Why the EU Has Such Feeble Social Policies: Fields and Political Work in the Case of Health

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Andy Smith
Centre Emile Durkheim, University of Bordeaux

Paper presented to the congress of the Council for European Studies, Madrid, 20-22 June, 2019

Abstract: Within analysis of European integration, the distinction between a 'social Europe' and a 'neo-liberal' one blocks analysis of what and who have actually built the European Union (EU) of today. Similarly, an analysis solely in terms of EU vs member state competency does not further research in this area either. To better answer the question why the EU has such a feeble social policy one needs instead to embrace a political economy of European integration which simultaneously tackles the fields (Economic, Bureaucratic, Party political and Expertise) within which the possibility of EU social policy has been discussed, then how scales of government have affected these debates and negotiations. From there one can ascertain how and why the best-resourced actors involved have worked politically to narrow the definition of 'the social' as a European problem and restrict its instrumentation. This claim will be illustrated using empirical examples from the health industry in the early 1950s and 2010s.

Introduction

The weakness of European Union's (EU) social policies in comparison to national ones is well known throughout academia and a wider public. Explanation, however, is generally reduced to 'what the treaties say' or the power of national governments on the one hand and, on the other, to a liberal bias allegedly built into the EU from the outset (Copeland, 2019). More precisely, the weakness of EU measures categorized as 'social' is attributed to legislation which has conserved power to develop such interventions at the national scale, whilst transferring responsibility for much of 'economic' policy to the European scale of government.

These beliefs and arguments are not in themselves wrong. However, they not only overlook why the treaties took the form they did and national governments retain such high levels of power in this issue area. They also reflect and perpetuate a superficial and misleading conception of what social policies are, how they relate to 'the economic' and the relationship of both to the capitalisms within and across which the EU has been built.

This paper is an attempt to develop an alternative explanation of why the EU's 'social policies' are so feeble which draws upon a constructivist and institutionalist political economy approach to policy-making which guides research around two concepts: 'fields' and 'political work' (section 1). From there, using cases from the health industry in the early 1950s (section 2) then 2010s (section 3), it will be argued that social policy in the EU remains essentially national because, throughout its history and within specific fields of asymmetric power relations, the best-resourced actors involved have worked politically to narrow the definition of the European 'social problem' and curtail its instrumentation. In short, EU social

policy is so weak because of how capitalism has been structured throughout Western Europe since at least 1945, and this due to the positions and dispositions of the actors from the Economic and Bureaucratic fields who have dominated its institutions and regulation.

1. Studying the Social within Political Economies: A Constructivist-Institutionalist Approach

Elsewhere a sustained and systematic argument has been made in favour of both generalizing constructivist and institutionalist analysis within studies of political economy and policymaking (Hay, 2016; Smith, 2016), then applying this in particular to the EU (Jullien & Smith, 2014). As our previous research has shown in a wide variety of cases (notably agriculture, wine, whisky, defence, pharmaceuticals), socio-economic activity takes place and is 'regularized' (Boyer, 2015) within social spaces we have theorized as 'industries'. Beyond common parlance, using industry as a concept enables research to grasp each specialized variant of socio-economic activity as being simultaneously a 'productive system' (typically involving financiers, producers and distributors) and an 'institutional order' (implicating interest groups and public authorities). Indeed, as Boyer himself has consistently underlined, what gives regularity to socio-economic activity are institutions, i.e. the sets of stabilized rules, norms and conventions which both constrain what actors such as private companies can do (e.g. make Scotch whisky only in Scotland), but also provide them with the very conditions that enable them to durably invest, produce and sell their products and services (e.g. by defining property rights). Indeed, all industries are recurrently structured by four sets of 'institutionalized relationships' which concern: i) property and finance; ii) employment; iii) production and iv) commercialization (Jullien & Smith, 2011 & 2014). Crucially, these relationships are never purely 'Economic'. On the contrary they all contain both a strong social dimension, due to their constant interplay with societal structures, and politics - precisely because, in each of the four sets of institutions, antagonistic social constructions shape actor perceptions, preferences, strategies and behaviour.

As regards the focus of this paper, what is important to highlight is that public policies either attempt to group together existing socio-economic institutions in new ways in order to reorient activity in an industry (e.g. the EU's 2008 reform of its wine policy), or to change specific industrial institutions (e.g. the introduction of market authorizations for pharmaceuticals in the early 1970s). What is crucial to research, however, is less the public policy as an output of complex decision-making, and more the actual degree of institutional change realized (our dependent variable) and, above all, its deeper causes[1]. Rather than

[1] By studying industries and their institutionalizations over time in this way, for example, in the case of the European wine industry we refuted analysis which had over-hastily attributed its change to 'globalization' and increased market-share taken by New World wines. We showed instead and why how institutions in this industry concerning market access and marketing had been modified alongside those concerning finance, before subsequently impacting upon others that concern production and employment. This shift co-related with shifts in power relations within the Fields of both Expertise (the rise of neo-classical economics, bio-chemistry and wine marketing) and the Economic (the empowerment of large wine merchants) (Itçaina, Roger & Smith, 2016). Similarly, in the case of governing medicines in France we showed that this did not change in the early 2000s simply as a reaction to 'scandals' over specific drugs, nor because of public policies hurriedly put in place to mitigate against them. Instead, our theory enabled us to show that institutions structuring the market access of medicines had become destabilized, leading in turn to a revision in the way the very production of these goods was regulated, as well as having knock on effects upon investment and employment practices. Simultaneously and more deeply, here institutional change co-related with a shift within the Expertise field (the strengthening of epidemiologists vs. clinical

repeat this ontological argument in its entirety, this section presents instead two concepts – fields and political work- which, as independent variables, translate my ontology of the socio-economic into the causal analytical framework that will be deployed in section 2.

Fields as the underlying structures of socio-economic activity

The first such concept, that of 'fields', provides a means of grasping how socio-economic spaces are structured by power relations which are invariably asymmetric (Bourdieu, 1992). A field denotes a space in which actors possessing varying types and amounts of resources (or 'capital') struggle to determine, then assert their relative value. Often corresponding more or less to a profession (e.g. medical science), each field possesses a specific hierarchy, set of recurrent issues, 'rules of the game' and 'common sense' (Mérand, 2015. Competition within each field is often ferocious, but is nearly always channelled within and by these parameters. Thinking in terms of fields therefore guides research, to identify 'both 'a Field of forces' that is structured by the objective distribution of different types and amounts of material, relational and symbolic capital, and a 'Field of struggle' that is driven by confrontations that seek to define the most legitimate capital portfolio and disqualify those of others' (Itçaina, Roger & Smith, 2016: 38; Bourdieu, 1993: 30). Empirical description of each Field is achieved by studying the objective distribution of different material and symbolic *capitals*, together with the *positions* of each actor as regards others. Here their respective position as regards their industry's institutions, and degree of power over them, provides a means of assessing their capital. This analysis is best achieved through the production of institutional change or stasis over time, combined with organizational histories via careful readings of actor biographies, statistics, the specialized press and interviews.

To conduct such analysis, one needs to produce data on four fields which have affected European integration from the outset: the Economic, the Party-political, the Bureaucratic and that of 'expertise'.

- The Economic field is made up of all the actors and organizations who participate in the financing, production and distribution of goods or services – activities which in turn reflect a segmentation of the field around specific industries. Formally, actors in this field may be 'public' or 'private', meaning that this categorization has no automatic impact upon their positioning within it. What counts instead is quite simply the amount and types of capital they have accumulated over time. At least in the case of post-1945 Europe, the Economic field is unsurprisingly one that has consistently featured a strong transnational aspect, but this however without it subsuming its national 'counterpart';
- As regards the Party-political field, the most obvious form of capital is electoral support, particularly when it translates into resources for having influence within the executives of public authorities (national governments, but also sub-national ones). Of course, electoral strength depends in turn upon how the parties concerned have rooted themselves within their respective polities. Despite undergoing a degree of growth in transnationalism since the first European Parliament elections in 1979, in

scientists), but also entailed depowering within the Bureaucratic field (the national drugs agency and the Ministry of Health) and repowering within the fields of journalism (strengthening an investigatory specialized press) and Party Politics (Ansaloni, Pariente & Smith, 2018).

Europe the Party-political field clearly remains overwhelmingly dominated by capital that is developed, reproduced and activated at the national or sub-national scales;

- As alluded to above, such activation however entails constant mediations with the Bureaucratic field, i.e. one made up of the individuals and organizations who participate on a daily basis in the public authorities formally charged with formulating and implementing policies. In virtually all member states and at the scale of the EU, in quantitative terms career civil servants dominate the Bureaucratic field. Through their selection, training and tenure, these actors possess particular forms of material, symbolic and relational capital of which a certain quantity, to be assessed empirically, is developed at the scale of the EU. Nevertheless, of course, these bureaucrats seldom monopolise policy-making and thus the change or reproduction of socio-economic institutions;
- Indeed, if input from actors located principally in the Economic and Party-political fields are either partners or competitors to civil servants for the making of policy, this process is also generally affected by actors from a fourth and final field, that of 'Expertise'. In many instances, actors considered to be experts in specific domains are formally scientists (e.g. the input of medical science into the market authorization of pharmaceuticals or economists into competition policy administration) (Laurent, 2019). However, actors can also be constituted as 'experts' via other sources of capital. In the EU, this has notably been the case for lawyers and other members of the legal profession (Vauchez, 2015).

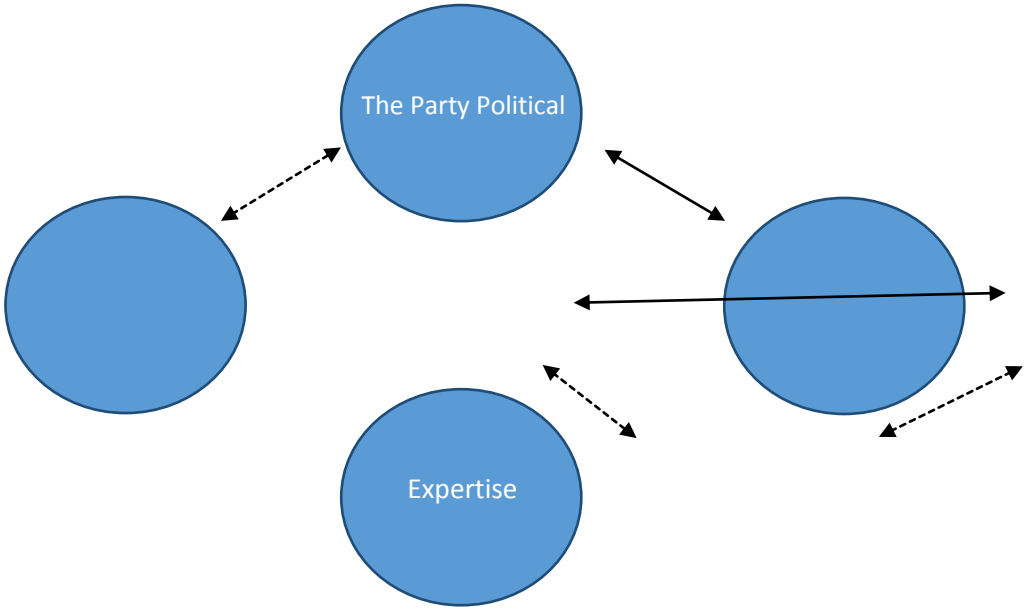
More generally, and contrary to many usages of the concept of a field (notably those of Bourdieu and his followers), it is vital to embrace the finding that fields are not inevitably delimited by national frontiers. Instead, it is more heuristic to consider that each field itself has no frontiers, but rather that capital relevant to different scales of regulation (the global, the European, the national, the local) strongly influences its respective morphology. The first pay-off for analysing specific components of European integration from this angle is that it enables research to map the actors involved and their respective capital over time, and this without assuming from the outset that national frontiers determine their power, their perceptions and their preferences. Capital developed in a national setting clearly impacts upon the respective power of each actor. For example, within the Bureaucratic field the Minister for Health in a large member state such as Germany obviously has more capital than their counterpart in Estonia. Nevertheless, national resources are generally less directly powerful in fields such as the Economic and that of Expertise. This is particularly important when one seeks to incorporate into analysis the transnational character of capitalism and, therefore, the tensions with national governmental organizations this form of political economy inevitably generates[2].

In summary, a major contribution field theory can make to studies of the EU is to guide research to think again about these tensions between actors seeking to govern socio-

[2] In *Euroclash* (2008), Neil Fligstein deployed the concept of fields in an effort to capture their transnational character. Nevertheless, often he fell into the trap of separating 'national' from 'European' fields, both conceptually and empirically. Moreover, his approach to fields is deeply interactionist and thus quite different from the structuralist definition adopted here and by authors such as Bourdieu. Consequently, he depicts the EU as a myriad of micro-fields (e.g. one for each market) whose membership is flexible and hierarchies are in constant flux. By contrast, the conception of fields adopted in this paper envisages them instead as far less numerous and highly structured by 'sticky' power relations which render change improbable but not impossible.

economic activity at the national or European scales on the one hand and, on the other, the financing, production and commercial activities of contemporary businesses and various other units of collective action (interest groups, union movements, etc.). As Figure 1 strives to encapsulate, at least in the case of the EU, conceptualizing the structuration of socio-economic activity using fields provides a dynamic means of mapping the actors involved in the making of policy at national and European scales over time, and this in terms of their respective capital, positions and consequent power relations (Georgakakis & Rowell, 2013). From there one now needs to theorize how actors mobilize to maximize their power over institutions within and across fields.

Figure 1: Socio-economic policymaking in Europe as a terrain affected by four fields



Key: _____ = regular contact & information flows; -------- = intermittent contact and flows of information

Political work: studying (re)institutionalizations sociologically

What even thick descriptions of the capital held by actors in different fields lack is any theorization of the cause of change, and that of the institutions of their respective industry in particular. Specifically, have institutions changed or been reproduced because of shifts within and between Fields, or vice versa? Rather than opt for either of these extreme positions, the alternative defended here is that institutional and Field change occurs simultaneously and is therefore co-produced.

Crucially, however, 'co-constitution' is not the end of the story and, therefore, describing this process 'thickly' is not as far as research should go. Rather, envisaging institutional and Field change as dialectical implies that analysis simply must supplement the structuralist tools of Field and institutional analysis with others from sociological forms of constructivism (Mangenot & Rowell, 2010) which guide research to produce data on the *work* of institutionalization. The key to developing such data is the concept of 'social representation' (Hall, 1997). The constructivism behind this concept stresses firstly that how actors interpret the world is structured by subjective representations of reality as it is, but also as it could be

(i.e. what is represented as 'necessary' as regards, the past, the present and the future). Secondly, this constructivism focuses analysis upon how certain representations become social (i.e. inter-subjective) through discussion, co-operation, powering and conflict. At least in the case of change or stasis within the institutions and fields that structure the economic, these processes entail three deeply recurrent forms of actor work I have defined elsewhere as *political*: problematization, instrumentation and legitimation (Smith, 2019 & 2014).

Constructing public problems: Just as Fields do not change because their asymmetries are criticized as unfair, institutions do not change just because some actors consider they have become sub-optimal. Instead, both potentially evolve only when the issue in question has been defined and framed in ways that render possible its fuelling of actor mobilizations. Indeed, to succeed this first step must then produce a second which codifies the issue into a 'problem' widely deemed deserving of public action (Gusfield, 1981; Rochefort & Cobb, 1994). For example, in the case of wine's institutional change alluded to above, change was predicated upon the public problem shifting from one of encouraging demand to meet supply (1970s-2003/6) to that of inciting producers to meet demand (2006 >). Here, not only were the categories of demand and supply redefined, but the responsibilities of public authorities and wine producers were significantly reframed. In so doing, capital was redistributed within the Bureaucratic and Economic fields, as well as in that of Expertise.

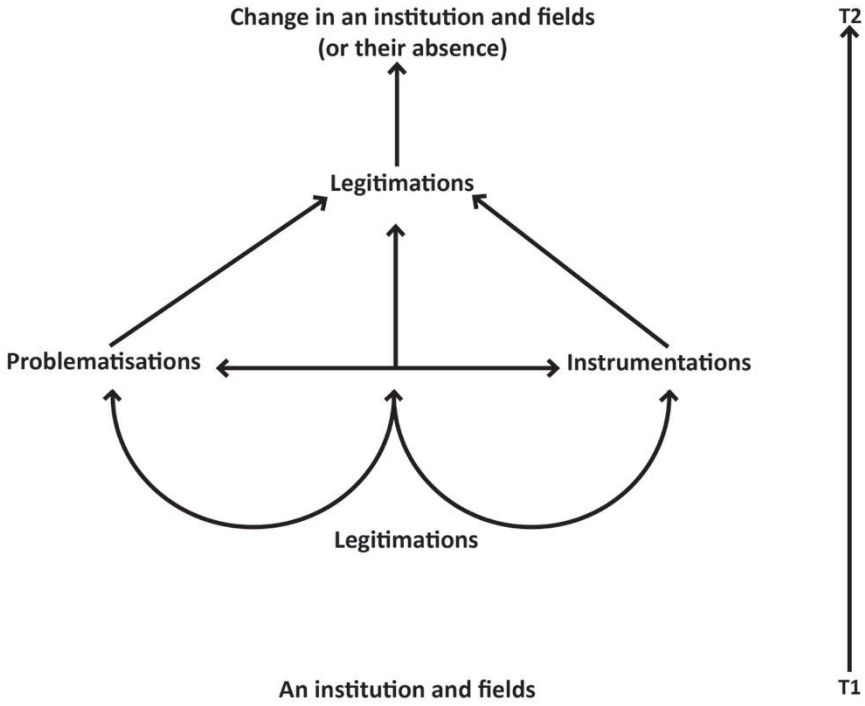
Calibrating policy instruments: In practice, defining such public problems goes hand in hand with the development and proposition of policy tools aimed at 'solving' them. Analytically, however, it is heuristic to study instrumentation as a separate process because it often involves different sets of actors, sometimes located in different fields and using other lines of argumentation (Lascoumes & Le Galès, 2007). In the case researched on reforming government of medicines in France alluded to above, for example, epidemiologists located in the Expertise field worked to re-instrument the national drug agency by proposing new types of data about the actual usage and effects of medicines sourced from their research, as well as the methodological tools used to generate it. Other actors simultaneously challenged the dominant influence of clinical science (and thus its emphasis on laboratory-centred data) within the Bureaucratic Field, and this by translating that data and those methods into proposals for new administrative procedures. The point is that instrumentation is never a neutral process and can only be fully understood by closely retracing the work that it entails on the one hand, and the distribution of capital within fields it affects on the other.

Legitimating problems and instruments: Crucially, problematization and instrumentation are not only cognitive and relational processes; they also contain a strong symbolic dimension. This is important because in order to achieve change in institutions and fields, convincing only technical specialists is rarely sufficient. Instead, work for change entails developing justifications, for example in terms of 'economic necessity' which appeal to a wider set of actors who also have a say in reinstitutionalizations and shifts in power relations (e.g. parliamentarians). Moreover, appeals for change which use symbols, rhetoric and 'dramatic' gestures are vital parts of legitimation that generally extends considerably beyond the technical (Lagroye, 1985). In the case of wine reform, biased depictions of 'the new consumer' were successfully brandished in order to convince producers, bureaucrats and politicians of the need for radical policy change. Similarly, reform of the government of

medicines in France took the shape it did partly due to the proposed redefinitions of problems and instruments being embellished by dramatizations of 'drug scandals' and 'bureaucratic bungling'.

In summary, the causal claim I have sketched out in this section, and sought to encapsulate in figure 2, is that institutional and power relation change is always brought about as a result of work by actors which entails the three recurrent processes presented above. This work is strategic in the sense that most of the time the actors concerned develop aims about institutions and Fields, then seek to carry them out through problematization, instrumentation and legitimation. However, stating that this work is strategic does not imply that it is based purely upon 'rational' calculus of costs and benefits, nor that it can simply be analysed using the tools of rational choice theory. Because universal rationality is a fiction non-deterministic political science cannot accept or afford, the perceptions, preferences and strategies of actors must, instead, be reconstituted through fieldwork centred upon actor work which, as Djelic underlines, 'is always embedded action' (2010: 34). Indeed, in order to shed light upon what she calls the 'interplay' of this work 'with power and conflict' (p. 34-5), links must constantly be made to analysis in terms of fields and inter-field mediations.

Figure 2: 'Political work' as the driver of institutional change and redistributions of capital within fields



2. Explaining the Impotence of EU Health 'Policy'

It is well known and documented that the Health industry in the EU continues to be governed essentially at the scale of the member states. This where most formal policies are set, budgets are generated and distributed, and the symbolism of each 'welfare state' has its

numerous effects. As will be shown below, the health dimension social policy is not without EU content and impact, but their effects on socio-economic activity are clearly much less than that of national institutions and actors. In order to explain the weakness of EU policy in the health industry, it is therefore important to examine political conflicts during which the institutions and fields which structure healthcare in Europe have been tilted so heavily towards the national scale. Using the analytical framework set out in section 1, this section outlines how and why the first of these conflicts took place in the 1950s (Davesne, 2017; Guigner, 2008). Drawing upon my own work on pharmaceuticals and their medico-economic evaluation in particular, it then proceeds to examine another more recent and surprising instance where EU-scale regulation has remained structurally weak.

2.1 Missed beginnings: why 'White Europe' ended up melting away

Although this is usually overlooked by standard histories of the EU, during the immediate post-war period when the CECA, Euratom and the CED were being devised, a series of actors also set in motion plans for a *Communauté européenne de la santé* (CES). Labelled at the time 'White Europe' (*Europe blanche*), or *le pool blanc*, the basic idea was to take the opportunity of the then ongoing nationalization of health systems in Europe to introduce European-wide measures to 'mutalize' improvements in health care and introduce ambitious preventive public health programmes. As Davesne highlights on the basis of archival evidence[3], for health specialists the period 1945-53 was 'an intense moment for the structuring of health and social policy systems' which generated new political spaces for defining problems differently and setting new instruments (2017: 93). Of course, we know that in the end these proposals were decidedly unsuccessful. The standard narrative is that the advocates of 'White Europe' ran into incompatibilities between the new national health systems[4], as well as a deep reluctance amongst foreign and prime ministers to give health the same priority as coal and steel or defence. Moreover, 'liberal intergovernmentalist' theory has also been evoked in order to stress the importance of resistance from a variety of interest groups (ranging from doctors to chemical and pharmaceutical companies). The claim here is that the preferences of these groups became the preferences of their respective national governments (Davesne & Guigner, 2013).

All these arguments and factors do indeed need to be taken seriously if one is to fully understand why 'White Europe' never came to be institutionalized. However, they can and should be marshalled differently in order to grasp why the health dimension of social policy never became 'a European problem' during this period and why, more fundamentally, the politics of capitalism at that time was its deepest cause. The story of the failure of 'White Europe' therefore needs retelling in terms of the fields, institutions and political work that structured and dynamized it.

From this perspective, the best place to begin is in the Economic and Bureaucratic Fields where proposals for European health policies were initiated. As Davesne shows, these proposals grew from modest bilateral agreements over social security arrangements for

[3] He also cites the historian Stephan Pumberger (2010).

[4] For example, in France 'nationalization' entailed more the unification of the social security system based upon contributor-funded insurance than the 'statization' introduced in the UK (Palier, 2005). In particular, this enabled general practitioners to preserve their private (*libéral*) status.

migrant workers made in 1948 between the governments of France, Belgium and Italy (p. 96). Over the following three years, attempts to extent these arrangements to medical care were formulated by the Council of Europe. Meanwhile a network of 'internationalist' doctors initially concerned with limiting epidemics by treating all patients regardless of their nationality, and centred upon the *Office international d'hygiene publique* (based in Paris since 1907), sought to extend the then burgeoning World Health Organization to help reconstruct Europe by modernizing its health systems in a mutually dependent way. Analytically, this problem definition and proposals for new, European-wide policy instruments therefore had two *loci*:

- Within the Economic field some employers (in need of migrant workers) and, more significantly, some health professionals (essentially public health-oriented doctors) began seeking to reposition themselves both nationally and at a European scale;
- Within the Bureaucratic field, some senior civil servants within health ministries, and sometimes even their ministers pushed the 'White Europe' plan for reasons of policy substance and even 'morals'[5], but also because they saw it as a means of improving their then lowly position within the field as a whole.

In concrete terms, in December 1952 political work undertaken by these actors generated a detailed (249 article) proposition by the French Ministry of health. Known as *Le plan Ribeyre*, this proposal advocated more intergovernmental cooperation over health insurance and medical research, but also a set of precise supranational and even federalist policy instruments which included:

- a common market for medicines (harmonisation of their regulation and categories);
- common standards for the training of doctors and other medical personnel;
- a common plan for the production of health resources (e.g. Artificial respirators);
- the building of European centres for applied medical research (by disease);
- public health programmes, such as the fight against alcoholism.

And all this to be run by a 'High Authority' for Health.

However, the political work which surrounded this ambitious plan failed to attract either cognitive or relational support within the hierarchies of both the Bureaucratic and Economic fields. In the case of the former, Davesne relates (pg. 147-154) that even within France itself, virtually no inter-ministerial mediations were attempted in order to convince powerful actors in the Department of Finance and the Ministry of Foreign Affairs to back the plan. Indeed, senior civil servants from the latter administration set themselves clearly against it. Even potential allies within the lowly *Ministère du travail* were neglected and thus never supported the initiative either. Moreover, as Ministers for Health, neither Ribeyre nor his successor Alfred Coste-Floret sought to open up an alternative 'front' within the Party Political Field, and this despite their receiving some support initially from Robert Schuman when he was Minister for Foreign Affairs. More significantly still, little preparation work was done with with the Health ministries and ministers of other European states meaning that, in the end, only Luxembourg's government unreservedly supported the French plan, whilst the backing their Italian and Belgian counterparts was only lukewarm.

[5] For example, the French minister for health in 1951-52 then again in late 1953, Paul Ribeyre, declared that this 'community' could not only work better than a CED but, because of its humanitarian aspect 'the need to reduce human suffering'), it would have more popular resonance than either that 'Community' or the CECA (Davesne, 2017: 116-8).

Significantly, more frontal and deep opposition to the plan for a 'White Europe' emerged simultaneously then spread in the Economic field. Well resourced and positioned opponents in this field included German and Swiss chemical and pharmaceutical producers, anxious at that time to avoid any European-wide regulation of their industries which would limit the benefits of their respective comparative advantage. More generally, trans-industry representatives of Dutch business convinced their ministries of economics and foreign affairs to be highly critical of the plan because of what they saw as a tenuous link to the economic (Davesne, 2017: 156).

In summary, given the power relations which structured both the Economic and the Bureaucratic fields in Western Europe in the late 1940s and the 1950s, together with the inability of 'White Europe's policy entrepreneurs to politicize and thus legitimize health as a European problem that demanded European instrumentation, the failure of this dimension of social policy to take root supranationally is unsurprising. What revisiting this historical episode using the concepts of fields and political work does enable us to grasp, however, are the deep causes of this flop. At that time, health care as a national public problem was in its infancy. Virtually no actors, not even partisans of 'White Europe' such as Ribeyre, framed health as an issue that was key to 'economic' reconstruction. Instead, as a public problem the economic was restricted to questions of production, sales and trade, thereby further institutionalizing a restricted, and essentially liberal, acceptation of the economic, at national scales, but also at that of the then emerging 'Common Market'.

2.2 When even 'economics' failed to legitimize an EU health policy: 2009-12

Jumping ahead sixty years from the early 1950s, as regards the EU-health relationship much had of course changed in the interim. For example, in the 1980s and 1990s pharmaceuticals came to be regulated extensively at the EU scale (Hauray, 2006). Perhaps even more significantly for linkages between health and 'the social', this was also a period during which public health campaigns, such as the fight against tobacco addiction, also developed a European dimension. Indeed, as Guigner has underlined (2008), by this time framing improvements in health as a contribution to economic development had become a means of legitimizing and institutionalizing a succession of EU measures in this issue area.

This said, studies I undertook with others in the early 2010s[6] have shown that such visible linkages of health to economics do not in themselves mean that power relations in this domain had shifted significantly by then. Nor does it show that a form of EU social policy has been introduced 'through the back door' around measures to improve health care across Europe. Specifically, within a wider research project devoted to the EU's government of industries (Jullien & Smith, 2014), when examining that of pharmaceuticals we came across an EU-wide initiative aimed at improving regulators' capacity to assess the 'medico-economic' added-value of each medicine, and this with a view to both reducing national expenditure on medicines and improving care for patients. What intrigued us in particular was on the one hand the commitment, and indeed the zeal, of the proponents of a

[6] This research featured around thirty interviews with actors located in Brussels, Paris, London and Prague. It was deepened, and indeed surpassed, by Cyril Benoît's PhD. dissertation (2016) which entailed many more interviews and sophisticated bilbliometrical analysis.

European governmentalization of 'Health Technology Assessment' (HTA) and, on the other, the political work carried out by a series of actors to oppose their initiative. Ultimately the latter clearly won out over the former. Once again, what follows is therefore another instance of a failure to institutionalize a form of social policy at the EU scale. The concepts of fields and political work enable analysis to go beyond superficial readings of this story, and this to reveal instead the deeper power relations and forms of agency that were its underlying cause.

The origins of medico-economic evaluation

If the period 2009-12 is at the centre of our analysis, one needs to go back to 1973 to trace the beginnings of the HTA movement. These emerged around the first study of the medical and economic costs and benefits of a technological innovation, the CT Scanner[7]. Carried out by a team within the US's Office for Technological Assessment (OTA), above all this study concluded that such costly devices were being introduced throughout the American health system without any prior evaluation or audit. This study was given widespread publicity and attracted attention from throughout the world[8]. Indeed, it became the catalyst for the development of an HTA segment within a transnational Field of expertise. In concrete terms, following an inaugural conference in Stockholm in 1979, actors located in this segment began to meet regularly in order to spread 'the usage of evidence-based medicine in decision-making as a moral imperative'[9]. As one French expert involved from the outset stated on interview:

> « C'était un projet de gens qui cherchaient à créer un domaine, des gens tous ahuris par le fait qu'on décidait sans données et sans méthode. Le ministre de l'époque nous disait, 'moi je veux un outil, car je prends les décisions et je n'en sais rien'. Aujourd'hui, il faut imaginer un monde sans agence, un monde ou les médecins se permettait de dire à un ministre 'vous êtes un salaud' » (when he refused that the social security system reimburse patients for the costs of a medicine)[10].

Notwithstanding the enthusiasm of its pioneers, it would be a mistake to consider that a homogenous transnational movement of experts then quickly and spontaneously institutionalized. In Sweden and the Netherlands this began to occur. But even in the 1990s, differences in objectives and methods meant that the movement's 'transnational scale was characterized by its hybridity, thereby creating a series of groupings that often fitted uneasily within the rhetoric that supposedly united them all' (Benoît, 2016: 143). Despite all this, international conferences and specialized journals provided the means through which this segment of the Expertise field managed to hang together[11]. Indeed, what is important to

[7] Written essentially by David Banta, this text ended up being published anonymously in 1978 as an OTA report entitled *Policy Implications of the Computed Tomography (CT) Scanner*.
[8] Interview with David Banta, Paris, 2012.
[9] Banta et al. (2009: 68). See also Benamouzig & Paris (2007).
[10] Interview with adviser to the French Minister of Health during the 1980s, Paris, mars 2012.
[11] In 1985, representatives of several national governments created the *International Society for Technology Assessment in Health Care* (ISTAHC). Renamed *Health Technology Assessment International* (HTAi) in 2003, today this organization claism to have more than 1000 members from 59 pays. Since 1986 it has managed a journal - *International Journal of Technology Assessment in Health Care* (IJTAHC)- which is both 'scientific' and aimed at a more generalist public. In 1993 a organization bringing together national health regulatory agency was formed: the *International Association of Agencies for Health*

underline is that although in a handful of countries, HTA was beginning to attract supporters and build institutionalized bases within the Bureaucratic Field, consolidation within this space only began to take place as of the late 1990s. Meanwhile, HTA was having virtually no impact upon the Economic field. Because of their power as regards the health industry's Institutional order, until the 2000s pharmaceutical companies and producers of medical devices were able to continue to propose their wares to regulatory agencies without them having to undergo any systematic medico-economic evaluation whatsoever.

As regards the EU scale, activity on HTA was again restricted to the Field of expertise until the mid-2000s. Indeed, as some of the founders of HTA today repeatedly underline, building upon inclusion of public health in the Maastricht Treaty signed in 1991, initially officials in DG Research identified 'value for money in health care' as a priority. Subsequently from 1994 to 1997 a first research project was funded by the EU's framework programme: EUR-ASSESS. Around 100 experts were involved in research focused upon the harmonization of methodologies for the evaluation of health care. Through attracting the support of key officials in DG research, the EUR-ASSESS project was followed by another ('HTA-Europe', 1997-2000), then yet another: 'European collaboration in HTA' (ECHTA; 2000-2002). Not surprisingly, each of these three programmes concluded that more EU action was necessary on HTA. Indeed, the Commission even published the findings of the HTA-Europe project as an unofficial policy document. Moreover, ECHTA's results lead to HTA being flagged as a priority issue to be dealt with in the EU's FP 7 research programme. Accordingly, in 2005-8 EU-wide collaboration was deepened by the launch of a 'EUnetHTA' joint project. Finally, this policy objective was then extended and made more ambitious in 2010-12 by a 'Joint Action', chaired this time by DG SANCO, that was inscribed in EU law within the 'cross border care' directive adopted in March 2011 (Directive 2011/24, article 15). Concretely, the Joint Action operated through annual conferences, work packages and the production of handbooks (e.g. on 'core models' or 'capacity building'). Additional legitimacy for this development stemmed from the conclusions of the 'High level European Forum on Pharmaceuticals' published by the Commission in 2008.

Overall then, co-operation over HTA at the European scale between 1990 and 2009 led to repositioning by a number of actors from different professions and disciplines (academics, employees of pharmaceutical and medical device companies, national agency staff) around the definition of a common, European public problem. Indeed, for the first time a significant set of actors within the Bureaucratic and Economic fields began to take seriously the possibility of a European-wide policy to introduce medico-economic evaluation. In short, by 2009 HTA had come to be seen by health specialists throughout much of the EU not only as a set of policy instruments that would help make European health services more efficient and effective, but also as a range of solutions (to commonly defined 'problems') whose diffusion would be facilitated and enhanced by EU-backed co-operation.

Why EU- shaped medico-economic evaluation has failed to institutionalize

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Technology Assessment (INAHTA). And, since 1995, an *International Society for Pharmacoeconomics and Outcomes Research* (ISPOR) has also become a key venue for debate in this issue area.

Indeed, when we began our empirical research in this area in 2010, HTA thus seemed to be a flagship initiative for DG SANCO around which its representatives were preparing to not only deepen co-operation between actors in the member states using their time-honoured methods (information generation, meetings, benchmarking, reports: Guigner 2008), but even to take on powerful actors within the pharmaceutical industry. Indeed, shortly afterwards the Commission's pharmaceuticals unit was shifted out of DG Enterprise and into DG SANCO, a move that many commentators saw as encouraging the emergence of a more distanced EU-wide approach to the contribution and costs of medicines within health care. However, and despite the adoption of the Joint Action in 2011, since then DG SANCO's enthusiasm for HTA has waned. More precisely, the representatives of this administration have not only chosen to concentrate their efforts upon supporting co-operation over the therapeutic aspects of assessing health technologies, they have also firmly put aside 'medico-economics'[12]. This shift in Commission policy is born out by interviews with other EU scale actors, such as an official from the European Generics Association:

> *'DG SANCO has become more and more concerned with the safety aspects of medicines. (…) Indeed, within the current Joint Action, medico-economics is largely being taken out of the debates. Instead, everything has become about safety and efficacy'*[13].

Recall that our research question here is why has this change of approach by DG SANCO, and more widely the Commission, taken place? At a time when the Commission as a whole has been urging health administrations in the member states to cut their budgets, why on earth did DG SANCO backtrack on medico-economic evaluations designed to improve cost-effectiveness in the name of the public interest, and in so doing deepen a 'social' dimension of the health industry's regulation? Our research here again underlines that both power relations and political work simply have to be combined in order to discover the deepest causes of this shift.

As extremely well resourced actors within the Economic field, representatives of pharmaceutical companies have clearly sought to 'tame' HTA in the following two ways. First, they have worked to discourage further development of its medico-economic dimension through proposing to conduct such studies themselves. Indeed, experts trained in medico-economics are increasingly being employed by pharmaceutical companies in order to either pre-empt or counter HTA studies conducted by public regulators (notably in France). Second, Big Pharma and its representatives have encouraged the involvement of the European Medicines Agency (EMA) in European co-operation over HTA because this organization itself prefers therapeutic to medico-economic evaluations and, until now, has largely supported the interests of large originator companies (see Benoît, 2016 for interview data on both these points). Meanwhile, however, it is important to grasp that potential challengers to Big Pharma, notably smaller generic medicines producers and health insurers, have not developed strong arguments and alliances as regards medico-economic evaluation at the EU scale. Consequently, through their respective political work, neither set of actors

[12] Interviewed in December 2012, a DG SANCO official working on HTA represented this situation in the following way: *'Some member states are still pushing for this. We in the Commission now say, 'let's focus first on the clinical dimension, and find out its added value in the clinical field'. (…) Meanwhile, of course, discussions about medico-economic evaluations will go on alongside in HTAi, etc'.*

[13] Interview, Brussels, December 2012.

have equipped themselves for even destabilizing the hegemony of large, multinational pharmaceutical companies in this field.

Just as importantly, in the Bureaucratic field actors attracted to medico-economic evaluation in principle have in practice channelled their energies and capital elsewhere. A first reason for this is that the 'austerity' driven cost-cutting of 2009-2013 ran counter to the more sophisticated analyses advocated by proponents of medico-economic evaluation. Whereas the latter often recommend that certain drugs should no longer be supported by public funding, several member states (notably Spain and Greece) simply cut this funding, and thus pharmaceutical prices, indiscriminately and without any reference to any sort of evaluatioPPn. As a representative of generic medicines underlined on interview, the post 2008 economic downturn accentuated such practices and even added an EU-scale layer:

> 'Our industry has been put under pressure by a new actor: DG ECFIN. It has even given specific prescriptions over health and medicines policies to countries like Greece and Italy. This is all about cost containment, which raises big problems for health services and the pharma industry in the medium and long term'[14].

Although the HTA movement, and the medico-economists within it, is opposed to such simplistic forms of cost-cutting, its emphasis upon cost-effectiveness has nevertheless long been interpreted by pharmaceutical producers as a threat to their turnover, profits and business models (Lothgren & Tatcliffe 2004). This fear has also been fuelled by a certain number of national pricing bodies who have actually used HTA, and thus medico-economic assessment, in this way (e.g. that of the Czech Republic: interviews, Prague, June 2013).

More obviously still, within the Bureuacratic field most national health and industry ministries have been very wary as regards what they see as Commission 'encroachment' on national, treaty-backed prerogatives. Officials from that body are obviously aware of this fear and have worked to depoliticize medico-economic evaluation by presenting the systematic sharing of data, and thus the pool of 'knowledge' it could engender, as a neutral 'no brainer'. Indeed, such a framing generates widespread agreement even amongst representatives of Big Pharma:

> 'Why should we do this exercise 27 times when it could be done only once? Here the position of the industry, and of the European Federation of Pharmaceutical Industry Associations in any case, has always been clear: we are in favour of one evaluation at the European level, as long as it is not on top of national ones'[15].

However, putting in place a system for such 'pooling' has prompted two overlapping debates. The first concerns how this scientific knowledge would be brought together and by whom? Moreover, how would it fit with national systems of appraisal? The Commission has never actually proposed that evaluating the social worth of a medicine, and thence setting its price and level of reimbursement, should be transferred to the scale of the EU. Nevertheless, many actors located in different fields fear that an EU-scale assessment system could be established and would inexorably threaten national modes of appraisal. For

[14] Interview, Brussels, December 2012.
[15] Interview, official from the European Federation of Pharmaceutical Industry Associations (EFPIA), Brussels, June 2010.

example, a pharmaceutical company's representative underlined on interview: *'National public health and reimbursement policies are about the collective interest (…). And what we also see is that social actors in the member states (…) all want social policies to remain national'*[16]. Indeed, representatives of national ministries of health state clearly that: *'as soon as things slide towards the organization of health care, i.e. to domains that are more part of national sovereignty, then we say 'stop!'*[17].

In short, framing HTA as incorporating the pooling of both therapeutic and medico-economic evaluations strongly incites all actors to ask the question *who decides?* (the national or the EU scale). Faced with this fundamental question of legitimacy, as in many other areas of European integration (Radaelli 1999), Commission representatives have sought to side-step the *who decides?* question by working to technicize the problems and instruments at issue. Consequently, seemingly consensual methods of discerning the safety of a medicine have been legitimized as an EU-scale competence, whereas controversial questions as regards how its price is set have been left in the hands of national decision-makers.

In summary, the case of the non-institutionalization of medico-economic evaluation at the EU scale provides another example of the weakness of not only the EU's health policy instruments, but also of its social policy more generally. Once again this case has featured a weak and intermittent connection of the problem, as defined in the Bureaucratic and Economic fields, to the Party political field. Throughout, national ministers have scarcely been involved, nor have national or European parliamentarians. Moreover, even the Expertise field where HTA and medico-economic evaluation was spawned, has not generated sustained mobilizations in order to legitimize even the pooling of methods and data at the EU scale as a political priority.

Conclusion

Indeed, the two case studies presented in this paper, together with the conceptual framework used to analyse them, have highlighted how power relations and political work within the Economic and Bureaucratic fields have been the cause of the weakness of EU policy initiatives in the health industry. It is within these fields that 'the economic' has consistently been framed in such a way as to limit the ambition of measures that do not directly concern production and trade, whilst simultaneously precluding transfers of public decision-making authority from the national to the EU scale. In so doing, these cases provide evidence that what has caused the feebleness of EU social policies more generally lies in the degree of autonomy developed by both the Economic and Bureaucratic fields, together with the forms of essentially depoliticized political work that have consistently been undertaken within them since the late 1940s.

Indeed, this paper confirms that taking a long term view enables research to engender the deepest explanations of European integration and its crucial relationship to the capitalisms of Europe. As Laurent Warlouzet convincingly shows for the period 1973-86, the image of 'an inexorably neoliberal Europe' is an 'illusion' (2018: 214). This is not only because some

[16] Interview, French pharmaceuticals interest group (le LEEM), Paris, October 2010.
[17] Interview, French Ministry of Health, Paris, November 2010.

outcomes of EU decision-making have not just concerned the operation of 'free markets'[18]. More fundamentally, there has been no neoliberal inexorability because throughout the EU's history of decision-making, other alternatives have consistently been discussed, discarded or adopted only in part. Research could do much better in analysing this disqualification or dilution of alternatives. The concepts of fields and political work provide a robust framework and set of methods for tackling such an agenda head on.

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[18] See for example the social dimension of the Common Agricultural Policy which was initially strong (1957-62), then was steeply downgraded for many years (1962-1992), then has since made a certain comeback.

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