Hanging out with Mr. Sanco: An ethnographic study of the European public health community

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Summary
This is a final report on a three-year study exploring the day-to-day reality of European public health interest groups’ experiences when they deal with the European Commission, and with the other main normative body in the health field – the WHO Regional Office for Europe.

In particular, the research focuses on the governance of European health strategies by the European Commission Directorate General for Health and Consumers (DG SANCO), and by the World Health Organisation (WHO).

The complex field of multi-stakeholder governance was conceptualised using a qualitative research methodology – political ethnography – which is an approach that provides insights into the lived realities of the participants. Study participants included civil society organisations (CSO) and business interest representatives. Interviews were also conducted with four EU Member State representatives, and with three WHO Officials.

The study findings could help develop the role of health within the broader EU governance structures building on the “Health in All Policies” (HiAP) approach, and the role of “evidence” in policy-making. Issues of leadership and accountability in participatory governance are also discussed.
I feel the gentle splashing of water in the half-empty/full bottle in my handbag. Did I need to get rid of it in order to proceed through the security check without provoking a search? The lobby is heaving with a cacophony of languages, and my queue is swiftly progressing, thanks to the efficient routine of the security guards; no time to turn back. I place the bag on the conveyor belt, watch it disappear into the screening tunnel, and step through the metal detector.

Past the gate, I take a sip from the bottle, reconnecting with the reality, reminding myself – this is not an international airport. I am entering the European Commission’s Charlemagne Building at the heart of the EU district in Brussels. (Research Diary, 3 May 2012)

Stories and public health

The discursive Brussels is a “bubble” which contains an “EU village” consisting of advocacy, lobbying, and debates surrounding policy, including health systems. What you are reading is an account about this policy space as representing a particular culture with its own established ways of communication and structures of power and apparent in many forms: economic, social, cultural, physical, and accompanied by local myths, and intertwined global narratives. This is not a report on lobbying in Brussels, nor am I going to lift the lid on astroturfing. Recent publications on the corporate power within the vast field of EU policy-making are numerous and robust.

Instead, this is an ethnography of actors in relation to political institutions, which aims to provide a “thick description” of governance in European public health from a stakeholder viewpoint. I have used the participant observer method, a form of interpretive research methodology, to explore the meanings that “particular political practices have for situational actors”, in order to illuminate a theoretical issue of political concern. In short, I collected and analysed data on stakeholder experiences of supranational governance in public health.

1 The study this final report is based on – ‘Forming EU Health Strategy: An Ethnographical Study of Stakeholder Positions and Governance in European Policy Making’ – was supported by a European Union COFUND/Durham University Junior Research Fellowship [under EU grant agreement number 267209]. The study was reviewed
My research is about multilevel governance, wicked issues, competing views, multiple realities, and layers upon layers of information, knowledge and data – documents, interviews, observational notes, conference participant lists, and social media quips. Therefore, the form this text takes is not a strictly conventional final study report. I will be drawing on the tradition of ethnographical writing, offering the occasional reflexive description of relevant events as experienced by myself as my accumulating knowledge about the field became amalgamated into the participants’ accounts. The way to bring together different discourses, ways and means of communication, e.g. the formal, the informal, the political, the satirical, the critical, is through composing a pastiche of writing: “Ethnographers who want to emphasise the variety of perspectives and relative lack of consensus ... sometimes construct ethnography that relies on fragments and the juxtaposition of disconnected or dissimilar pieces from the ethnographic record.”

What follows is an analysis of events that unfolded within the public health policy scene in Brussels between 2012 and 2015, as reported by me as a researcher and based on my “hanging-out” with the public health community, observing events and interaction, interviewing stakeholders and reading documents. The reason for including the researcher’s experience is clear: I am writing from a particular position, with a background and experiences that inevitably shape and influence the interpretation of the events and data I witnessed and collected. The strong voices of professional health and industry advocates that make their living in this Village could potentially influence or bias the results, as if it was a case of my “taking sides”. However, as I was listening to people’s experiences, and stories, it became apparent that the analyses would not be conducted according to the binary logic of true/false. Rather, the point was to conceptualise the research participants’ experiences in order to identify emerging themes related to multi-stakeholder governance.

I have spent a considerable amount of time working my way through many compelling, and often competing, arguments focusing on keeping my theoretical head on in order to provide a social scientific account of governance experiences. This is not an evaluation of the final policy products, the tangible end results – directives, mid-term evaluations, budgets or programme reports, or the Health Strategies. Instead, I am offering a glimpse of a (political) space during a particular point in time and exploring experiences that the health strategy formation processes generated. In its ‘White Paper on Governance’, the European Commission (EC) outlines its governance principles to include openness,

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and received ethical acceptance from Durham University’s School of Medicine, Pharmacy and Health’s Ethics Committee on 10 October 2012 (Ethics Application ESC2/2012/13).
participation, accountability, effectiveness and coherence. Although all five governance principles are interlinked, the remit of this study was to explore the first three.

The focus of the study was on the complexities and intricacies of governance as led by the European Commission Directorate General for Health and Consumers (DG SANCO) and the World Health Organisation (WHO) Regional Office for Europe. The point of this report is to empirically dig down into multi-stakeholder governance in order to see what it entails and what it lacks from the viewpoint of the participants. Exploring this issue will provide an inside view into the processes of supranational policy-making.

Political ethnography – Being a “Professional Stranger”

Why did I embark on this project? Previously, I had done consultancy work with a Brussels-based NGO in the field of healthcare management, but the policy space eluded me. I had the feeling that important events, meetings, gatherings happened all around, but that I was not aware of them, nor invited to attend them, although I should have been. Reading websites would not take me to the core, so I thought I should start to familiarise myself with the culture, its gatekeepers, and the key members of the community. My wish to understand the culture more deeply through participation, guided the choosing of the methodology - ethnographies have the virtue of providing “stories from the field” in “small scale and as they happen”.

Ethnography is a well-established form of qualitative inquiry, and political ethnography has gained considerable attention within the broader framework of qualitative research within the past two decades. Ethnographic studies of politics include projects in diverse geographical locations, such as Ukraine, the Basque Region in Spain, inner city areas in the US, to name a few, and cover topics which vary from civil war in El Salvador, Muslim girls and marginalisation in France, and health policy making in the UK. The methodology provides access to processes and interactions involving the exercise of power in which at least one government participates as actor, object, and/or influential third party. Political ethnography has three special features: 1) The researcher is in direct contact with political process, analysing the events as they unfold, through participant observations, 2) The policy itself is “the field” that bounds the researcher – not geographic borders, and 3) Documents play an important role as data.

In my study, the political process I wanted to explore was to be the forming of a new post-2013 EU Health Strategy. My “field”, i.e. the focus of the study was the over-arching European Health Strategy, excluding other more specific EU strategies, such as Alcohol Strategy or Mental Health and Well-Being Strategy. I used documents to guide the data collection, and conducted a stakeholder analysis on EC documentation of the participants that had submitted responses to the open consultation when the previous Health Strategy was being formed, as well as lists of their stakeholder forums. These documents gave me a rough idea of the different groups (NGOs, academic institutions, industries etc) that had previously been involved in the process.

Brussels is full of events. During my time in the field, I participated in 20-odd conferences, roundtables and seminars organised by the European Commission, think tanks and NGOs, observing how debates were constructed within this space. Whether the shared knowledge was scientific studies or advocacy information, it was often appropriated to appeal to the audience at an emotional and common-sense level. For example, a slide show of the family of an ill woman; the astronomical sums pharmaceutical
companies said they spend on R&D to benefit the health of “everyone” rather than their own profit margins; or a tobacco-directive battle reaching existential proportions, regarding the free will of human beings (by the way, there is no “free will” in addiction).

During the project I met industry representatives, who often appeared for interviews in pairs; seasoned (Deputy) Directors of NGOs with a decade or two of Brussels policy-making under their belts, enthusiastic NGO policy officers with plenty of trivia to add into conversations (percentages, years, memberships, name dropping), Member States’ diplomatic envoys and senior WHO officials. Out of the 45 emails I sent to invite people to participate in an interview, 27 replied “yes”. I was, however, turned down by two major public health NGOs in Brussels, one of them saying that they could not be quoted in a study that also involves industry stakeholders. As for the other one, their Director emailed, on behalf of the whole organisation, a short “thanks, but no thanks” note without a further explanation.

The original research plan was to follow how the process of forming the EU Health Strategy post-2013 had unfolded. Thus the news that no new strategy would be developed that I received in March 2012 resulted in a moment of hyperventilation. However, this is when the adopted research approach – qualitative, political ethnography – showed its strengths and adaptive qualities. It would be even more interesting and revealing to follow this unexpected turn of events from the governance (participation, availability of information, transparency of proceedings) point of view. And so it proved.

One of the key discussions regarding the ethnographic method is the insider-outsider dilemma, a debate that slides along the axis of objective-subjective knowledge. It is a conscious decision on my part to write in a first-person stance, to write myself into the text, rather than distancing my voice from this account. After all, it is through my experiences and analyses that the categories presented emerged. Conducting this kind of “critical ethnography” requires reflexivity from the researcher both in relation to the context, as well as being aware of my own position. I was a representative of academia – not a particularly powerful position in this field, nor a threatening one either. I overcame any challenges in accessing the field or in collecting data; the participants – who clearly had full diaries – were happy to clear an hour of their time to have the interview with me. A similar ethos applied to DG SANCO, where it was very straightforward to arrange meetings with some officials.

Then the question became – what should I write about a sphere where everyone writes from a different (political) position? Bearing in mind, as I had to, that the culture is populated by professional communicators, shrewd politicians, probing journalists, watchful mediators, spin doctors, argumentative lobbyists, feisty campaigners and mild-mannered civil servants.

Returning to the five governance principles set out above, three in particular merit further comment. First there is openness. It has become clear that for as long as there exists a narrative about an elusive, opaque “Brussels” that can be referred to as lacking in transparency, as corrupt, as the centre of lobbying power, the forces that oppose the EU project – UKIP for example – can use this narrative to grow stronger. This feeds a sensationalist media and gossipy discourse about “Brussels” which emerges for example in relation to lobbying. Power is sexy, thus the places of decision-making are by definition expected to be sizzling with dubious lobbying action. Yes, there are challenges with transparency at many levels of governance. Simultaneously, there are structures in place, many under revision, that enable a participatory governance process. While Brussels and politics are used as synonyms, paradoxically, there is a simultaneous process of de-politicization in the field of health.
policy-making, apparent in the “scientific evidence” narrative. Second, there is participation. From the stakeholder viewpoint, the Commission is easily approachable, and the open-doors policy is not just rhetoric. However, this governance approach gives rise to complexities due to differences in stakeholder resources (time, staffing etc.), making stakeholders feel as if they are competing against each other for attention. Third, there is accountability. Faceless decision-making is bothersome for many. Who makes decisions, and based on what evidence, are key concerns from the stakeholder point of view. Furthermore, what is the role of leadership, when discussing “heterarchies” - a new political framework characterised by new forms of coordination, deeply rooted within the political economy and political philosophy of neoliberalism - and global health governance?

The study participants talked about how “all” civil servants are working hard, doing their best, and the health Directorate-General is in essence doing good work, but is just lacking power within the wider governance structures of the EU. Indeed, public health is inherently political – a “messy” affair, that can get entangled with global webs of power. Supranational public policy-making is challenging because stakeholders and influencers are networked, and many policies related to public health are located outside the narrow area of health. The nexus of participatory governance, health and leadership is tough to steer. The role and ethos of these two institutions (the EC and the WHO), whose governance approaches were the focus of this study, differ. But there are common issues that can be drawn out from the data that relate to the complexities of multi-stakeholder governance. Therefore, in what follows, excerpts of interviews, analysis and descriptions of events will alternate, providing a view into public health politics in Europe more broadly.

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**Public Health is Sexy. Boring**

*Private interests have every interest in getting close to the policy-makers, because they want to have their thing sold across Europe, while their thing might not make people healthier or happier. Probably not, probably not. It might make life easier, but most of the time it’s more basic things that make people happier. It’s simple things like good food and physical activity and less to drink, it’s very basic things that people need. Don’t smoke, drink less, go out and move. It’s more fun with some apps... I mean people avoid accidents by taking away their rugs on the floor. It’s those basic things that you have to do, but it’s of course very boring.* (Director of a pan-European NGO)

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**Who was involved? Description of the data**

*Interviews*

I wanted to include in the study all relevant stakeholder groups that participate in the forming of EU health strategy. Therefore, I adopted a broad definition of civil society. Within the study, civil society organisations (CSO) were considered to be those groups that give voice to local and regional membership organisations, and have a large European/international constituency. The definition included for- and not-for-profit interests. These so called “Eurogroups” lobby the EU Institutions and federate interests from across the EU. Business interests are dominant in the group, but the Commission is funding a counterbalancing variety of umbrella groups whose purpose is to represent those groups that are poorly organised or resourced in order to bring their views into the debates.
I conducted 20 interviews with EU health policy stakeholders: the study participants represented General Interest Associations (GIA) (n=12), Professional Organisations (PO) (n=2), and Business Interest Associations (BIA) (n=6). In addition, I interviewed four representatives of EU Member States. I also conducted a further three interviews with the WHO Europe Officials, who had been involved in producing the Health 2020 Framework and the accompanying main implementation pillar, European Action Plan for Strengthening Public Health Capacities and Services (EAP-PHS) (see appendix 1 – Interview Participants). The interviews were transcribed verbatim and analysed through NVivo adopting thematic and narrative analyses. The focus of the European Commission element was on DG SANCO’s work on the EU Health Strategy and Programme (i.e. the instrument that is used to implement the health strategy), excluding other more specific topic-based health strategies (e.g. alcohol). Excluded from the study were also EU expert and advisory groups. The initial participant identification and selection was informed by the available EC documentation (Health Strategy background and consultation documents, DG SANCO stakeholder platforms and EU Health Policy Forum membership lists). In addition, event-participant lists provided a snapshot of the organisations actively participating in this sphere, and served as a reference source of who to invite for an interview.

The interviews took place in the participants’ offices in Brussels, apart from one interview that was conducted via a Skype call. On four occasions, two people from the participating organisation took part in the interview, thus the total number of interviewees in the 20 interviews is 24. The interviews were between 30 minutes and one hour in length. The interviewees’ experience in the field of European public health ranged from two years to 20 years. In addition, most of the EU public health stakeholders had experiences of working with the WHO and were thus familiar with its governance approach.

Participant Observations

I spent three years (2012-2015) in the field with the study participants, observing public health events in Brussels and taking notes of these observations in a research diary (see next page). The data collection took place at the time the EU health strategy Together for Health 2008-2013, was coming to an end, and WHO Europe was ready to launch the Health 2020 and the EAP in September 2012. The observations (n=23) were conducted at events hosted by DG SANCO, Committee of the Regions (CoR), European Economic and Social Committee (EESC), European Ombudsman, NGOs and Think Tanks (see appendix 2 – List of events). In addition, before commencing the interviews, I had meetings to introduce my study and to discuss issues surrounding the governance of EU Health Strategy with representatives of DG SANCO, WHO Europe, CoR and EESC.

“This health policy sector is overboarding with meetings. We are a small secretariat and we struggle sometimes to attend all the meetings which are happening on one day. So sometimes the office is empty because everybody’s going to a meeting. It’s a very rich culture, I must say.” (Director of a professional association)
Excerpt from the research diary: Jotted notes of observations at a DG SANCO event in Brussels

Thursday 3 May, 2012

Conference: EU Health Programmes: Results and perspectives, Venue: Charlemagne Building, De Gasperi Room, Hosted by the Commission, DG SANCO, open to all

The walk to reach the building from Rue de La Loi is a maze; the four-lane wide avenue is under major reconstruction, in order to better accommodate the Institutions. This is the EU quarter of Brussels.

Collecting my name badge and conference pack is straightforward, in English, French, German...

The horseshoe-shaped De Gasperi room is buzzing. Outside the entrance, poster presentations of successful projects funded by the FP7 Programme are on display. On the tables are headphones for the participants to listen to interpretations of the presentations and comments; on the side of the room stands a camera used to record the meeting and to broadcast some parts live online. The start is about 10 minutes late, opening by Commissioner John Dalli. We are informed that there are 700 of us, representing a variety of stakeholders.

The Chair of the event – Despina Spanou, Principal Adviser to DG SANCO – shows a slideshow presentation of Health Strategy, 10 years on.

An organ-transplant survivor tells her personal story, and the audience weeps. Very touching.

1st session

Order of topics: Rare diseases, organ transplants, health security (health threats, H1N1, bioterror), cancer.

Closing remarks by DG SANCO Deputy Director General Martin Seychell:

- there is a need to network the partners
- there will be different (financial) mechanisms to reach out to stakeholders: projects, tenders, conferences, joint programmes
- “no programme is more important than another”; it is about timing, prioritising actions to obtain measurable results, also to ensure as wide as possible participation
- networking outside the traditional field of health is important; “we need to prioritise actions with the highest leverage effect.”
Workshop 3: Promoting health, including the reduction of health inequalities*

*Hardly any mention of inequalities in the session...

Eurocare – European Alcohol Policy Alliance – struggled and lost a vote in Parliament as “the industries were far too strong…” (Mariann Skar)

During questions, a “year of the brain” advocate does a PR stunt for their 2014 campaign. This happens twice more – people try to use the question time as a platform to promote their projects, but the Chair (Clive Needle, Eurohealthnet) stops their outbursts after a short while.

The Chair addresses two men in the audience as “grand old figures” in health policy and gives them space to ask questions/to make comments. Finishing the session the Chair remarks: “You are the good guys! Together we can move mountains, go to the Commission and ask them to give us tools!”

Afternoon session

Paola Testori Coggi, Director General of DG SANCO, opens the session instead of “reporting from workshops” as stated in the programme. She seems to be in a hurry and says that she is between meetings on consumer law. She was supposed to launch a programme (HEIDI wiki) and give the closing remarks, but she leaves straight after her 10 minutes in this high-level conference.

During the lunch break people network and catch up with familiar faces. One floor down, some NGOs have stands showcasing and promoting their projects; the WHO is represented by one table of books on display – “do not remove”.

Panel debate: Which contribution for the Europe 2020 Strategy?

Josep Figueras (Director, European Observatory on Health Systems and Policies) emphasises: “it’s our health community”. Questions to the panel are asked by universities, a social security fund, a cancer-patient coalition, the UK Department of health.

Round table discussion

Committee of the Regions (CoR) has a strong interest in Public Health Policy (PHP) because it represents local & regional governments, who are often responsible for healthcare delivery in the Member State. The massive meeting hall is still full at 17.15 and the audience is attentive. Eurohealthnet representative John Considine asks a question about stakeholder involvement in forming health policy, noting that their members have reported difficulties in engagement.

Post-event thoughts

The Health for Growth discourse is at first confusing and might even make you cringe, with its strong connotation to money. However, during the conference, I realised how it soothes the disagreements within the “public health community”; because of the financial crisis in Europe, the austerity measures, “we are lucky to have a health programme” (M. Seychell), thus the threat is from outside not from within, which might reduce the competition between different stakeholder groups. It is “us” against “them” – everyone is important, but there needs to be prioritising, as it will benefit everyone in the long run.
A reflection on EVENTS

Some of the events listed in Appendix 1 include conferences that took place before I officially commenced this study in July 2012. As a researcher, an ethnographer, I did not enter the field of European public health with a “clean slate”; I had been involved in the scene through my consultancy work with the European Health Management Association (EHMA), as well as having a keen interest in understanding what this policy space is actually about. Indeed, this knowledge and experience was part of my research grant proposal and also the actual project xxxi.

The titles of the events I attended reflected some of the “hot topics” in European public health during the observations; health inequalities/equity in health; economic crisis; revision of the tobacco directive, eHealth, active and healthy ageing, nutrition and health; governance – including transparency and evidence; European Semester, and the Trans-Atlantic Trade and Investment Partnership (TTIP). Participation in the events also familiarised me with some of the spaces where officials and stakeholders intermingle, providing me with a feel for the culture and context. I participated in free events, not only due to a limited research budget, but also to observe as wide a range of stakeholders/participants as possible.

In a sense, the events constructed a Habermasian public sphere xxxii where debates about public matters take place. These venues – free access, by registration – are the postmodern coffee houses, cafes and public squares. Furthermore, the critique of the Habermasian conceptualisation of “public sphere” concerns the exclusivity of the sphere – for it was only for the bourgeois. Similarly, Brussels “Eurogroups” xxxiii have been labelled as the “elite” xxxiv that forms a public sphere, which ideally is open to all, yet in practice has a limited membership xxxv.

The Context: Health within the wider EU governance structures

At the heart of this study was the concept of governance, which is a concept described as “slippery” xxxvi and “versatile” xxxvii. Furthermore, the form of governance that was explored in detail within this study – participatory governance xxxviii – could be broadly defined as including all the processes of making decisions. xxxix

[Governance] is not political rule through responsible institutions such as parliament and bureaucracy – which amounts to government – but innovative practices of networks or horizontal forms of interaction. It is a method for dealing with political controversies in which actors, political and non-political, arrive at mutually acceptable decisions by deliberating and negotiating with each other. Governance is based on a variety of different processes with

It is said that the coffee on offer in the EU institutions’ events is made by a catering company off-site, then frozen and when needed, thawed for consumption. A woman in the European Ombudsman event claimed that we were actually sipping a drink made from some kind of “syrup.” (Research diary, 29. September 2014)
different authority bases, and highlights the role of voluntary and non-profit organisations in joint decision-making and implementation.

Good governance needs the involvement of stakeholders, and participatory governance should entail a strong degree of transparency, public access to information, effective ways of enabling stakeholder representation, and ways of engaging disadvantaged groups. As the definition of the concept of governance is not fixed, I adopted an exploratory approach to data, analysing what governance looks like/how governance is understood by key stakeholders in the field of European public health policy. What processes is it associated with, and where do the participants see themselves within the governance framework? Does the mix of arrangements engage stakeholders and offer opportunities to be heard, and what other (informal) ways of influencing are being used?

The institution responsible for drafting a strategy is the EC’s Directorate General for Health and Consumers (DG SANCO). In drafting policies, the Commission uses expert advice, ad hoc consultations, advisory committees, scientific committees, comitology committees, and independent agencies. In addition to this technocratic model of governance, which emphasises scientific evidence, the Commission uses participatory governance methods to consult with their wide stakeholder base, and to account for ethical, social, cultural, political and economic criteria when developing a policy.

Public health covers a diverse range of issues and “wicked problems”, such as obesity, tobacco control, alcohol misuse and health inequalities, thus it engages stakeholders across sectors. A broad range of actors participate in shaping the European Health Strategy, making health policy a contested area of EU decision-making. Numerous advocacy groups drive their own agendas, while industries lobby for their market products and services that can affect health.

Have you met Mr. Sanco?

“When you are here [in Brussels] there’s some things you don’t realise, and one thing is the use of acronyms that we do. One of my members had been asking: “Do you know who Sanco is? Have you met Sanco?, and gotten replies: “No I’ve never met Mr. Sanco, but Mr. Sanco is very important.”

She had been asking from many people, and nobody had met Mr. Sanco. It took her a long time before she finally understood it is the Directorate General for Health and Consumers, DG SANCO.” (Director of a pan-European NGO)

DG SANCO is dear to the participants of this study; there is respect towards the individuals working within the institution and the effort that is put into health policy-making. However, the strength of leadership and transparency of proceedings are insufficient. The stakeholders are in defence of SANCO; the DG is perceived as important but neglected and less powerful than it should be.

“How is DG SANCO perceived within the Commission, within the other units? Is it just a unit that has no power? We are a little bit concerned about how DG SANCO profiles itself within the EU policy debate. There is no money for health. Health is not the sector to be sexy, to be proud of, you have only problems in the health sector; we are not producing money, direct money. So the health sector is in itself a black sheep a little bit on its own.” (Director of a professional association)
“In fact, they [DG SANCO] are getting weaker. It seems that what they are doing, they are being watered down every time. They may have the best of intentions, but some people say ‘stop’ and, voilà. They are put under enormous pressure from DG Enterprise. Whatever they have can be held up in these inter-service consultations forever, and you are quite often saying to them: tell me, what can I do to help you? Please, I mean, we want the same thing potentially as you guys, so please help us out.” (Head of Department in a pan-European NGO)

**Key points: Health within the wider EU structures**

- The EC is organised into many DGs, and specialised agencies, each dealing with a specific set of policies. In this structure, DG SANCO has limited power and influence, which, due to the study participants, is because of stronger DGs concerned with the EU single market and economic development.
- The participants of this study perceived themselves as defenders of DG SANCO and health issues within the wider politics in this policy space.

**Practising the Health in All Policies (HiAP) approach**

Public health policies are a particular niche of the wider health-systems debate, which should – from the viewpoint of the participants of this project – be at the very heart of sustainable policy-making. Health (should be considered) in All Policies (HiAP). The study participants used the term HiAP to refer to the work that DG SANCO is and should be doing with other Directorate Generals in the European Commission, and to account for their own liaisons with a diverse pool of institutions and organisations. In the literature, HiAP is described as a horizontal approach to public policy-making, which emphasises cooperation across policy areas, with industry and nongovernmental organisations (NGO)⁹. The approach is founded on the values of human rights and social justice, seeks synergies between policy areas (e.g. education, employment and the environment), and avoids harmful health impacts, in order to improve population health and health equity¹. In the EU policy space, the term HiAP started being used in 2006 during the Finnish presidency of the Council of the EU.

“To me DG SANCO needs to be doing a lot more on Health in All Policies, but then they need more money and more people to do it. I don’t have any complaints at all about the people who work in DG SANCO. The people working in DG SANCO are hard-working, but they don’t have the facilities, resources and most importantly from the public health side, they don’t have the political power.” (Policy Officer in a pan-European NGO)

“The overall policy-making and public health would benefit from a better coordination of all actions. It’s too much in silos and would benefit from what they call cross-fertilisation.” (Director of a Department in an Industry Association)

The reasons for inadequate execution of the HiAP approach at the EU level could lie either in the absence of health within the wider framework of siloed EU policies, or in the weakness of DG SANCO when compared with other policy areas – not that dissimilar to the weaknesses found in Ministries of Health at national level⁹. In many countries, creating space for health within more powerful government departments is challenging. This is problematic when it comes to achieving effective horizontal governance¹⁰.
Getting your voice heard is important in a space filled with competing politics and lobbying. Indeed, Koivusalo et al. (2009) note how HiAP remains more rhetoric than action, but that “the rhetoric has to be seen as part of action”liii. Also, Pinto et al. (2015) argue that HiAP can function as a means to highlight the challenge of achieving both economic and social objectivesliv, which can then facilitate discussions on the political determinants of health.

“What we have seen is a lack of strong governance capacities at the ministries of health, a lack of capacities to communicate properly the health issues from the perspective of the other stakeholders.”

(HO Official)

While studies have shown complex issues surrounding CSO transparency, accountability and representation in the EUlv, their role as mediators of information within the EU policy space is a less researched area. These actors can play a critical role in promoting health action across sectors; they have the capacity to influence public opinion, and they can provide data and evidence on health and equity issues through their membershiplvii.

“Obviously we see the main three institutions [EC, Council, EU Parliament], we’re a key interlocutor on cross-cutting issues, but we also collaborate extensively with other health stakeholders.” (Director of a pan-European NGO)

The organisations that took part in this study identified DG SANCO as their principal Directorate General, but emphasised the importance of approaching and networking widely within and beyond EU institutions. While Commission work was often said to be organised in silos, with too little internal collaboration, the stakeholders talked to a number of DGs and other organisations. The participants mentioned the following liaisons: DG Internal Market, DG Communications Networks, Content and Technology, DG Employment, DG Justice, DG Transport, DG Finance, DG Agriculture, DG Enterprise and Industry, European External Action Service, DG Taxation, DG Environment, and the Executive Agency for Youth, Culture and Sport. Most stakeholders work also with other European Institutions, such as the European Parliament, Committee of the Regions (CoR), European Economic and Social Committee, academic institutions, and the World Health Organisation.

Some of the civil society organisations (CSO) perceived themselves as informed messengers between different DGs. Not a voluntary role, but something that has developed from their HiAP approach:

“So yes it [HiAP] is standard everyday business. We can play a role of trying to link all this where the European Commission sometimes have difficulties because they work very much in silos and they do not link very much between all of them. We can just say ‘well, you know, your colleagues are doing that and maybe it can be something to look at and to avoid duplicating the work’.” (Policy Officer in a pan-European NGO)

“Sometimes we also see that proposals come out from DG SANCO, but they are linked with DG Research, or they are linked with DG CONNECT. So there are sometimes three or four DGs who could have a say on this, but are the DGs aware of their different initiatives, have they formed a process? Sometimes we have to be ourselves the communicators between different DGs.” (Director of a professional association)
Transparent planning ahead could allow stakeholders, in their involuntary coordinating role, to help policy-makers to identify issues and links.

“I think if the European Commission officials were able to give us a kind of work plan of what issues are coming up, where they would like input, what are the challenges they face, what have they been able to identify in terms of lack of capacity in-house that they have, where they would like to bring in experts. We could also come in and say ‘okay we know that this is going on, in terms of implementation at the national level. We’re coming up against issues with either it’s employment, environment’. I think a cross-sectoral approach would be interesting.” (Director of an international health foundation)

This practical HiAP aspect exceeds the advocacy or lobbying role of the CSOs by adding a layer of mediating information to the process. When formal multilevel governance structures hinder HiAP work, as the participants note, it falls on the stakeholders to take over the communication and mediation of health impacts of the developing policies. As a WHO official put it: “The WHO has access to the ears of the decision-makers, but we cannot be too noisy, not like some NGOs”. For example, the European Public Health Alliance (EPHA) has been a member of the Transatlantic Trade & Investment Partnership (TTIP) Advisory Group hosted by DG Trade. Also, the decision to move responsibility for pharmaceutical products and medical devices from DG Enterprise back to DG SANCO in the formation of the 2014-2019 commission was credited to strong NGO involvement and lobbying.

While rhetoric and action conventionally reside at opposing ends of a scale, in the field of supranational public health, arguably, rhetoric can be seen as part of action, and “health arguments” can provide “policy space” for health articulation within EU policy making. For example, Think Tanks can be powerful forces in the formation of politically charged health policy.

The political context limits how health policy is formed, and therefore it is important to raise awareness of this situation. Macroeconomic trade, defence, foreign policy and international development policy play a role in major economic, social and health inequalities. Alas, within the current global, neo-liberal world order, the key political debates in public health revolve around the primacy of economic
policies over social policies\textsuperscript{hl}. These “political determinants of health”\textsuperscript{lxii} are evident in the policy space, within which DG SANCO drafts the EU health strategy. It appears that CSOs in the field of public health can act as mediators of information or as a catalyst to create space for health in policy debates. These are organisations that have knowledge of the everyday policy work and opportunities to form networks and build coalitions, in addition to the familiarity of the wider institutional context that has an influence on health matters in the EU. While “smoothly integrated in routine Brussels practices,”\textsuperscript{lxiii} the advocacy and lobbying by these “elite” CSOs\textsuperscript{lv} create policy space for health within a myriad of political determinants of health.

**Breaking internal silos for Health 2020**

“This [Health 2020] was not meant to be a book, a report, a document that was written in the backroom of a university or of the Regional Office. It was not just me locked up in my room but it was all the technical and other divisions of the [WHO] European Office taking part. This is an important stakeholder group because these are also people who work internationally, so the organisation was to be behind this itself.” (WHO Official)

**Key points: HiAP at supranational level**

* The structures and political determinants of health impose limitations on public bodies. These limitations can at points be transcended by stakeholders, who conduct HiAP work at supranational level, thus negotiating space for public health within the competitive, globalised policy space.

* By approaching a range of DGs, the civil-society organisations can help to establish and maintain links between health and other policy areas.

* The CSO role as mediators of information within the supranational policy space can raise awareness of the political determinants within which public health decision-makers operate, thereby supporting their opportunities to shape policies.

* It can be recommended that the institutions engaging in HiAP work acknowledge the role of CSO within their system, not only as stakeholders *per se*, but as mediators of information.

**The EU Needs a Health Strategy**

Many of the research participants said that their work is based on a particular, narrower strategy, project or agenda in relation to EU public health, rather than on the over-arching Health Strategy, but the view was strongly expressed that EU needs the strategy.

“I think that the strategy has been a very, very good initiative. To have one coherent strategy, I think that’s an important point to make.” (Director of a pan-European NGO)

“The overall strategy is also very important as the umbrella strategy of focusing on health. So I see it as an important instrument of pushing the health issues forward.” (Director of a pan-European NGO)

“The EU is developing a new public health strategy that is really quite important.” (WHO Official)
The public health community perceived the EU Strategy as essential for defending the place health occupies in the wider EU agenda. Thus the document plays a pivotal political role in helping DG SANCO form and argue their case on behalf of public health stakeholders. However, despite it being 2015, the EU Health Strategy, Together for Health 2008-2013, lives on.

DG SANCO decided not to form a new Health Strategy to replace Together for Health (initially envisaged to cover the period 2008-2013), but to continue with the existing one. There was no further stakeholder involvement in the framework; instead, DG SANCO presented in February 2013 a Staff Working Document, Investing in Health, as an “extension” to the current strategy. This policy document addresses in particular the Member States. From a governance point of view, the process evoked mixed emotions within the stakeholder groups.

I’m sorry if I look shocked – it will not be revised then?” (Director of an international NGO)

The decision that there would be no new EU health strategy post-2013 became part of my interviews with the stakeholders; some participants were vaguely aware of this decision, but for some it came as an unpleasant surprise.

“That [the revision of the current Strategy] is very un-transparent, which would mean we would need to lobby within DG SANCO and really select and fish for who is making the decisions and pushing the buttons, which is, well, not very transparent and obviously we will not be the only organisation that will be doing this.” (Policy officer in a pan-European NGO)

“And that’s a bit the fear; if the health strategy would be radically changed and the private sector would not be involved in that from the start, I think companies will say: ‘well why should we actually do this
on a voluntary basis if we don’t get a seat at the table and we cannot even discuss together?’ And I think that there should be a balanced discussion, rather than one-sided. I don’t think it’s very DG SANCO to be honest, because we have good relations with DG SANCO, so I’m a bit surprised.” (Director of Department in an industry association)

The time of the study was a turbulent one in the EU public health scene. In October 2012 the Commissioner for Health, John Dalli, resigned\textsuperscript{lxv}. This was also the time the public health community was expecting to get engaged in the new strategy, and Europe was in the grip of tough austerity measures. Information flow shrivelled during this time of change.

“Maybe because it’s a crisis time and people refocus on what they should be doing, there are more things done behind closed doors. Either it’s a refocus because of resources issues, or a change in the way policy-making is perceived. We’re in the middle of a change, but what we’ve been seeing for at least the past six months is not very engaging.” (a Director of a Department in an industry association)

Previously, DG SANCO has emphasised stakeholder participation in policy-making from the beginning. For example, in forming the 2008-2013 health strategy, it embarked on an extensive stakeholder consultation process, including an impact assessment and open consultation of stakeholders. The WHO Regional Office for Europe, on the other hand, has traditionally drafted documents and strategies to an advanced stage in-house before seeking stakeholder views. However, the tables seemed to have turned during this study; the WHO actively engaged stakeholders in the development of its new Health 2020 policy framework and strategy and the accompanying European Action Plan (EAP), developing the documents through a participatory process with Member States and a wide variety of other interested parties across the European Region.

“The consultative process [of Health 2020], was pretty open. There were consultations with civil society, although perhaps not as many as people would have wished, but there were.” (WHO Official)

Whereas it seems that the WHO was becoming more open to stakeholders, at the same time it seems that these interested parties had a decreasing role in the EC strategy. The situation implied a shift in the governance of each institution.\textsuperscript{lxvi}

I wonder what happened?

Public health is located within a broader health system, which in a situation of financial instability suffers as a whole. In response to this, supranational policy-makers in the main institutions – the EC and the WHO – have taken a stand on the importance of health investment for the functioning of societies. Both current Health Strategies for Europe perceive health to be a value in itself, but also an invaluable component of a strong economic system. Indeed, in recent years, the premise for the argument that acknowledging social determinants of health (SDH) and health inequalities across the board in policy-making will benefit societies as a whole, has been one of the focal points of global public health. There is a strong economic argument to the social determinants of health and health inequalities. The EC Investing in Health document could be seen to be in line with the wider public health movement in SDH, thus reaching beyond the subsidiarity-restricted EU health scene, and tapping into the economics-based argument to pave the way for health within the other policy areas. Perhaps this ethos was what carried through the “behind- closed-doors” process of the ‘No New Strategy’. Perhaps.

I also had a long chat with a senior DG SANCO official at a conference, who mentioned that the Commission’s approach is not to encourage the forming of DG-specific strategies any more, but to have a more coherent framework for policy-making across different areas via the Europe 2020 and the Horizon 2020 strategies. (Research diary, 24 November 2014)
Key points: EU needs a health strategy

* The EU Health Strategy works as a tool that can be used to defend the place health occupies within the broader governance structures

* Governance approaches can shift due to (unforeseen) contextual factors; from participatory to technocratic and vice versa

* In a time of instability and change, a public body will do well keeping stakeholders informed about the situation – even if it is only pointing out that staff and structures are changing

Accountability: System blaming vs. individual responsibilities

“All DG SANCO people are working hard, it’s the system that prevents things from happening!” was a narrative that the study participants used in order to emphasise how it’s the broader governance structures and powers that hinder public health from being higher up the policy agenda. This system-blaming ideology shifts accountability away from a particular person, department, and indeed a Directorate, making it difficult to challenge those making decisions and exercising power – until there is one bad apple in the bunch.

“You can put all the governance in place, and I think that DG SANCO has done, and I’m not entirely convinced that other DGs have been as good at it. I just think that at some point it’s up to an individual to be honest and correct, and not everybody is. So how do we deal with that? You expose it like the Dalli affair, as it is now called. So there are a lot of questions around this of course, and in the end things come out when there is a scandal if you like, or a hiccup, or something goes wrong.” (Director of a pan-European NGO)

While individual responsibility and dignity is called for, simultaneously, it was also the system – and governance structures of the supranational institutions – that were to blame for inefficiencies and opaque decision-making. In the Commission, the problem was that no one took responsibility for a dossier:

“The [problem is the] way the Commission is structured and the way it works, with lots of divisions in Luxembourg, Brussels, and with a different hierarchy. So if you ask them, I don’t even think they will give you a plain answer of who actually made a decision.” (Policy Officer in a pan-European NGO)

The lack of clear coordination was also noted in regards to the WHO system:

“I think the [WHO] coordination in Europe is not the most exemplary. A better coordination would be a real improvement. Where it has to be done, in Brussels or Geneva, for me it’s exactly the same. But you have to choose one or the other, not both.” (EU Member State representative)

Criticising the system is an understandable response, but is insufficient in improving things if the only remedy offered is to bring the whole organisation down (hard Euroscepticism). Instead, structural
problems in multi-stakeholder governance are more effectively handled through governance reform. Indeed, the two institutions that were the focus of this study were both doing just this. Since the completion of the data collection for this study, a new Juncker Commission is in place in Brussels with a new structure, aiming to get rid of some of the silo problems of the Barroso Commission. Also, a review of the EU Health Policy Forum\textsuperscript{2} is under way. On the WHO side, a major governance revision is currently taking place\textsuperscript{lvii}.

**Key points: Accountability**

*Supranational decision-making is said to be faceless, yet the public bodies’ staff include many familiar, friendly faces to stakeholders. Individual staff members do not add up to form a whole.*

*A public health institution needs to be clear about departmental structures and responsibilities, and publish this information.*

*Disassembling supranational structures does not offer a sufficient remedy to wicked problems; in a global, networked world, an intersectoral approach – such as HiAP and the whole-of-society approach – is a must.*

**Openness: Availability of information**

One aspect of good governance is information sharing: about forthcoming developments, organisational structure, decision-making. At times DG SANCO were criticised for lack of communication, in particular regarding their future plans.

“*Well there was supposed to be the Open Health Forum last year and it was cancelled. This year it’s been cancelled. Why is that?”* (Policy Officer in an international NGO)\textsuperscript{3}

“I think they [DG SANCO] are quite transparent in a way that they let you know what they’re doing, but of course nothing is published, and it’s very difficult to receive something really concrete, some documents for example.” (Policy officer in a pan-European NGO)

While some felt that the information from the Commission was not sufficient, others felt there was too much one-way communication from the Commission, and the lack of a two-way exchange, which goes to show the importance of accounting for the contextual factors:

[The EU Health Policy Forum] is a meeting of one day where you have lots of presentations from the European Commission to the stakeholders and what is going on inside the European Commission and the new things coming out. Presentations usually from the EU presidencies [of the Council of the EU] as well to see exactly what they are putting in their programmes, so let’s say lots of information, and

\textsuperscript{2} The EU Health Policy Forum gathers twice per year, bringing together 52 umbrella organisations representing public-health nongovernmental organisations and patients’ organisations (NGOs should cover a broad range of issues and have member organisations in all or most EU countries), organisations representing health professionals and trade unions, health service providers and health insurance bodies, and businesses with an interest in and a commitment to health promotion, protection and improvement. [http://ec.europa.eu/health/interest_groups/eu_health_forum/policy_forum/index_en.htm](http://ec.europa.eu/health/interest_groups/eu_health_forum/policy_forum/index_en.htm)

\textsuperscript{3} Named as one of the main tools to engage with the wide audience, the EU Open Health Forum, was to have been organised in April 2013 with the theme ‘the future of EU health policy’, but it did not take place.
my feeling is that there is less and less discussion, real discussion on the content and on the strategy to be issued.” (Policy Officer in a pan-European NGO)

Governing multi-stakeholder forums is a bit of a rubber band; when providing information, the critique concerns one-way communication, or if engaging a sub-group form the wider stakeholder population, it verges of technocratic governance, and limits the openness of the process, at worst privileging some agendas over others.

In addition to lack of information on plans and events, the organisational structure could be confusing to the stakeholders who wish to liaise with the Commission. It can be difficult to locate a person, even a department that is responsible for a particular policy initiative.

“So for us it’s not always very clear how DG SANCO works, who makes the decisions, what they’re aiming at. Recently, the restructuring of DG SANCO with the different departments was very unclear; where is [our main concern] going to be, who is taking care of this issue then and in what way? For us it’s not always clear how this is decided at all.” (Policy Officer in a pan-European NGO)

Complaints relating to lack of transparency within the EU Institutions have consistently topped the list of complaints to the European Ombudsman. The issues have mainly regarded the institutions’ refusal to grant access to documents and/or information, meetings taking place behind closed doors, and the opaque way in which members of EU expert groups are appointed. The murkiness of decision-making processes was a particular theme that emerged in my study.

“But who makes the decision after a consultation? Who gets together? How does that work? That is not clear, and that might be good to clarify; like, based on these and these and these points, or these and these and these things, DG SANCO made that decision and then this is the outcome of that. And then you can disagree with them, fine, but then at least you know. And that would be definitely helpful.” (Policy Officer in a pan-European NGO)

The transparency narrative became intertwined with the act of lobbying and decision-making:

“Where do the Commission get their ideas from? I think you’d have to ask the Commission that, but one can only anticipate that they get them from a varied range of sources. I couldn’t put my hand on it.” (Head of Department of a multinational corporation)

“It’s not clear when you have the impact assessment, etcetera, why they [DG SANCO] have or have not taken comments or positions on-board.” (Head of Department in a pan-European NGO)

“Everyone is lobbying. We are lobbying, pharma is lobbying, industry is lobbying, other NGOs are lobbying. How is this taken in consideration, and based on what leverage do these people [in the Commission] then make the decision? That is not very clear. So we are not saints, we are also lobbying and we are also trying to push for stuff like all others. How far are all these influences taken into consideration? That is not clear at all, and specifically related to transparency.” (Policy Officer in a pan-European NGO)
Who’s got the power, then, to most influence the forming of the EU Health Strategy? The study participants saw that industry (singled out by NGOs) and NGOs (mentioned by industry) have the means to influence policy-making. This situation was mainly discussed in relation to resources, and the competition between NGOs and industry. While said to be an important stakeholder group in supranational public health, the NGOs did not perceive themselves to be particularly powerful and influential in policy-making:

“What we as NGOs do doesn’t really matter, unfortunately, to be honest. I mean we can talk and talk and talk, but it’s what the Member States do, and legislate on, that’s the only thing that really matters. Or the Commission, I mean somebody has to legislate and decide, and then we can talk. And researchers can research, but it doesn’t really matter.” (Director of a pan-European NGO)

It has been suggested that all new policies should be accompanied by a statement of the evidence consulted in their preparation\textsuperscript{\textit{ix}}. The drafting phase of a health strategy could be likened to basic steps in conducting research; collecting data, analysing it, and publishing results. In my study, it emerged that there is a vast amount of data (consultations, platforms, expert groups), and the results are made public. However, the step in the middle – which data were used/discarded, and what was actually done with the data, and by whom in order to reach the conclusions, is not made explicit enough.

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Shedding Light on Decision-Making

“We prepared a compendium of all stakeholder comments [on Health 2020], where we listed all possible comments by all possible stakeholders, and against each one. It’s in a table format – accepted, non-accepted – if not accepted, why it’s not accepted, with justification. We had to write letters to ministers, to other institutions in order to explain to them, to counter comment, and to interpret why.” (WHO Official)

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**Key points: Openness**

*It is important to delegate information to stakeholders, as well as offer opportunities for two-way communication

*More transparency is needed in decision-making processes; who made a decision and based on what data/information

**Evidence & policy: The reign of the scientific narrative**

One strong theme that emerged in the data was the use of evidence in policy-making – the idea that health policies should be evidence-based (EC), or informed (WHO)\textsuperscript{\textit{x}}. Both organisations were pondering over the best ways to manage the wealth of data available, and how to make the process of using data at different points in policy-making more transparent. From the research participants’ viewpoint, however, what counts as evidence, and whose knowledge counts was not particularly clear.

The so called “Eurogroups” serve the valuable function of bringing information to the Commission, which lacks the staff and research resources to learn about every issue\textsuperscript{\textit{xii}}. Worth noting though is that this information providing – also known as advocacy and lobbying – is not a straightforwardly positive
issue. Policy-makers need to distinguish between good and bad data, and aim to reduce the influence of misused “facts”, possibly presented by interest groups\textsuperscript{\textlxxi}.

There was competition between different stakeholder groups in providing evidence.

“[I]f you want to influence policy, yes, meeting with them [EC officials] is important, but also providing the evidence. And this is somewhere we’re often challenged because we have limited resources, our members have limited resources – financial and human resources – and we don’t have the same means as industry to provide us with all we need.” (Director of an international NGO)

Although coming from competing interest backgrounds, profitmaking and not-for-profit actors used the same narrative tactics, leading to a gridlock: “Less politics, more science I think would be good.” (Director of an industry association) “We actually believe in evidence-based policy. And I’m not sure if I continue to believe that it happens, because I think we all have very good evidence and yet we do not actually necessarily get the policies which reflect that evidence.” (Director of a pan-European NGO)

Conspiracy theories were rife, and interest groups blamed for a bias in funding distribution which, paradoxically, seemed to benefit both for-and not-for-profit stakeholders:

Industry view: “Projects that are actually funded by the European Commission, conducted by advocacy groups or NGOs, which receive funding to undertake this project... are presented as research when really it’s nothing more than a policy paper. So this is the problem that we’ve seen recurrently happening; funding being given to particular advocacy groups or particular researchers within a particular school of thought of public health, to inform the debate, which is then presented as irrefutable evidence.” (Director of an industry association)

NGO view: “There seem to be a few organisations that get all the funding, and they’re industry-backed and so you know, if you have a European project that is industry-backed, and that you know industry has a position then it’s not, the outcome, the results are not going to be radically different from what industry is lobbying for!” (Policy Officer in a pan-European NGO)

Being an academic researcher in the field, many study participants discussed “evidence” with me, without the interview questionnaire including any particular questions about this. I represented a university with a strong research reputation, an institution renowned as capable of producing “real” evidence, that is, scientific evidence. This particular narrative about science was repeated as the key to transparent policy-making, ethical decision-making, and as an antidote to politics-based policy-making. However, what became apparent simultaneously was that the virtues of scientific research were strictly limited to a positivist paradigm, leaving only limited room for other types of evidence\textsuperscript{\textlxxiii}. Similar observations regarding the autocratic rule of “hard” scientific evidence have been made in other policy fields, such as agriculture\textsuperscript{\textlxxiv} and climate change\textsuperscript{\textlxxv}.

All actors – NGOs, the industry and European institutions – are captured by the discourse of science-based policy. Why does this matter? Being stuck in a positivist rut, i.e. the emphasis on “hard science,” gives companies a tool to pursue their aims in the field of public health. The evidence-based “quality mark” has been misappropriated and distorted by vested interests, such as the drug and medical-devices industries\textsuperscript{\textlxxvi}. If quantity is perceived as the premise for valid evidence, it is clear that money wins; the ones who have the economic resources to pay for the “right kind” of research will produce
the results they need: “we believe in strict science, and we have to rely on strict science.” (Director of an industry association)

“They [the EC] should take a closer look at how the research is being conducted and how the results are being presented. So I think the Commission also has some responsibility to play there if they are giving out so much funding, giving out so much money, that they should really keep an eye on what is being said and what is being done.” (Head of department in a pan-European association)

The power of this “scientific evidence” narrative is clear in the field of public health; people have a deeply held desire for data and concepts that help simplify (rather than capture) messy realities with a preference for “concrete”, “hard” data. This “ideology of scientism”– the notion that policy should be driven by statistics and research – is delaying, for example, the development of the Global Convention to Protect and Promote Healthy Diets, which could be modelled along the lines of the WHO Framework Convention for Tobacco Control (FCTC) since the industry, a.k.a. “big food”, insists on policy being based strictly on global empirical quantitative data.

Asking if health equity can survive epidemiology, Schrecker (2013) points out:

“Although examples exist of sound RCTs of large-scale policy initiatives... many kinds of interventions and policies cannot be assessed using RCTs, for reasons of ethics, costs, logistics, or all of these. Even when an RCT is conceptually possible, insisting on evidence from RCTs may build into intervention research a bias against larger-scale, contextual interventions that are difficult to evaluate in this manner”.

Dissolving the evidence gridlock, in which different advocacy groups go head-to-head to establish the superiority of their project, requires a governance approach that acknowledges and makes explicit epistemological politics. The aim of this process is not to dismiss the value of scientific research. On the contrary, since “political determinants of health” can overrule evidence, and “policy-relevant facts are the result of an intensive and complex struggle for political and epistemic authority”, there should be further transparency on what evidence is considered valid at what points of policy-making, and when and how non-science information is being used.

“There’s a map floating around of the complexities of the global food system* and there’s just inter-linkages everywhere. And the notion that you can tackle these problems in a linear way, that linear rationalism will get you where you want to be, which is very strongly imbued in the scientific method – that it can all be sorted out with a randomised controlled trial – it doesn’t work in this.” (WHO Official)


Key points: Evidence use in policy-making

* Policy-makers need to consider the wealth and value of different types of data at different points of policy cycle

* The typologies of evidence that are needed and used should be clearly signposted to stakeholders, and updated per policy initiative

Participation in public health policy-making: Some formal tools

The EC is required to consult broadly outside the European Institutions. The engagement tools that the participants discussed included open consultations, which offer “everyone” the opportunity to participate in public health policy-making in the EU, and the EU Health Policy Forum (HPF). In addition, two Commission-run “platforms” (alcohol and nutrition & active life style) were discussed by the participants. Although not directly linked with the forming of the overall EU Health Strategy, the gatherings are an occasion at which the CSO and industry groups are sat around the same round table.

“I think DG SANCO actually has been quite proactive in setting up stakeholder structures. They’re very generous towards all the stakeholders. I wish other DGs were as generous towards all stakeholders as DG SANCO is.” (Director of a pan-European NGO)

While the formal opportunities to participate in policy formation were seen as good, the engagement tools had some shortcomings. These included the timing of consultations, the amount of time reserved for consultations, the (dis)use of the consultation responses, and un-transparent analysis of responses to a wide consultation.

“For a democratic organisation like ours, the timelines [of consultations] are quite limited. If you think we have to consult our members, draft a position or respond to the questionnaire, send it out to our members, field their comments, work out where there is conflict, work out a sort of compromise, send it out again – I mean it’s quite time-consuming.” (Director of a pan-European Association)

“There are some members [of our NGO] that are really, really active, and they respond to all the documents that we send to them, and some others are small, so it’s difficult for them. They’re basically run by volunteers.” (Policy Officer in a pan-European NGO)

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4 A recent example includes the 85,000 responses submitted to the tobacco directive consultation; The Director of Smoke Free Partnership, Florence Berteletti-Kemp, speaking at an event in the European Parliament on 19 February 2013, alleged that most of the responses came from the tobacco industry. In the official Commission (2011) ‘Report on the public consultation on the possible revision of the Tobacco Products Directive (2001/37/EC)’, industry representatives accounted for 2.71% of the responses, while citizens provided 96.03% of the responses. The affiliation of each participant was self-declared. [http://ec.europa.eu/health/tobacco/docs/consultation_report_en.pdf](http://ec.europa.eu/health/tobacco/docs/consultation_report_en.pdf)
In other cases, it was the stakeholders, not the Commission that underperformed:

“Normally the consultation is long enough but very often you have a tendency to do it very close to deadlines, so it’s probably also a matter of internal priority; it can be that we do things close to deadlines also.” (Director of a pan-European NGO)

Some participants asked for a more targeted approach:

“I think next to the traditional consultations, I think you need to bring on a very specific topic, a small group together. You need to bring the key stakeholders together, and work on very specific things and make sure that it leads to hardcore legislation.” (Director of a professional association)

“There needs to be put in place a system whereby all relevant stakeholders are formally consulted, and there’s some kind of weighting system given to the outcomes of the consultations.” (Head of a Department in an industry association)

While stakeholder analysis is a tool widely used in public health policy-forming at country level, no framework exists for the supranational level. This is surprising, when thinking about vast networks in supranational public health, and how the major governing bodies of European Health Strategies (EC and the WHO) engage in participatory governance practices, without making it explicit how the stakeholders were chosen in the first instance.\(^5\)

Choosing stakeholders is a process with technical, political and ethical aspects, and the process should address questions of legitimacy, representation and credibility. Stakeholders should be included when there are good reasons to do so, not when their participation is “impractical, unnecessary or imprudent”.\(^5\) EU is still “a young polity” that has “an unusually dynamic population of organized interests”.\(^5\) Therefore, a forward-looking supranational stakeholder analysis, which determines stakeholders’ relevance to policy on an ongoing basis, could be useful. Commercial directories and the EU transparency register provide an overview of the actors, however not everyone is registered or visible. The most critical say that there is a lack of “true lobby registration system”, since there are many organisations that come to Brussels for a specific purpose and then leave without establishing an office.\(^6\) In the field of EU public health, collaboration between different EC DGs\(^6\) would be essential to identify relevant stakeholder groups (e.g. CSOs active in environmental issues).

Many participants in this study were or had been members of the EU Health Policy Forum, which was seen by some as an opportunity to influence decision-making and decision-makers directly.

“[The EU Health Policy Forum] is an opportunity for us to have a direct input on consultations and policy documents, which then goes straight to the highest level in the Commission. Whereas if it’s general consultations, then obviously we’re in a very large mix and we’re much less influential.” (Director of a pan-European NGO)

\(^5\) To give an idea of the vastness of the ecosystem – the EU Transparency Register includes 674 public health NGOs, and the WHO Europe consulted 250 NGOs for Health 2020.

\(^6\) Public health stakeholders often liaise with DG Research, DG Employment, DG Agriculture, DG Education, DG Trade, DG Connect, and through these institutions, with stakeholders outside the public health policy field.
“I think it is a useful forum to go to when you are new to health policy in the EU, because you are able to meet with Commission officials, you’re able to hear about many of the challenges that they’re faced with, organisational, political etc., and I think this is an important thing to keep in mind.” (Director of an international NGO)

I was interested in observing the proceedings of the Forum as a researcher, but my request to participate in the event was turned down by the Commission. However, I had a phone call with the official in charge after the meeting, and I was sent the presentation slides, thus received pretty much the same information as the stakeholder participants. Two HPF members volunteered to take me along to the meeting, if I would like to attend. For ethical reasons, I turned the invitations down, since I had had the following email exchange first:

While the interviewees criticised the Health Policy Forum for being too much of a one-way communication channel from the Commission, it was also was seen as important and useful, in that it created opportunities for stakeholders to meet, discuss and debate, thereby enabling and supporting the forming of a community of practice:

“I think there’s enough trust and understanding now between the organisations, and the platform that the Health Policy Forum has given us has helped to generate that trust for us to work together on a strategy, and not be too partisan and really think about a strategy that’s going to benefit the whole community and not just put one particular constituency to the forefront, and I think that’s also very important.” (Policy Officer in a pan-European NGO)

Similarly, bringing stakeholders together for the drafting of the WHO Health 2020 provided a forum to debate issues in the run-up to the final document:

“Many Member States started buying into the Health 2020 before it was finished, because through its extensive consultation process, it created opportunities for Member States and other stakeholders to
create a common understanding of some of the big issues, for which understanding was limited or controversial. So to basically have the opportunity to debate the facts, some of the key evidence, and to be in the same room and hear different people say “ah right” (WHO Official).

**Key points: Participation**

*Open consultations are appreciated as a tool that supports wide, democratic participation. However, they are not perceived as a particularly influential way to partake in the policy-making*

*More focused stakeholder consultation was welcomed; developing a framework for supranational stakeholder analysis could be recommended, making links between stakeholders in different policy areas.*

*Face-to-face meetings and forums are very important in multi-stakeholder governance, as these occasions facilitate a shared space within which participants can discuss, debate and learn about the varied views and possible synergies*

**Informal exchange: Early Birds and Open Doors**

The stakeholders interviewed for the study wanted to become involved in policy-making from the very early stages.

“Now if you’re talking about an influence, the best or most effective way to influence is to get your ideas across before the consultation comes out. The earlier you can get in the more effective you could potentially be.” (Head of Department in an industry association)

“We try to be early. That is my main goal, to be aware of what’s going on as early as possible, so we try to influence when they [DG SANCO] write the proposals as early as possible. It’s far easier to get in some opinions on an early stage while it’s on the drafting.” (Policy officer in a pan-European NGO)

This early bird mentality served a purpose for the stakeholders to have their views and agendas included in the policy process from the very beginning, prior to formal consultations. But it had also been recognised by a WHO interviewee who had been involved in the drafting of the Health 2020, as a way to engage stakeholders, giving them “ownership” of the policy product:

“If you want to have true engagement and interest, try to bring them [the stakeholders] into the process as early as possible. Not when it is already advanced, then they may feel they don’t have much influence” (WHO Official).

The ownership of the WHO Health 2020 strategy, for example, was seen as a means through which to facilitate the participation of CSOs into the implementation of the framework. The switching from in-house expertise to a more open participatory governance mode had required the WHO to map out the civil society field:

“The NGOs [issue] is a tricky one because it’s diverse. I mean there is a list of a very, very few NGOs who are – as we say – in official relation with WHO but these are very few. That was not enough for us [when forming Health 2020]. So we needed to go out of our way to reach out to as many as possible.” (WHO Official)
It emerged in the data that the Commission practises an open-door policy in terms of who can have a meeting with them. It is as simple as making an appointment and presenting your agenda. The stakeholders who took part in this study perceived DG SANCO as an easily approachable institution. Most of the participants had developed personal relationships with the personnel and were able to simply “phone them and get into their office and talk to them and say what you need, what you want, that’s it.” (Director of a professional association) Their experience was very similar to my exchange with the officials, that is, sending an email, and having a meeting.

“My feeling is that NGOs working on public health issues are seen as the good guys, and from that perspective it means that we do not have that much difficulty to get in touch with civil servants.” (Policy Officer in a pan-European NGO)

“We have direct contacts at the level of head of unit and director general in DG SANCO. And we meet them a couple of times a year, but it’s not fixed. It depends on what’s happening politically basically, so we have established relations with them.” (Director of a pan-European NGO)

From the NGO viewpoint, industry representatives could be “pushy”, “engaged” and “committed” to selling their ideas to the EC. This was perceived as a difference in attitude:

“We as NGOs could be better at that. I have to admit it, because I believe so, and I see it all the time. The people who approach the Commission officials or the policy-makers are the industry, and it’s not that they have more to say, but you can see the NGOs, they stand in the corner and the industry always approaches. And they could just as well have been the other way around. It’s a matter of who goes. Yes, it is open.” (Director of a pan-European NGO)

Some participants noted how they are lacking resources and staff members to actually arrange, conduct, and follow-up face-to-face meetings with the Commission officials. It became very clear that industry representatives were much more active in engaging with this kind of activity than civil society groups were.

Further transparency was sought on whom the Commission is actually having meetings with – an initiative echoed in the recent work of the European Ombudsman, Emily O’Reilly.

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7 The European Public Health Alliance (EPHA) organised a Professional Development Programme (PDP) in December 2013, which aimed to “train those new to the ‘EU bubble’ to get an introduction to the European Union and more particularly to European health advocacy”. [http://www.epha.org/a/5854](http://www.epha.org/a/5854)
“The [Commissioners’] agendas need to be open. Whom they meet, when they meet them is very important. We were actually keeping track of the Commissioner at one point, because it was taking so long before we got a meeting. So we saw how often he was meeting the industry. I understand that DG Enterprise or DG Trade meets industry and not NGOs, that’s logical. I understand that when I request a meeting with the Commissioner for trade that I’m down on the list, the other ones will have priority. But when I request a meeting with the Commissioner for health, then I should come higher on the agenda and the industry should come lower. Then we got a meeting, but it took more than half a year.” (Director of a pan-European NGO)

“It’s not transparent as to who is meeting with the commission, when and on what. And I think there they should be a little bit more transparent, they shouldn’t meet willy-nilly with everybody all of the time.” (Head of Department in a pan-European NGO)

Open doors may be good for participation, but this ethos of neoliberal governance does not guarantee balanced representation, since CSOs often lack the resources (staff and time) to take advantage of the opportunity.

“They need to see how different our interests and resource are, and that is not always seen. The NGOs just have to comply if there’s no funding for participating in a meeting, there’s nothing we can do, we don’t get the decision, and there’s a certain imbalance.” (Director of a professional association)

“And of course we have a big team of experts in all areas.” (Head of Department in an industry association)

Financial support is currently the main tangible measure adopted by the Commission in aiming to level the playing field. From the smaller organisations’ viewpoint, this was fundamental to their operation, and would not compromise their independence.

“We can be already quite happy that the European Commission took into account that they needed to finance and to support some networks of NGOs in order to have a kind of balance between private interest, who have the financial means to be represented, and those who don’t have. It’s never enough but it’s already something. It’s never perfect, because it means we are very much financed by the European Commission. For some stakeholders, it means that we are biased, although we do not have this feeling. Our feeling is that actually the European Commission is letting us do our work and speaking on what we need to speak.” (Policy Officer in a pan-European NGO)

There is competition between CSOs, NGOs and industry, and also among industry players. While it was clear that the not-for-profit organisations often struggled to match the resources and influence of the for-profit stakeholders in the public health field, it is worth noting, that “not all commercial stakeholders should be put in one basket; many companies are important job providers.” (Personal exchange with a WHO Official) Indeed, small and medium-sized enterprises (SME) have different powers in the policy-making agora than big multinationals:

“With this membership it’s very difficult to get everyone on-board, and the big companies are often the leaders, they have the resources, they have the capabilities and the capacity to be at the forefront.” (Deputy Director of an industry association)

Overcoming the lack of resources, the smaller organisations pull their strengths together:
“We work with a whole lot of other organisations in formal, less formal and completely sometimes ad hoc constellations. Everybody has got some connection somewhere and if we actually work more closely together, we multiply it.” (Policy Officer in a pan-European NGO)

Despite the engagement of stakeholders into policy-making from early stages, and the open-doors approach and networking, there is a concern that governance can fail the most disadvantaged groups.

“I would say the most excluded are probably the ones who are the most difficult to reach. You have networks representing homeless people for instance, or very poor people or people with mental health issues. Those kinds of networks can have big difficulties to make their concerns heard and vocal, because they are speaking about [members of the] population who are at very high level of risk.” (Policy Officer in a pan-European NGO)

The challenges to multi-stakeholder governance become embodied through the heterogeneous field of stakeholder groups. There are those who work for-profit, and those who do not, but within this division, there are groups with more resources (funding, staff, networks) than others on both sides of the stakeholder forums.

“What is our possibility to influence the European Commission? I can say nil. We are a very small association, and one of the complexities in associations is that you have very big associations with a huge amount of people, which also have a direct economic impact, which have more economical power to balance the discussion by saying – ‘well all the health, or whatever sort of European policy you are installing, it has an effect on the possibility of people to work and so on’.” (Director of an industry association)

**Key points: Early birds and open doors**

*Pre-formal consultation is a very important time in policy-drafting for the stakeholders to have their views put across to a public body*

*The early stage is also important for the policy-makers to engage stakeholders in the process, as it creates ownership of the product*

*Open doors are good for participation, but do not guarantee balanced representation, as there remain huge power differences within and between stakeholder groups*

**The leader of the pack: Who?**

What is the relationship between participatory governance and leadership? If the promise of the HiAP and the whole-of-government/society approaches is to enable the participation of many stakeholders, pulling together and drawing from the expertise of civil society networks – who should take the lead? In terms of the EU Health Strategy, DG SANCO and their top officials were perceived as responsible for balancing different views, and forming the strategy with the EU Member States.
“I think it’s SANCO that should be responsible for it [EU Health Strategy], together with the Member States. And then the stakeholders give input. SANCO really has to take ownership and push, or else it will be floating around.” (Director of a pan-European NGO)

If a Commissioner or a Director General really wants to take something forward, they can succeed. So the persons at that level have the possibility of counteracting the enormous influence of industry.” (Director of a pan-European association)

Marrying the HiAP approach, participatory governance and leadership does not come without challenges; the stronger the stakeholder networks you have, the more dispersed power becomes:

“This is all about power. If you engage with more people, it means that you have to give away power to others so that they can lead, and trust them. And people are afraid of losing their cocoon.” (Director of a professional association)

DG SANCO is expected to display strong leadership, while simultaneously reaching out to other DGs. Whereas stakeholders see clear opportunities and benefits for public health in the HiAP approach, it also poses a potential threat to the actual existence of DG SANCO itself:

“If I look at public health in general, other DGs have taken up so many parts of DG SANCO – agriculture, food, etc. DG Agriculture is way much more now on health issues and health focus regarding food than SANCO is. Wellbeing is related for instance also to [whether] you have a job or not. So DG Employment is taking a lot of this part. DG SANCO as a branch got overtaken by other DGs on their health issues.” (Policy Officer in a pan-European NGO)

Similarly, a WHO official noted the complexities of the participatory governance approach, in that although Member States do not want to see civil society equal to them in decision-making and managing the organisation, at the same time they need the NGOs on board to aid implementation.

“Of course the WHO has to be a bit careful because it’s a Member State organisation, and the Member States think that they’re democratically managing the organisation. They don’t want to share that prerogative with NGOs or with private business. Although in reality with this multi-sectoral nature of the disease burden and the influences on the disease burden and this whole notion of whole-of-government, whole-of-society, of course you have to talk to civil society, you have to talk to private business, whether you can get too close to them is another issue, but you have to talk to them.” (WHO Official)

The data showed that the EC is perceived as being about politics, money and legal power, while the WHO is perceived primarily as representing science and guidance, and less about economic interests: “The UN is dealing with global peace and security, while the EU is about trade and business” (WHO Official). What connects these realms is that at the end of the day the policy space is all about ideologies and politics: “Everything the WHO has done in the past has been agreed by every Member State, so it must have a huge political influence.” (Member State representative)

The Commission’s official view on the global health governance is straightforward:

“The EU supports the World Health Organisation, as the leading authority on global health in the United Nations system. It speaks with one voice in the WHO’s governing bodies.” (xxxix)
In addition, the EU Council has called on EU Member States and the Commission to acknowledge an increased leadership of the WHO in addressing global health challenges. Official documents between the EC and the WHO emphasise the collaboration between these two organisations.

Also, from the stakeholder viewpoint, the relationship seems to be warming up in Europe:

“I think there’s a very, very close synergy. We’ve seen this over the last couple of years, and more and more within the EU strategy. WHO European region has actually been asked to do some of the work, which will then feed into the EU strategy. So I think that it’s very synergetic.” (Director of a pan-European NGO)

“My impression is that it’s [the collaboration between EC and WHO] progressing more and more, and probably it’s linked to the fact that for quite a long time the WHO and DG SANCO were not really collaborating in a very positive way. But it’s progressing. I would say it’s progressing quite a lot.” (Policy Officer in a pan-European NGO)

However, the supranational leadership matrix is manifold, with great challenges that revolve around accountability and funding.

“You [the EC] have the possibility of taking decisions, without having the responsibility of those decisions.” (Member State representative)

“My experience is that the Member States are very nervous always with the Commission, because of power – the Commission will decide and they will rule. So the Member States are always eager to go to the WHO, because that’s their comfort zone, they can push in their positions. Somebody listens to them; it’s their designs, their policies... What I know is that the WHO has no money and the Commission has money – that’s the difference. And you know that those who pay, they have a lot to say.” (Director of a professional association)

“After the United States government, the second largest provider of funds to the WHO is the Gates Foundation. Now Gates is not a government, he’s not a sovereign state; he’s just a very rich man who has founded this foundation. If the Member States would provide more money that would be helpful, but right now they won’t, so if Bill Gates is standing there with a very large cheque you have to be a very brave organisation to say ‘no thank you’.” (WHO Official)

Observed from the governance viewpoint and in particular from the transparency and accountability ideal, the debate is coming full circle: if the current supranational governance in public health is said to be lacking transparency, it should be borne in mind that in the alternative, and increasingly common philanthropic, governance mode there is much less “visibility of the market and its negative impact on human well-being.”

“The OECD is also focusing more on health and health systems now, and is actually asking the Member States to provide almost the same data as they do with the WHO and DG SANCO. So there are more actors, bigger actors now as well that are working on similar issues.” (Policy officer in a pan-European NGO)
**Key points: Leading European public health**

*The stakeholders expect strong leadership from DG SANCO

* Intersectoral cooperation poses challenges to leadership; many health determinants are located under different DGs

* Public health stakeholders see synergies between the recent work done by the EC and the WHO, and welcome this change

* Global leadership is attributed to the WHO

**Final thoughts: Not a village but a global system**

Health systems are messy, complex, multi-layered; European public health is a web of interests that come together to form the Health Strategies. While the issues at hand are influenced by global streams of ideologies, trade agreements, competition, economic arguments, calls for (de)regulation, and so forth, the impacts are felt locally, by individuals and communities. Yet it is important to be careful so as not to make the field appear too distant, complex, and unmanageable/governable, and not to construct a narrative in which the wickedness of the problems is close to impossible to resolve, with the mess being managed and controlled by only a few (financially) powerful actors. This is because some premises for decision-making should be very clear, namely, that health is a human right with the prevention of illness and the cherishing/creation of wellbeing a sound and ethical aim.

"Values are very important. I mean at the end of the day it’s all about values really – the political, social and economic values. It’s very difficult to prove scientifically whether Mr Obama is right or Mr Romney is right isn’t it, I mean it’s about do you share one of their values or their other values." (WHO Official)

The stakeholder interests in health strategy are numerous and often clashing, thus it is an inevitable function of supranational policy-makers to take decisions and to choose. In order not to become overwhelmed by the discord of competing voices, what must be known and made explicit is the ground on which to stand; to reflect on the many social and political determinants of health. From there it becomes possible to identify and engage with relevant partners, and to do so via health diplomacy. Networks are needed. Courage is needed. Negotiating skills are needed.

Solidarity as a value and appeals to social justice do not figure automatically or prominently in multi-stakeholder policy-making processes: "Is the moral argument good enough, or do we need also strong economic arguments? What are the arguments we can use today to persuade a Minister of Health and more importantly to persuade a Minister of Finance that investing into prevention could generate a lot of dividends?" (WHO Official)\(^8\)

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\(^8\) For example, universal healthcare is part of the Millennium Development Goals: the aim is to guarantee health care as a human right. There is evidence that universal healthcare can be economically beneficial. In the US, where universal healthcare is not guaranteed, the total expenditure is about 17% of GDP, while in continental Europe and in the UK, which do provide universal healthcare, the total private and public...
To conclude, there are some key points in this report that I wish to highlight in regard to multi-stakeholder public health governance, and want to leave the reader to ponder in terms of how they might help to inform and shape the future of multi-stakeholder health policy-making.

**First**, during my time in the field, I was surprised by how strong a community feeling there was in the public health area, and how easy it was actually to join in and discuss different topics with the stakeholders and the EC and WHO officials. This speaks volumes for the culture under study; my initial puzzlement about the policy space as an exclusive “bubble” was proven to be a misconception. Health is a challenging policy field, but the particular subculture that works in this area in Brussels and across Europe, is dynamic and porous.

**Second**, many of the study participants had a particular focus on their work (e.g. illness, social group, policy), and were more familiar with the specific related EU strategies. The over-arching European health strategy was not being used as a reference for the daily chores, however, it was said to be a highly important document as a tool to lift up health-related policy issues.

**Third**, public health does not exist in a void, but in a political space that becomes increasingly constructed/restricted by global flows of economic power. The public health stakeholders navigate their way around the wider culture of supranational policy-making, interacting with numerous groups and networks. They noted how most policies have a link to health – the ways in which they link up just need to be made more transparent.

**Fourth**, transparency regarding decision-making and evidence use in the field of public health needs strengthening. Since the influences are mixed and viewpoints many, it is fundamentally important for the decision-makers to signpost clearly how strategic conclusions were reached. What evidence was used, how and why (not)?

**Fifth**, despite the challenges to leadership and the difficulties in balancing contradictory/competing agendas of the stakeholders, participatory governance is a useful framework. Engaging stakeholders early on in drafting a health strategy provides them with a feel for the ownership of the product, thus supporting the likelihood of their involvement in the implementation. Furthermore, providing a platform for the stakeholders to get together to discuss and debate the contents of a strategy/framework, creates an opportunity to form networks, find synergies, and also to identify enemies.

Finally, I end with a word on the research methodology. Traditionally, ethnographies have not striven to produce analyses that are generalizable across cultures and locales. This is not strictly true in regard to my study; the principal themes that emerged from the data demonstrate how stakeholders operating within the European governance structures are by definition linked to global issues. The exchange between a local NGO and a Eurogroup becomes elevated to the international level via advocacy work and networking. The bubble is actually a globe.

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Expenditure is between 9.2% and 12% of GDP. See more at: [http://www.elsevier.com/atlas/story/people/health-care-policy-should-not-focus-on-finance#sthash.3H5CyZv1.dpuf](http://www.elsevier.com/atlas/story/people/health-care-policy-should-not-focus-on-finance#sthash.3H5CyZv1.dpuf)
### Appendix 1. Interview participants

<table>
<thead>
<tr>
<th>Stakeholder group*</th>
<th>Description</th>
<th>Number of informants</th>
<th>Description of informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Interest Associations (GIA)</td>
<td>Pan-European and international nongovernmental (NGO) organisations, including patient organisations, consumer organisations and social insurers. Some had a narrow specific interest in the field of health and others had broader encompassing interests</td>
<td>12</td>
<td>Interviewees 1 to 6 were Directors or Deputy Directors of a GIA; interviewees 7 to 12 were Policy Officers</td>
</tr>
<tr>
<td>Professional Organisations (PO)</td>
<td>Organisations representing professionals in the field of health</td>
<td>2</td>
<td>Interviewees 13 and 14 were Directors of Professional Organisations</td>
</tr>
<tr>
<td>Business Interest Associations (BIA)</td>
<td>Associations representing industries, and representatives of large companies</td>
<td>6</td>
<td>Interviewees 15 to 20 were Heads of Departments in industries or industry associations</td>
</tr>
<tr>
<td>EU Member States (MS)</td>
<td>EU Member State representatives</td>
<td>4</td>
<td>Interviewees 21 to 24 were representatives of EU Member States</td>
</tr>
<tr>
<td>World Health Organisation</td>
<td>Staff members who had been involved in drafting the Health 2020 and/or the European Action Plan</td>
<td>3</td>
<td>Interviewees 25 to 27 were WHO Officials</td>
</tr>
</tbody>
</table>

*Adapted from Kohler-Koch & Quittkat (2009)
Appendix 2. Participant observations at events


Committee of the Regions (CoR), **Governing a Multilevel Europe** conference, 2 December 2014


European Policy Centre (EPC) **TTIP: Implications for the Health Sector**, 19 September 2014, Silken Berlaymont Hotel

**EPC, Post-Health Council Briefing**, 23 June 2013, Thon Hotel Europe


European Ombudsman, **"International Right to Know Day" Transparency and public health – how accessible is scientific data?** 29 September 2014, Altiero Spinelli building, European Parliament

**6th European Public Health Conference**, Brussels 13-16 November 2013, Health in Europe: are we there yet? Learning from the past, building the future.

DG SANCO Conference, **Applying Behavioural Insights to Policy-Making: Results, promises and limitations**, 30 September 2013, Charlemagne Building.


European Economic and Social Committee (EESC), **Civil Society Day**, 6 March 2013

The battle against tobacco, cancer and health disease – the adoption of the **Tobacco Products Directive** event, 19 February 2013, European Parliament

**EPC Roundtable, eHealth Solutions – Additional cost burden or efficiency factor for Europe’s health systems?**, 30 November 2012, Residence Palace

Friends of Europe, European Policy Summit, **Why Health is Crucial to European Recovery**, 27 November 2012, Solvay Library

The European Policy Centre (EPC), **Active and Healthy Ageing – with ICT?**, a Policy Dialogue, 16 October 2012, Residence Palace

EuroHealthNet, **Equity Week, Working Together for Health and Wellbeing**, 29 May 2012, Renaissance Hotel

**EUROHEALTH** Net, **Equity Week** , The Road to 2020 and Sustainable Health Systems – a European challenge, 31 May 2012, Renaissance Hotel

**European Public Health Alliance (EPHA) conference – Restructuring Health Systems: How to promote health in times of austerity?** 6 June 2012, EESC Building

**DG SANCO, EU Health Programmes: Results and perspectives** Thursday 3 May 2012, Charlemagne Building

Friends of Europe, roundtable, **Encouraging Healthy Eating and Active Living in the Family Setting**, 1-2 December 2011, De Warande

Health Action Partnership International (HAPI), **EU PROGRESS Project: Working for equity in health**, 26 November 2012, Thon Hotel EU, Brussels


Brussels – the Capital of Europe II

The barbed wire is being set up around the EU quarters of Brussels – it is time for another European Summit of the Heads of State and Government of the European Union. The familiar, dull soundtrack to the meeting – dub-dub-dub-dub-dub-dub-dub – is provided by helicopters circling the sky until late at night. A few pre-agreed demonstrations are likely to appear around the EU Council buildings, where people wave placards and carry banners. They are chaperoned by a police entourage – just like the high-level decision-makers. Army troopers – carrying assault rifles – oversee the flow of vehicles.

The main topics of the meeting are immigration and security.

In the park next door, children are feeding ducks and enjoying the swings of the newly refurbished playground. I count about 10 different languages being spoken. (Research diary, Brussels, 26. June 2015)
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