendations’ to the Member States through so-called ‘country fiches’. These documents address the most important ‘challenges’ in (social inclusion, pensions and) health care for every country, as the following examples illustrate:

- Commenting on the 2009 German national strategic report (health section), the Commission concluded with regard to quality in long-term care that ‘[E]ven though quality has been steadily increased during the last years, quality controls show clearly that there is still a lot of scope for improvement’ (European Commission, 2009a: 12) (authors’ translation).
- Regarding the quality of health care in Austria, the European Commission suggested that the system should take into account the point of view of the patient (and not the institution), that it should allow for more flexible transfer between different types of provision (inpatient/ambulant/long-term care, etc.) and that ‘patients’ rights had to be strengthened through clear standards’ (European Commission, 2009b: 9) (authors’ translation).
- Drawing on the French NSR, the Commission found that access to health care is increasingly problematic, both from a financial and geographical point of view. The Commission also noted the absence of coercive regulation in France with regard to the control on evidence-based medicine as well as the need to prioritize ambulatory care (including with a view to avoiding unjustified use of hospitals) (European Commission, 2009c: 7-9).
- Finally, the United Kingdom was asked to ‘look at ways of improving integration of health and long-term care services and addressing discretion in the assessment of needs and eligibility rules’ (in the UK, local authorities determine eligibility and access to care), as ‘co-payments and additional user charges that are not covered for persons above the means-tested threshold can act as barriers to accessibility’ (European Commission, 2009d: 9).

Even though these messages may come across as rather ‘light’ for the outside observer, they are highly contested and inevitably give rise to extensive bilateral negotiations between the Commission and the Member States, which will firmly attempt to ‘control the damage’. At least some of these messages were not appreciated by German, Austrian, French or UK civil servants and politicians. In our interviews it became clear that they were not felt as ‘soft’ messages (at all) and in some case led to strong interrogations about continuing the Social OMC overall.
Indicators: a growing but preliminary portfolio

As far as indicators are concerned, work within the health care strand has lagged behind for a long time as compared to the areas of pensions and (especially) social inclusion, for which there is an agreement on a full battery of commonly agreed EU indicators (i.e., harmonized at EU level) (Atkinson and Marlier, 2010). For health, a ‘preliminary portfolio’ of commonly agreed national health care indicators (with commonly agreed definitions and assumptions) was adopted in June 2006 (European Commission, 2006: 7-13 and 40-50). At a second stage, the SPC adopted a new list of indicators for the monitoring of the health care and long-term care objectives of the Social OMC, as well as two new health related indicators to be included in the overarching portfolio in 2008. The list as it stands now is made up of 18 primary indicators, 12 secondary indicators and 4 context indicators regrouped according to the common objective they refer to (European Commission, 2009e). Even if the new list is comprehensive, it is still ‘preliminary’ and ‘incomplete’: the full list of indicators and their meaning have not been agreed upon; review is scheduled as new data become available. Work is being continued regarding long-term care (this dimension is not fully reflected in the existing list) under the new Europe 2020 Strategy, and the ISG is considering developing other indicators covering dimensions such as care utilization, out-of-pocket payments and asthma care.

In general, difficulties in data collection and handling, as well as political risks, have all slowed down the work on indicators and therefore the health care OMC as a whole. The fear of Member States to lose control over this important policy field (see section 8.2.1) is constantly present throughout the process and becomes particularly obvious when it comes to the development of indicators. Germany, for instance, was one of the countries that largely opposed the interference of the European level in health care policies and as a result refused the introduction of any further indicators in this area (see also Box 8.2 for a UK example).

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12 Critical OMC scholars such as Flear argue that even indicators for access and quality of care ultimately seek to optimize performance, by providing the means to assess whether objectives are met, and thereby ensure that equity and solidarity are subordinated in a neoliberal frame (see Flear, 2009).
Box 8.2  Indicators in the health care OMC: a sensitive issue

Consider, by way of illustration, the fact that the European Scrutiny Committee of the House of Commons in the United Kingdom in 2004 refused to scrutinize the Commission’s Communication through which it proposed to extend the OMC to health care (European Commission, 1999). The Committee in fact wondered ‘why such exchanges of views as are required could not be achieved by other, less intrusive, means (the Minister refers, for example, to the existing or proposed Commission and Council groups on health services and medical care)’ (UK Parliament, 2004: §9.9). In his response to the Committee, the Minister said that he detected no wish by Member States to use the OMC as a means to devise ‘new legislation or new targets or new EU indicators’ and that ‘we are not having (new) targets foisted upon us by anyone’13. Apparently, this convinced the Committee: in March 2005, the Committee explained that it had assuaged its concerns when the Minister ‘told us repeatedly that the application of the method would not lead to the imposition on the United Kingdom of new targets and indicators’14. And yet it warned the government: the Committee looks ‘forward to receiving the progress reports the Minister has offered to provide. We shall scrutinize them, in particular, to see if they include any targets or indicators for Member States’15.

In other words, the OMC might look ‘soft’ but, in some cases, it feels quite hard to those who are touched by it.

In view of Member States’ resistance highlighted above, it may not come as a surprise that so far no targets (quantified objectives) have been set in the context of the health care OMC. This stands in contrast to the Social Inclusion OMC, which now has a ‘headline target’ in the newly adopted Europe 2020 Strategy16.

But it is worth noting that the European Commission is building up pressure on Member States that provide long-term care in a devolved context to set national targets – as is shown by the following claim in the 2008 joint report: ‘[n]ational guidelines and targets can ensure uniform provision across the wide spectrum of service providers and the different levels of government involved in the management and financing of long-term care services’ (European Commission, 2008b: 90). There is no a priori reason why such targets could not be extended later on to drug prescriptions for general practitioners for instance, or other health related issues. The operation of other ‘soft law’ mechanisms (economic policies, employment, social inclusion) has made it very clear that once target setting has become an accepted instrument of a given OMC, the pressure to establish national or even EU-wide targets is hard to ignore for any Member State.

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14 Ibid., para. 9.14.
15 Ibid., para. 9.15.
16 The poverty target is one of 5 ‘headline targets’ within the EU’s new strategy for smart, sustainable and inclusive growth. Its aim is to promote social inclusion, in particular through the reduction of poverty, by aiming to lift at least 20 million people out of the risk of poverty and exclusion. The target will consist in reducing the number of people in the EU (120 million) who are at risk of poverty and/or materially deprived and/or living in jobless households by one sixth (European Commission, 2010).
**Policy learning through Peer Reviews**

A final instrument of the health care OMC’s toolbox is the Peer Review programme, which is at the heart of the OMC’s learning objective. Each year between eight and ten Peer Reviews about issues relevant for social protection and social inclusion are organized in the Member States (host countries) and funded by the PROGRESS programme (European Parliament and Council of the European Union, 2010). Many Member States, stakeholders and experts are indeed interested in sharing experiences during either of the two modalities of PROGRESS Peer Reviews: ‘good practice’ Peer Reviews, during which a Member State suggests a policy that has produced (exceptionally) good results; or ‘policy problem’ Peer Reviews, where an ineffective policy is studied and remedies are suggested. As a senior civil servant in the Commission explained: after ‘all this hesitation, the Member States now “discovered” the OMC. If we were to follow all the issues they proposed (as topics for mutual learning), it would completely flood the Social Protection agenda for years to come’[^17].

As can be seen in Table 8.1 below, Member States participated in a total of 50 Peer Reviews (2005–2010) – organized through the PROGRESS programme[^18] – on topics related to social inclusion, pensions as well as health and long-term care. Eleven out of those 50 Peer Reviews dealt with the issue of health and long-term care, which is quite significant in view of the fact that Peer Reviews cover no less than 10 key issues in total[^19]. As can be obtained from Table 8.1 below – with the exception of Denmark and Slovakia – all 27 Member States have at some point participated in a Peer Review on health care. It is also striking that no differences can be observed when comparing the participation of ‘old’ and ‘new’ Member States, since both are equally present in each of the columns. This balanced picture differs when it comes to the organization of Peer Reviews: up to now, eight mostly ‘old’ Member States have hosted Peer Reviews, while Hungary is the only new Member State in the list of organizing countries. One could draw the tentative conclusion that even though the new Member States are equally interested in learning from other countries, they still seem to be afraid of (or at least uncertain about) organizing Peer Reviews and actively sharing their own models as examples for mutual learning.

The topics that have been discussed range from ‘social integration for people with mental health problems’ and ‘freedom of choice and dignity for the elderly’ to ‘cost containment in the pharmaceutical sector’, ‘ensuring a functioning health care system in regions with declining and ageing populations’ to ‘coping with behavioural disorders in the patient’s home’ in the case of Alzheimer’s. A recent Peer Review in this area, held in October 2010 in Germany, assessed ‘achieving quality long-term care in residential facilities’. Interestingly, the latter Peer Review was organized a year after the Commission’s rather straightforward comments on this issue in the 2009 Joint Report on Social Protection and Social Inclusion. Moreover, Germany hosted three topics that have been discussed...’

[^17]: Interview with Former SPC Secretary, European Commission (Brussels, Belgium, September 2007).


[^19]: In addition, the first Peer Review covering health care in particular was not held before 2006.
Peer Reviews in the area of health and participated twice in Peer Reviews organized by other Member States, thereby outing itself as one of the keenest participants amongst the Member States (only France and Poland have participated even more intensively). This fact is quite remarkable for a Member State which has been among the most resilient to get the OMC in this area on tracks in the first place.

Table 8.1 Participation in Peer Reviews on health and long-term care topics (2005–2010)

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<th>Attended Peer Reviews (as host or participant)</th>
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Source: Peer review in social protection and social inclusion website20.

The critical reader may argue that ‘participating in Peer Reviews’ does not necessarily equal ‘policy learning’. In fact, Greer and Vanhercke pointed out that learning in the health care OMC runs the risk of being of a limited kind as often the wrong people will do the learning (i.e. representatives of the international units participate, and not the line officials) (Greer and Vanhercke, 2010. The problem here is that new governance matters in particular when it successfully escapes international units and strengthens transversal specialist networks that share worldviews or policy goals (political scientists have many names for these: epistemic communities and policy advocacy coalitions are the two most common) (Haas, 1992; Jenkins-Smith and Sabatier, 1994). Our own research confirms the concern that the Peer Reviews in the area of health care are mainly an exercise for a select group of civil servants and experts (Vanhercke, 2011a).

This brief overview of the overall architecture of the health care OMC suggests that it has most of the formal features of a ‘textbook OMC’: common objectives, national strategic reports, joint reports, indicators and Peer Reviews. The next section will look at whether this toolbox has so far delivered concrete results.

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8.3 Looking for a needle in a haystack: the impact of the health care OMC at the domestic level

Our assessment of the effectiveness and impact of the Social OMC uses Belgium as its main case study, while referring to evidence from other Member States when this is available. The assessment is first of all based on two waves of interviews with European, national, and sub-national civil servants, politicians and stakeholders (social partners and NGO representatives) working in the areas of poverty and social exclusion, pensions and health care. A first wave of 32 interviews was conducted during the second half of 2007, mainly providing information about the preparation of the 2006–2008 national strategic report, and the impact of the OMC until that moment. A second round of 20 interviews was conducted in December 2010, providing insights in the 2008–2010 reporting exercise. The 2010 round of interviews was complemented by an on-line survey which contained some 40 closed questions and was completed – between November and December 2010 – by 59 experts working in the three policy fields. Twenty respondents indicated to have their primary expertise in health care. We corroborated all the claims made by our respondents by confronting them, first, with the views of other interviewees and, second, with as many primary and secondary sources as possible.

To OMC critics, it will not come as a great surprise that by and large, Belgian health care experts who answered our 2010 on-line survey do not seem to think that the NSR process stimulated a genuine policy debate among the participants in the OMC process, or among a wider public (45% of them ‘strongly disagree’ with this suggestion, while 20% agree). Similarly, only a small minority of health care respondents thinks that ideas associated with the Social OMC are discussed in the key social policy discussion forums in Belgium. Unsurprisingly, then, merely 10% of health care experts in our on-line survey would agree with the statement that the ideas associated with the Social OMC are being reflected in the policy decisions in Belgium. A recent assessment coordinated by the Public Policy and Management Institute (PPMI) came to very similar findings. Drawing on in-depth country studies in 11 Member States, the impact of this strand of the Social OMC was indeed found to be weak across these countries when compared to the significant impact of the social inclusion and pensions strands.

Does this mean that actors do not see a genuine added value in pursuing this strand of the OMC? The results of our research indicate that this would be jumping to conclusions. In the following we present four different mechanisms through which the health care OMC could exert some impact, and conclude with some (admittedly modest) examples of potential substantive impact.

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21 Belgium, Denmark, France, Germany, Italy, Lithuania, Poland, Portugal, Romania, Spain, and the UK.
22 ‘Evaluation of the effectiveness and impact of the Social OMC since 2006’ (Deliverable 7) (2011) and ‘Suggestions for improvement and strengthening of the effectiveness and impact of the Social OMC’ (Deliverable 8) (2011), both reports produced by experts led by the Public Policy and Management Institute, on behalf of the European Commission.
8.3.1 Prudent mirror effects

A first element we call ‘prudent mirror effects’. First of all, several of our health care interviewees explained that for them the real added value of the NSR process is that it creates a platform for discussion between levels of government, as well as a domestic network which can be activated for other purposes (e.g. exchange of information). Thus, in Belgium, the NSR’s health care chapter results from consultation between several administrations: the Federal Public Service for Social Security (which is in charge of the overall coordination), the International Department of the ‘Federal Public Service for Health, Food Chain Safety and Environment’, the administrations of the three Communities and (more sporadically) the National Institute for Health and Disability Insurance (INAMI/ RIZIV). The document that is being produced through this consultation process (i.e. the health care section of the NSR) is considered to be the only document in Belgium that provides an encompassing overview (in Dutch and French) of the health care policies of all levels of government\(^{12}\). This makes it a rather unique document in the Belgian institutional setting. Regrettably, in view of the human resources invested in this document, it would seem that only its authors are aware of its existence.

Note that a similar (self-)reflection or mirroring experience has been identified in Germany: in 2007, a report was published on behalf of the federal Ministry of Health, in which data were collected on all health and long-term care indicators (see Schneider et al., 2007).

According to the Minister for Health this report was the first attempt to systematically compare and contrast the German health care system with the other EU Member States (using indicators selected/developed at EU level), not only at the national level, but also with regard to all sixteen of Germany’s Länder (Ibid.). The OMC was identified as the main reason to conduct this study. Perhaps even more interestingly, the report includes a clear ranking of Member States (highlighting the three best performing countries within the tables). This rather open and explicit assessment of policy performance is a quite surprising step, especially coming from a Member State that put up some heroic fights against such ‘rankings’ at EU level.

8.3.2 Spreading of Peer Reviews as a domestic governance tool

Above we explained that physical participation in PROGRESS Peer Reviews is restricted to a rather small group of OMC insiders. This does not, however, mean that these events do not reach a wider audience. Most respondents in the pensions (79%) and social inclusion (66%) strands claim (in our on-line survey) to have read, at some point, a document, statement or study produced by Peer Reviews. With regard to the health care OMC, this is the case for 50% of the experts. As important is that those (civil servants, social partners, academics) who have participated in a Peer Review are almost invariably satisfied (and mostly quite enthusiastic) about the information provided and the issues discussed, and would very much like to be

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involved more frequently (that is, if the Peer Review is directly relevant for their work, which normally means that it is as practical and detailed as possible).24

Perhaps this high satisfaction rate is one of the reasons why in Belgium the practice of organizing Peer Reviews has been spreading from the EU to the federal (e.g. on child poverty, active ageing, communication in pension systems), regional (e.g. on integrated services for target groups, access to housing and inclusive education) (Flemish Parliament, 2011: 11) and local level (including, again, on child poverty). Several interviewees suggest that the group of people who participate in the European Peer Reviews should be enlarged (e.g. including the local level). Finally, note that ‘learning’ is not restricted to Peer Reviews: several of our interviewees referred to their participation in EU Presidency events on social issues (80% of health care experts in the on-line survey have participated in such events). Taken together these people constitute an increasingly large ‘OMC Community’.

8.3.3 National steering capacity

A third element that is raised quite regularly by actors in our case study has to do with the Social OMC’s (alleged) contribution to national steering capacity (e.g. use of data and indicators). The enhanced capability for more systematic comparison with other countries is cited by most of the actors as one of the most important contributions of the Social OMC.

Our interviews (in Belgium and other Member States) confirm that the OMC has increased (institutionalized) awareness of policies, practices, and performances in other countries, by non-state actors as well as by governmental actors. As one key observer explained: ‘With Europe, it is more in the national culture to look for what the neighbours are doing’.25 In fact, the replies to our on-line survey with regard to this question are quite striking: in all three strands a majority of respondents believe that the NSR process indeed improved national steering capacities. Given the difficulties in the development of health care indicators described in section 2.2.3, it may come as a surprise then that 65% of Belgian health care experts confirm the impact on national steering capacities in our on-line survey.

Note that the consultation between several health care administrations described in section 3.1 would provide an excellent opportunity to further improve the national steering capacity in this area: according to our interviewees this inter-institutional coordination improved between the two rounds of NSRs (2006–2008 and 2008–2010 respectively), and it is even considered to be quite unique in the sense that there is no other platform in Belgium where all (federal and Community) administrations consult with one another. This is why the Federal Public Service (FPS) Social Security intended to institutionalize this newly created structure with a view to

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24 Interview with Health Attaché, Permanent Representation of Belgium to the EU (Brussels, Belgium, 10 December 2010); Interview with Director of the Social Department, Public Centre for Social Welfare of Leuven (Leuven, Belgium, 30 November 2010); Interview with Senior Advisor, Federation of Belgian Enterprises (Brussels, Belgium, 30 November 2010).

25 Interview with Head of Unit, Social Protection and Social Services, DG V, European Commission (Brussels, Belgium, 24 July 2007).
organizing the follow-up of the health care section of the NSR, but this plan was postponed due to the overloaded agenda of the 2010 Belgian Presidency of the EU.  

8.3.4 The needle in the haystack: health inequalities  
While all previously mentioned examples of ‘mechanisms’ through which the health care OMC could work (mirror effects, spreading of Peer Reviews and the contribution of this strand of the Social OMC to national steering capacities) are governance related, there is no solid evidence confirming any substantive policy change – i.e. influence of the OMC on policy framing, agendas and legislative outcomes – as a result of this.

Nevertheless, the developments regarding the issue of health inequalities should be further considered, as they may point to a more substantive impact of the OMC. Thus, some of our interviewees claimed that the Commission’s insistence on the topic of ‘health inequalities’ – through the joint reports, indicator development, an SPC Opinion as well as through PROGRESS funding in support of innovative action in this field, etc. – led to increased awareness about this topic, which was also reflected in the 2010 EPSCO Council Conclusions. The Council indeed adopted the SPC Opinion about ‘Solidarity in Health: Reducing health inequalities in the EU’ that pays considerable attention to the links between social inclusion and health equality, thereby referring extensively to the Social OMC (SPC, 2010). For de Ruijter and Hervey (2012) ‘the equality agenda, articulated in terms of social cohesion (rather than individual rights/non-discrimination), seems to be the most likely way forward’ if the health care strand is to become a success in the future.

Apart from the topic of health inequalities, German interviewees claimed that the EU’s focus on quality management in long-term care somewhat changed perceptions about this topic (see discussion about Peer Reviews and country fiches in section two). Note that in the aforementioned Social OMC assessment, Lithuanian interviewees explained that the concept of integrated long-term care was first institutionalized in their country in response to the OMC process. Similarly, the OMC would have contributed to the initiation of discussions about the topic of long-term care in Poland. But so far these claims have not been clearly confirmed by ‘triangulation’ (a combination of different sources) and so they cannot be taken for granted.

8.4 Tracing EU significance: a patchwork of ‘soft’ governance and instrument hybridity  
While the previous sections of this chapter looked at the domestic impact of the health care OMC, this section discusses whether the health care OMC has any significance at the EU level. The key

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26 Interview with Former Advisor, Federal Public Service for Social Security (Brussels, Belgium, 2 December 2010).
questions are: is there any empirical evidence to substantiate such ‘EU impact’ claims; and, as important, is there evidence of any kind of interaction between policy and law at the EU level?

### 8.4.1 OMC as a template for EU ‘soft law’ mechanisms

A first indication that an assessment of the significance of the OMC should not discard the EU level, is the fact that the Barroso Commission, not known for being a special advocate of new governance in the social field, ‘has continued to propose new OMC processes when faced with the perceived need for joint action in politically sensitive institutionally diverse policy fields’ (Sabel and Zeitlin, 2007). And in spite of all the scepticism (especially from academics), many (if not all) of ‘other’ Commission-led new governance processes on health care – which include the European Health Policy Forum, the High Level Committee on Health and the High Level Process of Reflection on Patient Mobility – sooner or later refer to the OMC as a ‘goal to attain’ (EHPF, 2003: 7; European Commission, 2001: 26 and 2003: 5; Kyprianou, 2005: 6). Thus, it seems that the OMC has become a ‘template’ for EU ‘soft law’ mechanisms in health.

This finding is confirmed by the fact that, even within the limited field of health care, new proposals for launching OMC processes arise on a regular basis: the European Commission has been thinking out loud about starting new applications of OMC-type processes to areas such as organ donation and transplantation (European Commission, 2007: 10)\(^{29}\) as well as nanosciences and nanotechnologies (European Commission, 2005: 4). Others would like to see the method to be applied to obesity and cancer screening, or to e-health (European Commission, 2004: 16)\(^{30}\).

### 8.4.2 Interaction with other (harder) EU instruments: ‘soft-to-hard-to-soft’ governance

A crucial finding is that the substantive messages coming from the Social OMC have been used to – selectively – influence ‘harder’ forms of EU ‘soft’ governance, including the new Integrated Guidelines for implementing the Europe 2020 Strategy. The Council adopted (in October 2010) six broad guidelines relating to the economic policies of the Member States and the EU, and four guidelines concerning the employment (and in fact also social) policies of the Member States\(^ {31}\). Integrated Guideline 10 (see Annex 1) deals with ‘promoting social inclusion and combating poverty’ and underlines the role of pensions, health care, and public services in maintaining social cohesion. Note that the common social objectives for health care enter into Guideline 10 primarily insofar as they contribute to ‘social exclusion’ goals. Indeed, the latter refers to the need for modernization of social protection systems (including access to health care) so that

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\(^{30}\) Interview with Deputy Head, Health Strategy Unit, DG SANCO, European Commission (Brussels, Belgium, 8 October 2007).

\(^{31}\) Their aim is to provide guidance to Member States on defining their ‘National Reform Programmes’ and implementing reforms, in line with the Stability and Growth Pact.
they can provide adequate income support and services ‘while remaining financially sustainable and encouraging participation in society and in the labour market’. In sum, at least on paper, the Europe 2020 Strategy welcomes some key social dimensions, including (access to) health care, back to its heart (through the Integrated Guideline 10), after these issues had been removed from the Lisbon Strategy during its 2005 revision.

And yet, this new situation entails some serious risks, most importantly that the ‘social dimension’ (including health care) becomes subsumed into the growth objectives of the new strategy (see the reference to ‘financially sustainable’ and ‘labour market’ in the aforementioned Guideline 10), especially in light of the recent strengthening of the Stability and Growth Pact. This is why one author claims that in ‘a decade from now linguists may use the phrase ‘Social dimension of Europe 2020’ as an example of an oxymoron’ (Vanhercke, 2011b). And yet, many of our interviewees refer to the fact that without the Social OMC, the economic discourse regarding (the financial sustainability) of health care systems would regain its earlier monopoly. To put it differently, the Social OMC is also about occupying the health care territory vis-à-vis the economic players (especially the ECOFIN Council and its Economic Policy Committee) – in other words, to support the ‘social’ agenda of DG Social Affairs and its network over the alternative ‘economic’ frameworks and networks.

The OMC has also started to interact with the EU’s financial instruments, and the European Social Fund (ESF) more particularly. For de la Rosa it is clear that the relationship between the two instruments works both ways: if the ESF strengthens the OMC, the latter may in turn influence cohesion policy (de la Rosa, 2007). Hervey and Vanhercke highlight the interlinking between the OMC and the ESF (Hervey and Vanhercke, 2010). For these authors, the fact that the ESF Regulation for the 2007–13 programming period explicitly refers to the Open Method of Coordination on Social Protection and Social Inclusion represents a case in point of ‘instrument hybridity’. Indeed, for these authors ‘there is no reason why in the near future certain elements of the health care OMC would not be taken into account by the Commission, de jure or de facto, to determine whether expenditure is eligible for assistance under the Fund’ (Hervey and Vanhercke, 2010). The recent appeal from the Council of the European Union (European Council, 2011) to make more effective use of EU financial programmes with a view to health system innovation and reducing health inequalities seems to confirm this claim.

The link between the OMC and the Community method has also received considerable academic attention. De la Rosa explains how the Social OMC ensures a regular follow-up of certain non-discrimination directives (de la Rosa, 2007). An example in the area of health that can highlight the interlinking of the OMC and the Community method is the Directive on the application of patient’s rights in cross-border health care which contains an entire chapter on ‘Cooperation in Healthcare’ (European Parliament and Council of the European Union, 2011).

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Within chapter four of this Directive, five types of cooperation can be identified which are clearly inspired by the OMC. Examples include:

- Mutual assistance and cooperation: Member States shall engage in 'cooperation on standards and guidelines on quality and safety and the exchange of information (…)’ (Article 10);
- European reference networks, which could ‘encourage the development of quality and safety benchmarks and help to develop and spread best practice within and outside the network’ (Article 12);
- Concerning rare diseases: ‘The Commission shall support Member States in cooperating in the development of diagnosis and treatment capacity (…)’ (Article 13);
- With regard to eHealth, ‘The Union shall support and facilitate cooperation and the exchange of information among Member States working within a voluntary network (…)’, while one of the objectives of the eHealth network shall be to ‘draw up guidelines’ (Article 14).

According to Sauter (2012) these elements are not key in the harmonization setting of the Directive but ‘nevertheless important to the continued collaboration between the Member States in this field, and by creating cross-border policy communities they may contribute towards providing support for further integration of health care markets – possibly by spill-over, and including further harmonization’. One possible example of such spill-over effects could be that Member States engage in deliberation about key notions such as ‘good quality care’ (which may have different interpretations and expectations across, and within, the Member States). Such deliberations could take place in the context of any directive that includes ‘soft pockets’ such as the ones found in the Directive on the application of patient's rights in cross-border health care (Szyszczak, 2011). According to Hervey (2012), the latter Directive’s chapter IV on ‘Cooperation in Healthcare’ has the potential to lead to changes in national practices, not through the ‘classic Community method’ of granting legal rights to individuals within the EU, ‘but by promoting convergence of approaches through mandatory transparent sharing of practices and consequent recognition of practices that are successful, and their development into benchmarks of best practice’.

In this context it seems worthwhile to have a closer look at the EU’s Health Technology Assessment (HTA), created as a European-wide coordination framework with a view to a better coordination of national HTA actions. The HTA seems to be a case in point to illustrate the formalization (and thereby further institutionalization) of OMC-based cooperation, which is moving closer to a rule of law framework of good governance practice. Indeed, in spite of the fact that HTA collaboration takes place outside the OMC framework (in fact there is not even a single cross-reference made between both instruments), the instruments used within this collaboration are strikingly similar to the OMC toolbox (even if the HTA has a clearly narrower focus in terms of substance). The (simplified) step-by-step development of HTA33 (see Box 8.3) – which started off as a political process and was ultimately inserted in the EU Patients’ Rights Directive – not only illustrates how ‘soft’ governance is consequently translated into ‘hard’ EU law. It also illustrates how ‘hard’ law ultimately reverts to ‘soft’ governance for its actual implementation. This ‘soft -to-hard-to-soft ’ development clearly shows that the ‘interaction’

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33 For a further discussion, see Baeten and Palm (2013).
between law and policy in the European health care arena is developing into a ‘hybridization’ of instruments.

**Box 8.3 Health technology assessment as an example of EU’s ‘soft-to-hard-to-soft’ governance**

The term Health Technology Assessment describes a ‘multidisciplinary process that summarizes information about the medical, social, economic, and ethical issues related to the use of health technology’. Its aim is to inform and thereby contribute to the formulation of safe, effective and patient focused health policies. Potential subjects of these assessments are for instance diagnostic and treatment methods, medical equipment, pharmaceuticals, rehabilitation and prevention methods or organizational and supportive systems within which health care is provided.

In 2004, as a result of the work of the High Level Group on Health Services and Medical Care, HTA was identified as a ‘a political priority’ by the Council and the Commission, who recognized ‘an urgent need for establishing a sustainable European network on HTA’. Thus, the European network for Health Technology Assessment (EUnetHTA) Project was set up under Danish leadership to create an effective and sustainable network for HTA across Europe that could contribute to HTAs in Member States by providing necessary information.

In the follow-up, the EUnetHTA Project became the EUnetHTA Collaboration in November 2008 – thereby deepening the degree of its formalization. Since 2010, activities are organized in the framework of the EUnetHTA Joint Action 2010–2012. The EUnetHTA now brings together government-appointed organizations from EU Member States, the European Economic Area (EEA) and the European Free Trade Association (EFTA) countries as well as regional agencies and non-profit organizations that are involved in the field of HTA with the overall aim to, ‘facilitate efficient use of resources available for HTA, to create a sustainable system of HTA knowledge sharing, and to promote good practise in HTA methods and processes’. To achieve these aims, the EUnetHTA uses many instruments that can also regularly be found in other new governance mechanisms as for instance the creation of a database on HTA, the guarantee of common standards and the involvement of all relevant stakeholders.

Most recently, Article 15 of the Directive on the application of patients’ rights in cross-border health care identifies HTA as an area where ‘The Union shall support and facilitate cooperation and the exchange of scientific information among Member States within a voluntary network connecting national authorities or bodies responsible for health technology assessment designated by the Member States’. Note the striking similarity between the language used to describe the aims, activities and tools of HTA coordination and OMC jargon.

**8.4.3 ‘Soft’ governance and the Court of Justice of the EU**

A final illustration of the OMC’s significance at the EU level is more cautious. Hervey (provocatively) examines adjudicating by the Court of Justice of the EU ‘in the shadow of the

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36 For more information about EUnetHTA, see the website of the EUnetHTA Joint Action <www.eunethta.net/> accessed 4 November 2011.
informal settlement’ (Hervey, 2010), thereby inverting the idea of ‘bargaining in the shadow of the law’. In her analysis, Hervey shows how new governance can cast a shadow over adjudication processes and influences the CJEU’s way to frame and solve problems as well as its reasoning by taking account of and learn from the ideas and concepts that are developed and spread within the informal settings. Even though the concrete case studies do not directly deal with the Social OMC (they relate to the European Employment Strategy (EES) and the Bologna Process on Higher Education) the findings are highly relevant for our study. Indeed, they do not only indicate the mere possibility that the CJEU would take elements of new governance into consideration, but take this one step further by illustrating that this kind of spill-over is happening already.

Furthermore, Hervey argues that the soft norms that develop within the new governance frameworks form part of the interpretation of the Treaties, which the Court in turn has to apply in its ruling. In the field of health services, positions that are developed within the framework of informal settings that deal with possible reasons to justify a restriction of the right of free movement of services have to be taken into account by the CJEU when it interprets Article 56 Treaty on the Functioning of the European Union (TFEU) (Hervey, 2010). In any case, it seems that the Court is no more blind to governance measures than it is to legislation or proposed legislation: it will increasingly be inspired by the outcomes of the governance process in its judgements. More particularly when it comes to the question of proportionality, as well as when the Court has to interpret difficult notions such as ‘undue delays’, ‘solidarity’ or a definition of ‘public interest’ in the context of cross-border health care services. Unsurprisingly then, legal scholars like Dawson conclude that ‘the political nature of processes such as the OMC – which allow governments to multilaterally defend and review important social policy objectives – may offer the European Courts a useful source of information and legitimacy in determining where the boundaries between the internal market and national welfare states really lie’ (Dawson, 2011).

This said, the potential influence of the Social OMC through the *erga omnes* effect of CJEU rulings should not be overstated: even if it is true that all Member States would be indirectly influenced by (preliminary or non-compliance) rulings taking into account elements of the OMC, scholars like Obermaier who assess the impact of the (then still) ECJ rulings on domestic social policy, conclude that the impact of these rulings is far less potent than previously thought (Obermaier, 2009).

38 The concept of a ‘shadow of hierarchy’ (see Mayntz and Scharpf, 1995) is used to describe governance settings where the threat of a direct state intervention (understood as the introduction of binding rules) leads to the adoption of voluntary agreements. The main idea is that informal settings are most likely to be effective when a strong hierarchy is looming in the background. Such a ‘shadow of hierarchy’ provides a crucial incentive for both governments and non-state actors to take non-hierarchical rulemaking and/or service provision seriously. Since self-regulation allows for greater flexibility, the involved actors can influence the policy outcomes. For a more detailed account on the impact of the ‘shadow of hierarchy’ in governance settings without government, see for example Börzel and Risse (2010).
39 And see Baeten et al. (2010) for a discussion of how Member States creatively adapt their domestic legislation in the shadow of patient mobility case law.
In sum, when compared to the somehow disappointing results regarding the (lack of) impact of the health care OMC at the domestic level, this section provided some arguments as to why the health care OMC should not be discarded too easily: at the EU level, this process has some significance, first, as a template for EU ‘soft law’ mechanisms in health, and second as the centre of various interactions between policy and law. Note that both at the domestic and EU level the impact of the health care OMC is largely of a procedural nature, while so far (almost) no firm evidence of substantial impact (influence on policy contents) could be provided. The next section addresses the question why this is so.

8.5 Explaining limited substantive impact: lack of ownership and actor rivalry?

Section three made it crystal clear that OMC in health care is by no means shaking domestic social policy-making and there is no convincing evidence that actors in health care policy consider the OMC as an important, or even useful, tool in domestic policy-making, as opposed to the Social Inclusion or Pensions strands of the Social OMC. Therefore this section tries to find some explanations for the limited impact of the OMC in this policy field.

8.5.1 Ownership of a closed shop

Earlier research on the effectiveness of the OMC has clearly highlighted ‘leverage’ as an important mechanism for any OMC to have an impact (or in other words to produce effects on the ground). Indeed, only when an OMC instrument is being ‘creatively used’ by actors to pursue their goals, one can expect it to have an effect. This section therefore examines stakeholder participation within the health care strand of the Social OMC focusing, again on Belgium as our main case study. It is clear from the stylized description in section three that the Belgian NSR-process in health care is by and large a ‘closed shop’ which only involves administrations of the different levels of government. Political actors come in only at a very late stage, when the NSR is formally adopted at an ‘Inter-Ministerial Conference’ (IMC). Some of the most important actors in health care policy-making, such as the mutual funds and health professionals, are not involved. Writing about the health care OMC, Dawson equally finds that the method generally relies on those already within the ‘inner circle’ of ‘Europeanized’ participants; pointing again to the finding that there is little evidence of the multiplication or ‘broadening’ of accountable actors (Dawson, 2009). This low level of stakeholder involvement in the health care strand clearly contrasts with the writing of the Social Inclusion section of the OMC.

See for example Hamel and Vanhercke, 2008 for a discussion of the different usages of the Social Inclusion OMC. B. Vanhercke explains how, against the odds, the Pensions OMC became a selective amplifier for reforming Belgian pension policies (see Vanhercke, 2009).

For a detailed account on the importance of leverage as a mechanism to explain the OMC’s impact as well as for an argument to distinguish between the ‘impact’ versus the ‘adequacy’ of the OMC, see Vanhercke (2010).
NSR (sometimes referred to as NAP/Incl), which has been opened up, step by step, to a wide range of actors in many Member States.\textsuperscript{42}

Note that one can find two (tiny) ‘holes’ in this ‘closed shop’ image of the health care OMC in Belgium. First, several drafts of the NSRs (including the health care chapter) are being proposed – by the representatives of the FPS Social Security – to the social partners in the context of the National Labour Council. But even though this procedure was confirmed by the representatives of both sides of industry during our interviews, both employer and employee representatives explained that these sessions involved nothing more than ‘information’, and could certainly not be seen as ‘participation’.\textsuperscript{43} Secondly, the main author of the health care chapter of the NSR explained that he presented a draft of this chapter to the ‘Actions’ Task Force\textsuperscript{44} in charge of the preparation of the National Action Plan on Social Inclusion, thereby ‘opening up’ the process, a (little) bit. Clearly, these nuances do not change the overall picture of the health care OMC as a well-kept secret. This gloomy picture is further confirmed by more specific questions in the aforementioned on-line survey: while Belgian policy-makers and stakeholders are in general rather familiar with the OMC features, our health care respondents seem to agree that most social policy-makers have not read the national strategic reports or the joint reports. The same is true for the aforementioned country profiles (which are part of the joint reports) and the supporting documents (Commission staff working paper) produced by the European Commission, which are even less known. This raises obvious questions with regard to the ‘ownership’ of the health care strand of the Social OMC. The aforementioned Social OMC assessment confirms that the visibility and ownership of the health care strand is problematic in several (not to say all) Member States, including in France, the UK, Germany and Denmark.

It can thus be safely concluded that the potential of the health care OMC to produce widespread learning effects, or to lead to creative use of the OMC tools at the domestic level, is very weak. Furthermore, it became clear that actors within the field of the health care OMC were only partly informed about the process as such.

\subsection*{8.5.2 Actor rivalry}

A second explanation for the limited impact of the OMC in health care is the very nature of health and health policies. Health is a horizontal issue that plays a role in many different aspects of daily life (nutrition and food safety, transport, working conditions, housing etc.). The European Commission has recognized that health is determined to a large extent by factors outside the

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\begin{itemize}
\item \textsuperscript{43} Interview with Senior Advisor, Federation of Belgian Enterprises (Brussels, Belgium, 30 November 2010); Interview with Advisor, Studies Department, Belgian General Federation of Labour (Brussels, Belgium, 9 December 2010).
\item \textsuperscript{44} This Task Force is presided by the federal ‘Social Integration’ administration. The Regional administrations are equal members of the Task Forces, together with a variety of stakeholders (service providers, NGOs, experts).
\item \textsuperscript{45} Interview with former Advisor in the Federal Public Service for Social Security (Brussels, Belgium, 2 December 2010).
\end{itemize}
health area (for example agriculture, education, and environment) and that effective health policy must thus involve all relevant policy areas. This can be seen in the EU’s Health in All Policies (HiAP)46 approach which is also identified as one of the four key principles in the EU Health Strategy 2008–201347. This complexity makes health policy hard to influence in any case (including through EU ‘soft law’). But there is more: the multifaceted nature of health policy makes this a governance territory where different actors from different policy fields try to influence decision-making through a variety of channels. The resulting actor rivalry exists simultaneously at different levels of governance.

At the broader EU level different actors want to have a say when it comes to health care decisions. As Hervey and Vanhercke show, no less than five different sets of actors try to expand their influence on the EU health care debate: the ‘social affairs’, ‘internal market’, ‘public health’, ‘economic’ and ‘enterprise’ players. Together, they create a very crowded law and policy-making space to which actors bring their conflicting agendas and different understandings of health policies48. According to Greer and Vanhercke the variety of actors, concepts and agendas reduces the ‘effectiveness’ of this OMC strand, since it entails huge competition for time and political attention with other health policy issues and processes. An additional element is the European Commission’s internal divisions (including cleavages between DG Employment, Social Affairs and Inclusion on the one hand and DG Health and Consumers on the other), which allows the Council and national governments to reassert control49. In other words: there is a clear lack of leadership in the European health care debate. De Ruijter and Hervey point out that even though health care policies remain on the EU agenda, it is due to this institutional fragmentation that health care is ‘side-lined from the OMC’ (de Ruijter and T.K. Hervey, 2012).

Actor rivalry does not only take place between actors from different policy fields (e.g. the EPSCO and ECOFIN Council formations), but can equally be found among the EU’s health care initiatives. Apart from the OMC, there are several other fora (such as the recently revamped Working Party

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46 The Health in all Policy (HiAP) approach has been given a lot of attention while it figured as a major topic on the agenda of the Finish Presidency of the EU in 2005. The core of HiAP is to examine determinants of health that can be altered to improve health but are mainly controlled by the policies of sectors other than health. The core ideas and values of the HiAP approach of the EU is similar to The Health for All policy framework of the WHO (see, for example: ‘The Health for All policy framework for the WHO European Region: 2005 update’ <www.euro.who.int/en/what-we-publish/abstracts/health-for-all-policy-framework-for-the-who-european-region-the-2005-update> accessed 4 November 2011).


48 Take for instance the ECOFIN Council Conclusion on health systems in the EU that was adopted in December 2010 and that is clearly driven by an economic approach towards health care: in its conclusion, the ECOFIN Council stresses the necessity to further enhance effectiveness within the health care systems of the Member States in view of the need to ensure long-term sustainability in public finances (Council of the European Union, 2010a).

49 Note that an inter-service group on public health was set up with the purpose to improve coordination on health within the different Commission departments. More than 20 departments are represented within this group that also has several thematic sub-groups, dealing with dynamic health systems, global health, health and environment and HIV/AIDS. For more information, see the website of DG SANCO: http://ec.europa.eu/health/health_policies/coordination/index_en.htm accessed 4 November 2011.
on Public Health at Senior Level\textsuperscript{50} and the European Health Care Policy Forum\textsuperscript{51}, which pursue their own interests and agendas. As a result, the health care OMC is merely ‘one of many’ instruments that are available (compare this to the area of Social Inclusion, where the OMC is clearly the leading governance tool at the EU level (Greer and Vanhercke, 2010).

Thirdly, actor rivalry also exists between the EU and other, international organizations that deal with health care, notably the World Health Organisation (WHO) and the OECD. While the WHO seeks to achieve ‘the attainment by all people of the highest possible level of health’ within the UN framework\textsuperscript{52}, the Organization for Economic Cooperation and Development (OECD) mainly provides comparative analyses on health care systems in industrialized countries. The latter has thereby acquired specific experience in the field of statistics and policy recommendations. Note that several of our interviewees in the health care strand referred to OECD data (instead of data obtained in the OMC framework), since these data have a longstanding tradition and are often more developed and detailed.

Apart from this longstanding OECD expertise (that somehow competes with the EU statistics in the field of health), the 2008 WHO’s declaration of the ‘Tallinn Charter: Health Systems for Health and Wealth’ provides another example for actor rivalry at international level. The Charter identifies common values and common health challenges in the European region in the context of demographic and epidemiological change, increasing socio-economic disparities and limited resources\textsuperscript{53}. States thus declare their commitment to act on seven different priorities (including to invest in health systems and related sectors, promote transparency, and make health systems more responsive to people’s needs). Note that ‘foster cross-country learning and cooperation on the design and implementation of health system reforms at national and sub-national level’ and ‘engage stakeholders in policy development and implementation’ are equally part of the commitment to act\textsuperscript{54}. The WHO will therefore provide cross-county coordination ‘including the measurement of performance and the exchange of experiences’ on these commitments\textsuperscript{55}. Furthermore, the Charter foresees the identification of objectives, which in turn should be specified in a measurable way to allow for explicit monitoring of progress\textsuperscript{56}. The Programme of the Tallinn Charter thus seems to almost reinvent the core features of the OMC, including

\textsuperscript{50} In June 2011 the Council of the European Union decided to ‘initiate a reflection process under the auspices of the Working Party on Public Health at Senior Level aiming to identify effective ways of investing in health, so as to pursue modern, responsive and sustainable health systems’. This sounds quite familiar to the mandate of the OMC in this policy field. The first report from the Working Party is expected by the end of 2012 (European Council, 2011).

\textsuperscript{51} The European Union Health Care Policy Forum is a stakeholder organization that hosts a diverse range of pan-European health NGOs as well as industry associations. Its stated aim is ‘to contribute to and advise on the development, implementation and evaluation of EU health-related policies and actions and to empower European citizens in health for life’. See European Commission (2009g: 3).

\textsuperscript{52} Constitution of the World Health Organization, Article 1.

\textsuperscript{53} See World Health Organization, The Tallinn Charter: Health Systems for Health and Wealth, Recitals 2 and 3 of the Preamble.

\textsuperscript{54} Ibid., p. 2 (Commitment to act (6)).

\textsuperscript{55} Ibid., p. 2 (Commitment to act (7)).

\textsuperscript{56} Ibid., p. 3 (Strengthening health systems: From values to action (12)).
common objectives, monitoring, learning and stakeholder involvement. The Tallinn Charter thereby represents another striking example of the density of actors and initiatives that seek to influence policies in this field.

8.6 Wrapping things up: ‘soft-to-hard-to-soft’ governance in the EU

Health is and will continue to be an area within which the competence of the EU institutions is highly constrained. This has been reconfirmed by the Treaty of Lisbon. At the same time, however, health is no longer a 'non-topic' for the EU, and neither the EU institutions, nor the governments of the Member States, can now retreat from that position. Indeed, (a) the longstanding political incapacity to adopt ‘positive’ legislation in health (with the key exception of the recent Patients’ Rights Directive); (b) an increasing impact of EU law on national health care systems; and (c) a divided policy space (with different sets of actors claiming a say in health care issues), have spurred consecutive rounds of EU policy initiatives (pressed for by domestic policy-makers), to deal with the unintended consequences. One of those initiatives has been the Open Method of Coordination.

In section three we saw that the health care OMC is by no means shaking domestic social policy-making. Even if many Belgian actors working in the areas of social inclusion and pensions do perceive the OMC as an increasingly important, and useful, tool in domestic policy-making (features of both, the social inclusion and pensions strand, are being picked up by a variety of actors and used to pursue their policy goals), there is no convincing evidence that this would be the case in the area of health care. Here the OMC remains a largely hidden process, only known to a very small circle of – mostly federal – civil servants. These findings were corroborated for a variety of other Member States. And yet we provided a few examples of needles in the haystack: we described prudent mirror effects (Belgium and Germany), discussed the added value of Peer Reviews, the contribution of the Social OMC to national steering capacity (e.g. use of data and indicators) and the plausibility of OMC influence on substantive issues such as quality in health care.

This relatively gloomy picture can, to a large extent, be explained by two (related) factors: weak ownership by stakeholders, and the fact that the health care policy arena is characterized by extensive actor rivalry. We described such rivalry, first, between different actors emanating from different policy fields (related to health policy); second, between actors and instruments within the health care arena; and third, at the international level, between the EU and other international organizations with a longstanding tradition in health care policy coordination. Nevertheless, one should not forget that this institutional fragmentation can at the same time also represent an opportunity. As de Ruijter and Hervey point out correctly, the diverging concepts and responsible actors in the field of health care also make different institutional routes available in case one becomes politically blocked (de Ruijter and Hervey, 2012).

57 See Article 168.7 TFEU: ‘Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them.’
In spite of its general uncomfortable institutional position (competing as it is with a variety of EU initiatives in this particular policy area) and the small substantive impact that it has exerted so far on national health policy, section four of this chapter shows that the OMC is increasingly seen as a template for EU health care governance. At the same time, there are indications that law and soft modes of health governance are increasingly interacting, as it is the case between the OMC and different financial instruments, especially the ESF. The influence of ‘soft’ governance on the adjudicating of the CJEU and the finding that the CJEU is sometimes inspired by the outcomes of ‘soft’ governance processes, are further examples of the interaction between law and policy in health. The ‘soft pockets’ in the new Patients’ Rights Directive as well as the ‘soft-to-hard-to-soft’ development of the HTA framework, point to the increasing hybridity of EU instruments in the field of health care. In turn this finding suggests a more nuanced discussion about ‘hard’ and ‘soft’ law in the EU, and more generally speaking also about ‘Social Europe’. In view of its multiple functions (supporting domestic reform, strengthening networks, shaping political consensus, influencing hard(er) modes of governance), it seems that the health care OMC is there to stay. More important than whether it will ‘survive’ is the question as to who will engage.

In other words, the crux of the matter is the following: it is not the ‘hardness’ or the ‘softness’ of the OMC that matters, but its capacity (or, as is the case in health, its failure) to stimulate creative appropriation and action by European, national and sub-national actors. This confirms Scott Greer’s observation that EU governance mechanisms, including those in the health care field, will continue to flourish only if they promote some kind of tangible benefit for participants, either involving learning or governance or both (Greer, 2011). Now that the contours of the reinvigorated Social OMC are becoming increasingly clear, it will be up to policy-makers and experts alike to make that happen in the Europe 2020 Strategy (SPC, 2011).

58 The Lisbon Treaty amends Article 152 EC, to further enhance (or possibly constrain) the Commission’s competence to encourage cooperation between the Member States in the public health field. This Commission-sponsored cooperation includes, ‘initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation’. See Article 168.2 TFEU.
Annex 1: Integrated Guideline 10 – Promoting social inclusion and combating poverty

The extension of employment opportunities is an essential aspect of Member States’ integrated strategies to prevent and reduce poverty and to promote full participation in society and economy. Appropriate use of the European Social Fund and other EU funds should be made to that end. Efforts should concentrate on ensuring equal opportunities, including thorough access for all to high quality, affordable, and sustainable services, in particular in the social field. Public services (including online services, in line with Guideline 4) play an important role in this respect. Member States should put in place effective anti-discrimination measures. Empowering people and promoting labour market participation for those furthest away from the labour market while preventing in-work poverty will help fight social exclusion. This would require enhancing social protection systems, lifelong learning and comprehensive active inclusion policies to create opportunities at different stages of people’s lives and shield them from the risk of exclusion, with special attention to women. Social protection systems, including pensions and access to healthcare, should be modernised and fully deployed to ensure adequate income support and services – thus providing social cohesion – whilst remaining financially sustainable and encouraging participation in society and in the labour market. Benefit systems should focus on ensuring income security during transitions and reducing poverty, in particular among groups most at risk from social exclusion, such as one-parent families, minorities including the Roma, people with disabilities, children and young people, elderly women and men, legal migrants and the homeless. Member States should also actively promote the social economy and social innovation in support of the most vulnerable. All measures should also aim at promoting gender equality. The EU headline target, on the basis of which Member States will set their national targets, taking into account their relative starting conditions and national circumstances, will aim at promoting social inclusion, in particular through the reduction of poverty by aiming to lift at least 20 million people out of the risk of poverty and exclusion.’

Source: Council of the European, 2010b (emphasis added).
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‘Soft-to-hard-to-soft’ governance of health care in the EU


