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Public health on the EU agenda, why?

The creeping expansion of public health in the European Union

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Abstract

This thesis discusses the surprising evolvement of public health onto the EU agenda. The overall research aim is to investigate and develop potential explanations for the process of public health policy making in the European Union. By using Multilevel- Governance, Agenda-setting theory and Policy Networks, this thesis develops a theoretical framework for the research in question. Case study design and Process tracing are used when different documents concerning public health from 1980-2012 are analysed. The importance of convergence of opinion among expert networks in the initial phase of the policymaking process is highlighted. Four agenda setting strategies are deployed (Mobilizing supporters, Arousing interests, Capacity Building and Claiming authority) to illustrate how different actors try to place these issues higher onto the public health policymaking agenda and the difficulties for public health to claim authority on the EU level. Other factors affect the public health policymaking process, such as: external events, the issue at hand, and market harmonization. This thesis suggests that public health policymaking process should best be understood as a multilevel process, were different actors on several levels affect and reinforce each other, in this environment the European Commission acts as the central hub for public health in the European Union.

Key words: Public health, Agenda-setting, Multilevel-Governance, Policy-Networks, Policy- making
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1 Introduction

The start of the worldwide economic crisis, and especially its effect on European states and the European Union (EU), has and continues to occupy the policy agenda for the member states, the Council of Ministers and the European Council. However, the economic crisis has severely challenged the traditional belief in the supremacy of the market, and has instead led to a greater focus on other dimensions of EU-level cooperation. The EU is seen by many actors as largely an economic cooperation, with the internal market and the four freedoms, but this perception this thesis argues, is over-simplified. Quotes like this are still used frequently by scholars:

"*But even if they no longer have to be justified in functional terms, measures proposed by the Commission in the social field must be compatible with the "economic constitution" of the community, that is, with the principles of a liberal economic order"* (*Majone, 156*)

This may have been true in the context before 1990, however change is taking place. The argument here is instead that other dimensions of EU cooperation are important, even if the economic dimension remains the dominant one. One is the so called "Social Dimension" see for instance *Majone (1993), and Scharpf (1992,).* The European population is aging, and people are suffering from more welfare diseases such as obesity and cardiovascular disease. Heavy consumption of food, alcohol and tobacco are three products contributing to the risk of health complications. To give one example, by the year 2050, the number of people in the EU aged 65 and older will grow by 70%. The 80+ age group will grow by 170%[1], which clearly reflects the challenges the EU faces, with high demands on health care. To combat such health risks, more public health[2] policies could be implemented in the European Union. In that way, certain diseases could be prevented, relieving some pressures on the welfare systems of EU member states. Public health could also be seen as a cross border issue, because Europe is a common internal market where harmful substances such as alcohol and tobacco flow free. This risk demonstrates an increased need for cooperation in this policy area following the functionalist approach.

Sebasiaan Princen in his book Agenda setting in the European Union, outlines the development of social policy and public health, specifically how it has evolved onto the policy agenda. He shows empirically how there has been a shift in EU focus from market integration to other policy areas such as health care (*Princen, 2010 p. 75*). He argues that during a large part of the Community's existence, most health issues have come onto the EU agenda through the back door. According to him, EU matters have mainly been concerned with the improvement of the free movement of goods and workers. Therefore, the area of

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[1] http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf
[2] "*Public health is the science and art of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for diseases and injury prevention… Public health works to prevent health problem before they occur"* http://www.whatispublichealth.org/

health policy has been largely neglected until the early 1990's (*Ibid p.80*). This is an interesting aspect concerning the European Union, which has largely been seen as a project about markets and money, with for example the internal market and the EMU. Using wording in fundamental EU documents such as treaties, he explains how there has been an increasing focus on health within the EU. Words concerning market integration have changed since the 1980's, in favour of words focusing on purely health issues. This to some extent confirms Pollack's famous article from 1993 and again 2000, entitled "*Creeping competences*"[3].

The importance of health is also reflected in the treaties and the legal documents of the European Union:

- *European Economic Community 1957 (58)* No referral to explicit powers for the Union
- *Single European Act 1986 (87)* No referral to explicit powers for the Union
- *Treaty on the European Union: 1992 (93) art 129, Qualified majority voting*
Social protocol 1992 (93) No referral to explicit powers for the Union
- *Treaty of Amsterdam: 1997 art 152, Qualified majority voting*
- *Treaty of Nice: 2000 (2003) art 152, Qualified majority voting*
- *Treaty of Lisbon 2007 (2009) art TFEU 168, Qualified majority voting*

Also in the area of competences, this trend is evident:

- *Exclusive competences:* Only the Union legislates in this area, member states do this only when authorized or implement EU measures, (*Article 2 TFEU*)
- *Shared competences:* both member states and the Union can legislate; shared responsibility is grated to both actors to realize a common goal. Social policy is included here but excludes common safety concerns in public health. (*Article 4 TFEU*)

Social policy and public health could therefore be identified as shared competences. But the Public Health article (*Article 168, TFEU*) sets limits and boundaries for their legal use. Despite this, the union does have competence in this area which it may use. The EU has been traditionally concerned with issues related to the economy and market integration, yet has recently increased its cooperation in the public health area. How can this be explained?

• Potential factors affecting the public health policymaking process

"A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities…" (Article 168, paragraph 1 TFEU) This is the beginning of the so called public health article, which demonstrates the legal and political importance shown to public health in the treaty. Despite this described evolvement,

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[3] The expansion of community competences, what was stated in the original Rome Treaty has expanded widely and continued during crisis to new domains according to Mark A. Pollack.

scholars such as Jenny Cisneros Örnberg are questioning the real effectiveness of the public health article.

> *"The Article stresses the importance attached to public health in the political process (Randall, 2001). However, so far the article has not achieved great importance in practice, since it specifically excludes, with a few exceptions, binding legislation. Furthermore, Article 152 emphasizes that health policy is a member state responsibility and the EU should only support and supplement national actions, not substitute for them. Given the importance attached to subsidiarity in health matters, the idea of so-called added value has been presented as a criterion for EU actions and policies"*

This highlights the practical rather than solely legal dimension of public health at the EU level, namely the output on public health and the effectiveness of public health in the European Union. How can this dimension be understood? To put public health on the EU agenda is one step, but taking decisions among 27 member states is another more difficult and important step. Scharpf's concept of the joint decision trap could contribute to a better understanding. Scharpf's definition of the joint decision trap suggests that the requirements of (nearly) unanimous decision-making in the EU's Council of Ministers, combined with conflicting preferences among member governments, will systematically limit the problem-solving effectiveness of European Policies.

It can be argued that the Council of Ministers and the member states are not giving much priority to public health, and mostly take national decisions in this area, ensuring that other, "more important" issues such as the economic crisis continue to occupy the policy agenda. However both the European Commission (EC) and the European Parliament (EP) are active in promoting public health. for example the Commission regularly releases action plans such as one entitled "*Health Programme 2008-2013*[4]" Also the creation of Directorate C, which works to address public health questions within the Directorate General of Health and Consumers[5](SANCO) is an example of the EU taking public health policy more seriously. Other important actors are, for example, NGOs and interest groups such as the European Public Health Alliance (EPHA[6]), which push for public health to take a more prominent role in the European Union arena. Questions from Members of the European Parliament (MEPs) on the floor of the EP have also shifted from issues such as those focusing on harmonization of taxes and exercise duties on products like alcohol and smoking, to those focused more directly on public health, such as on the negative health impacts of tobacco and alcohol consumption rather than simply their economic impact. Lobbying is also big in this area with, for example, the tobacco industry pushing for their own interests (*Princen, 2010 p. 83).* Public health is regulated in the treaties and has been set on the European agenda, but despite this, Europeans have not seen increased actions from the governmental institutions, Council of Ministers and the European Council in this area.

What actors are the drivers behind the Public Health process? And how do they affect the process?

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[4] http://ec.europa.eu/health/programme/policy/2008-2013/index_en.htm
[5] http://ec.europa.eu/dgs/health_consumer/index_en.htm
[6] http://www.epha.org/

Public health and especially the view on tobacco and alcohol are two politicized products with different public perceptions about their respective risks. For instance with tobacco, certain countries in North Western Europe, such as Iceland, Ireland and the UK, have adopted far reaching anti-smoking policies while others such as Austria and Latvia have been much less active (*Ibid*). On the alcohol front, the Nordic countries have adopted policies to reduce the consumption of alcohol, such as Sweden with its state-run monopoly on the sale of alcohol products, while there are others such as Germany that see alcohol simply as a commodity. This highlights deep tensions between the member states, and perhaps the ability for the Union to act jointly in certain areas of public health. These two products are also examples of how the EU has succeeded and failed in reaching a common understanding. Princen states the following:

> *"Both smoking and alcoholism issues have come onto the EU: s governmental agenda: that is, the set of broader issues that are discussed among policymakers. However, alcoholism issues have hardly appeared on the EU's decision agenda (the set of issues that are up for active decision- making), while smoking issues have established themselves firmly on that agenda"*

Other examples where the issues are not so deeply politicized are Thalidomide (discussed in 1965) which is a harmful pharmaceutical that trigged actions for regulatory harmonization in Europe. Acquired Immune Deficiency Syndrome (AIDS) and BSE (better known as Mad Cow Disease) were other health-related issues on which there has been EU-level cooperation (*Ibid p.80).* These issues are not that highly politicized and there is a common perception about the risks.

How do diverging perceptions about public health affect the process of public health policy making in the European Union?

1.1 Research formulation

The aim is to investigate and develop potential explanations for the process of public health policy making in the European Union.

1.1.1 Research questions

1. What actors are the drivers behind the public health policymaking process?
2. How do different actors affect the public health policymaking process?
3. What factors affect the public health policymaking process?
4. How do diverging perceptions about public health affect the public health policymaking process?

2 Policy- Making in a Multilevel Europe

This section represents the theoretical framework of the thesis. First will previous research bee outlined that can be used in the thesis after that follows a description over the so called new dimension "Social Europe" acknowledge by some and also critical voices describing this dimension will be analyzed. The second topic in this section represents public health in the European Union. Previous work is outlined and possible insights to the thesis are considered. After that, the thesis turn to the more theoretical dimension of this chapter Agenda setting theory, Policy making, Open method of coordination, multi level governance and finally policy networks.

2.1 Previous research

2.1.1 Social Europe

The area of social policy in the European Union has not been thoroughly investigated, in comparison to other policy areas. This of course has several reasons, one being that parts of this policy area has limited community competences. A second reason is that social policy is a sensitive issue that is closely connected to the welfare state and the sovereignty of the member states, which are often reluctant to give up this area of state jurisdiction, A third reason is that social policy is an area primarily handled by member states. This is also reflected in the literature, such as in traditional European integration theories and in the previous lack of research over a long period of time. However researchers have recently analyzed and written about the so called "Social Europe" as a new dimension of European policy, compared to the past focus on the importance of the market. This is highly relevant, with the economic crisis and a new perception about a more fragile economic system which is with is today.

Another dimension is the tension that exists between a free market without any barriers, and an interventionist system. For example, labour unions, and the harmonization of health care, are highlighted by an article by Giandomenico Majone entitled *"The European Community Between Social Policy and Social Regulation".* Another article, *"Contours of a European Social Union in the Case-Law of the European Court of Justice,"* explores the tension between national welfare systems and the rights of the citizens (Koen Lenaerts and Tinne Heremans). Other studies concern labour laws, working rights, and the role of the national welfare state (see *The European Social model (Scharpf, 1992)* or the Union's global role in social policy (see *"The European Union's global social role"* by Jan Orbie, Lisa Tortell, Robert Kissack, Sieglinde Gstöhl, Jan Wouters and Nicolas Hachez). Another example is the article "*Towards A European Social Model? Trends in social insurance among EU countries 1980-2000" by* Ingalill Montanari , Kenneth Nelson and Joakim Palme.

Pochet & Degreyse outline in their article the evolution and progress of social policies, also describing the new trends in the Lisbon treaty (see "*Social Policies of the European Union").* Monica Threlfall argues that a regional integration process in a wide range of social fields developed in the EU despite facing both problems and dilemmas during the years of the integration process. (see "*The Social Dimension of the European Union Innovative Methods for Advancing Integration").*

These examples may demonstrate an acknowledgement of other dimensions of European Union cooperation that go beyond economic matters. To show that public health is a growing and evolving policy area in the EU that is in need of further high-level research, the next section will continue with previous research on public health in the EU.

2.1.1.1 Public Health in the European Union

"A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities…" (Article 168, paragraph 1 TFEU)

This is the beginning of the so called public health article, which demonstrates the legal and political importance shown to public health in the treaty. As stated in the Research aim, my main interest is not social policy as such, since social policy consists of a broad range of issues such as labour standards and labour laws. However, public health is the focus of this thesis. Scholars in this area have mainly focused on certain products concerning public health. For example, Jenny Cisernos Örnberg focuses on the "The Europeanization of the Swedish alcohol policy". This article is somewhat limited due to its narrow focus on Sweden however there are certain aspects that are interesting. For example, she uses the concept of framing products, in this case to be a public health danger instead of being seen simply as a commodity. Framing as a concept that will be elaborated as a theoretical tool later in this thesis. This author has also written about gambling "Gambling problems as a political framing: Safeguarding the monopolies in Finland and Sweden" Another product is tobacco with "European policymaking on the tobacco advertising ban: the importance of escape routes " Sandra Adamin, Esthet Versluis and Hans Maarse, With food, asbestos, chemicals and gender equality "from Common market to Social Europe. My aim is not to focus on certain products, dilemmas or one member state, but instead focus on the policy process of the Union on public health, and from that result emerges possible explanations to why public health has appeared on the agenda. In order to analyze the process and understand the policy process a theoretical framework needs to be constructed that follows in the next section.

2.2 Policy making in the European Union

The argument in this section is that policy making and the surrounding logics in the European Union differ depending on which policy is in focus. Each area attracts different actors and the institutional elements are different etc. To understand the public health process, an understanding of the policy process in general is required as a basis. This will be further elaborated below.

Policy making in the European Union needs to be defined more broadly in order to create a model that explains public health policy making in the European Union. The public health policy process should also be defined independently of the general policy process. Regarding the policy making process in this area, work has been done with, for example, the book "*Policy- Making in the European Union"* by *Helen Wallace, Mark A. Pollack, and Alasdair R. Young.* Gerda Falkner's book "*the EU decision traps: Comparing Policies". Fritz Scarps book "Delegation, agency, and agenda setting in the European Community"* These three books contain chapters concerning social policy, and especially a focus on the policy making process in the Union. One book describes the process of putting issues on the EU agenda *"Agenda Setting in the European Union" by Sebaastian Princen.* These books will serve as an inspiration in creating a model of the public health policy process in the European Union. However as Majone has stated,*"No single method, however powerful, can match the complexity of European Governance" (Majone 2006 p.16).* Being aware of that, an extensive discussion is required.

In order for me to define and understand the policy process of public health, categorization and definition of different *policy modes*[7] *is required*. My first notion of understanding is that policy making in the European Union differs considerably between different policy areas. This follows along the lines of for instance Mark Pollack's statement "*The need to guard against overgeneralizing about the EU policy process, But instead being open to the prospect that policy-making may differ considerably and systematically across issue areas" (Pollack & Wallace, 2010 p. 16.* This notion is not new when scholars analyze national policy making (*Kingdon 1995, Loui, Jones & Baumgartner 1997 and Princen 2004*), however this belief has not always been well anchored among scholars of European integration theory. One example is the distinction made between high and low politics. Foreign policy could be an example of high politics that is closely connected to "hard" issues of state and the sovereignty over the state. Low politics on the other hand concerns "softer" issues such as trade policies and environmental law where the pressure from societal groups is high and influential, as seen from an intergovernmental perspective. But this kind of ranking of issues is not very accurate and neglects issues such as financial crises and pandemics that can change state behaviour drastically. Instead, this kind of ranking focuses too much attention on state behaviour as the only actor, and the focuses on the so called "*Grand bargains" (Morcavick),* to the detriment of the importance of daily policy making. This view contributes instead to an oversimplification that is unhelpful within a sophisticated policy environment such as the EU. Intergovernmental approaches have a tendency to diminish the importance of daily policy making processes, and assume instead that the important decisions are taken and set in the EU treaties (*Princen, 2010 p.5*) Neo functionalism on the other hand, predicts quite deterministic outcomes, and increasing integration, and thus has a hard time accounting for stagnation in European integration (*Ibid p.6)*

Instead a more detailed and more feasible way to describe the whole policy process is Alasdair Young's understanding of the policy process. Alasdair Young outlines the different steps, in a more detailed and clear way (2010 p. 52-67)

Agenda-setting: deciding what to decide

"*Agenda-setting is the outcome of an interplay between various actors in different venues who*

(happen to) strive for similar policies" (Princen, 100) This step, it is argued, is one of the most important for one to understand how the public health process was introduced onto the EU agenda, and thus will help me to reach an increased understanding of the policy process. This dimension will be further elaborated later on in this chapter.

Policy formulation: what are the alternatives?
Here the theoretical concept of policy network will be utilized and elaborated, to explain how the different alternatives are carefully selected in order to create concrete policies. This will be discussed in a later section.

Decision-making: choosing what (not) to do

Implementation: national legislative and executive politics:
Implementation is an important element. However, in order to consider the aim and the questions in this thesis, implementation will not be brought into the empirical analysis and investigated. Rather, it is the evolution of public health that is most interesting, so the process leading to the outcome is more important than the actual output from the policy area.

Policy feedback: completing and shaping the policy cycle:

The policy process more broadly, is fundamental to a good understanding of the model proposed here. This, along with the actual implementation part of the process, will help to constitute an understanding of the policy process in the European Union. Within the policy process, different policy modes should be defined, as they are key to understanding this policy process.

One way of categorizing different policy modes is using Helen Wallace's definition. She goes through five variants of policy modes. The classical Community method, the EU regulatory mode, the EU distributional mode, policy coordination and intensive transgovermentalism are those five modes. These five modes provide the advantage of avoiding the classic debate between policy making as supranational, and policy making as intergovernmental, as seen by *Wallace (2010 p. 90*). Majone elaborates around different policy-making modes in his book, and also concludes that the traditional distinctions between intergovernmental and supranational are not feasible. This argument supports this thesis. Explained by Wallace, policy coordination as a new policy mode will be discussed and used.

Policy coordination: Policy coordination is characterized by the following elements according to Wallace:

- *The Commission as the developer of networks of experts or epistemic communities or of stakeholders and/or civil society, and accumulating technical arguments in favour of developing a shared approach to promote modernization and innovation;*
- *The involvement of "independent" experts as promoters of ideas and techniques;*
- *The convening of high- level groups of national experts and sometimes ministers in the Council and occasionally the European Council, in brainstorming or deliberative rather than negotiating mode;*

- *The development of techniques of peer pressure, "benchmarking", and systematic policy comparisons in order to encourage policy learning;*
- *Dialogue (sometimes) with specialist committees in the EP as the advocates of particular approaches; and*
- *Outputs in the form of "soft law" and declaratory commitments rather than "hard law" and binding commitments oriented at gradual changes in behaviour within the member states.*

This mode is the one most closely related to the public health process, and captures key dynamics of the process. Also it is also the one that is most closely related to the public health article in the treaty which has been described. This model could help in understanding the public health process better, and help to better sort the empirical material when the research is conducted. One element that I consider to be of extra importance to understanding the public health process is the agenda phase, which will be further elaborated in the next section. My understanding is also of a multi-level European Union, working in different networks in order to form policies or issues. Therefore the agenda phase and a multi-level Union will be the theories described.

2.2.1.1 Agenda- setting theory

The importance of agenda setting in the European Union has largely been neglected by many scholars. Although a few scholars have written about this (*Tallberg, Princen)* to mention two, the bulk of agenda-setting studies have been done in the domestic policy arena, and especially in relation to the United States (*Kingdon, Loui, Baumgartner and Jones).* The main inspiration for agenda setting comes from Sebastian Princen, Jonas Tallberg, Pollack and Wallace, who use concept and definitions which are applicable to the EU context.

So why focus on Agenda setting? Sebastian Princen outlines three explanations as to why we should pay more attention to agenda setting:

1. A greater understanding of policy making in the European Union should be acknowledged; deciding which issues are on the agenda is as much political as deciding the actual issues themselves;

2. It may contribute to highlighting possible "structural biases" that are inherent in the policy making process; the institutional and political framework favours certain interest over others, by analyzing the agenda this can be identified.

A greater understanding of the general European integration process can be acquired, for instance which issues and range of issues the EU deals with can indicate certain patterns (*Princen, 2004 p.22)*

Agenda setting is said to be a highly political process, within which different actors seek to push for certain issues[8]. Along with this, certain issues are excluded from the agenda by certain actors if those actors determine that changes are not required (*Princen, 2004 p.21).*

The Commission is usually portrayed to be the chief agenda setter in the European Union. This perception is over simplified. As Princen notes, the Commission does not act in a vacuum, it is instead influenced and directly confronted by a range of actors both inside the EU but also outside (*Ibid, p.23).* Instead the focus should be on the process, and the factors that shape the political agenda. It is practically impossible to trace the start of an issue or proposal because it is generally not possible to trace the vital source of an idea. A more feasible way to approach it is to identify the set of political or other factors that contribute to the rise and fall of issues on the political agenda. The focus should be on the process in which actors form coalitions and how issues are framed. (*Ibid, p. 23).*

Baumgartner and Jones (1993) have created an interesting approach called "venues" for policy making, an approach which has been later adapted by Princen (2004) to fit the conditions in the EU. Venues are the formal decision making arenas in a political system. The institutional design of these venues is important because it determines which venues are available for decision making. There are three conditions that affect which venues are available:

1. Which specific task(s), authorit (ies) and resource(s) are available?
2. Who participates in it?
3. The procedures by which it comes to a decision?

A useful method, according to Baumgartner and Jones in successful agenda setting, is to pick the correct venue to pursue the actors' motives. (*In Princen, 2010 p.11*). They continue and outline that often for fundamental policy changes to take place; actors must successfully change and use venues that are most receptive to the issue at hand. This is outlined in a famous theory they choose to call *venue shopping* (*Princen, 2004 p.27).* Even if this is applied to the US context in their work, this theory can also be utilized at the national level of democracies or within the present EU institutions. However the EU is substantially different from the nation state and this should not be forgotten. As mentioned before in the policy making process, the institutional design and the actors differ according to the political system in place. This contributes to the fact that certain issues attract more reception by the EU while others attract less. The EU also consists, through its institutions, of alternatives venues were issues can be addressed. For example the Commission is a different venue than the European Parliament. This theory can even be applied on a more detailed level, where different Directorates within the Commission have contained within themselves different venues which deal with different issues. This reflects the dynamics of agenda setting process, and the shifts in the overall EU agenda (*Princen, 2010 p. 12).* However agenda setting in the European Union cannot be understood as a separate process; different venues complement each other in terms of what they can specifically contribute to the issue. The debate within one venue can strengthen the debate in other venues. In other words, this can be considered similar to the

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[8] *"An issue may be defined as a conflict between two or more identifiable groups or procedural or substantive matters relating to the distribution of positions or resources (Cobb and Elder 1972 p. 82)*

multi-level governance perspective, with several levels affecting the process within the EU level as a whole (*Ibid p.15).* Also the argument that domestic groups sees the EU as an alternative arena to bypass their governments on certain issues. "*The EU, then simply becomes an alternative lous of decision-making for groups, politicians and civil servants seeking the most favorable place to push for their preferred policies"* (*Ibid p. 27*). To sum up, an actor who wants to place an issue onto the international agenda has a choice between different venues that hold different views on different issues. Whether an issue ends up on the EU agenda depends on if that is the right venue for the issue, and if the EU has the correct tools at its disposal (*Ibid p.30).* One example of this is EU's regulatory instruments used with a given issue. The use of an instrument differs considerably between different policy areas, and whether an instrument is legally binding (meaning the EU can legally enforce the decision) can make a difference (*Tallberg, 2002).* The EU's recommendations and soft instruments that are at hand may also be of use in agenda setting, since hard power tools are not always the best approach. For some important issues, a consensus on international issues is required using soft instruments, so consensus may be reached within venues which offer these instruments instead. The discussion of soft legal instrument in the EU will be discussed in the next section.

Three different agendas can be identified in the literature: the political or formal agenda, the public or systematic agenda, and the media agenda. The focus here will be on the political agenda, which can be explained as the set of issues that are seriously considered by decision-makers. The reason for this choice is that this thesis focuses on the policy making system of the EU, not on the opinions from media and the public (*Princen, 2010 p.21).* Three key concepts can be identified in the agenda setting literature: *conflict expansion*, *issue framing* and *institutional constraints*. These three factors play a prominent role in deciding if the issue ends up on a particular agenda.

Conflict expansion: One key to get an issue high on the agenda is to extend conflict to an increased amount of actors. This can be done by gaining the attention of not just a small circle of experts, but also from the public as a whole (*Baumgartner and Jones 1993: 83, Cobb and Elder 1972, 103, Schattschneider 1960:3).* For example, environmental groups can politicize an issue to raise public awareness, and simultaneously include a larger group as its audience. In that way, they force the issue higher onto the public agenda. From here, decision makers are more likely to take up the issue for consideration, since more public focus is trained toward the particular issue (*Princen, 2004 p.29*). Another important aspect in conflict expansion is the concept of *framing. "By defining and re-defining an issue, the line between proponents and opponents of a proposal may be drawn differently"* (*Ibid p. 29*). Kingdon (1975) gives the example of mass transport, where the proponents of greater investments in this sector have tried to sell their program as a solution to traffic congestion and environmental pollution. In the EU context, the actor also needs to demonstrate why the issue should be brought up to the EU level. To do this, an actor needs, to some extent, to construct a story as to why the issue is truly European in scope (*Princen, 2004 p.32).* For example, anti-smoking policies have used economic integration arguments in order to bypass the legal restrictions on health related harmonization, even though their motive concerned public health and not economic barriers (*Ibid p. 33*).

Another important element that can change the agenda drastically is *external events.* These are typically completely unthinkable and unanticipated, but can drastically change the landscape. For instance, after the terrorist attacks of September 11, 2001, and the fight against terrorism, are two examples (*Ibid p.30). Institutional factors* are also fundamental for agenda

setting. As mentioned previously, there are some institutions which are more receptive to certain issues than others. Because institutional structure is part of what determining which interests get access to the agenda, it is fundamental to understanding agenda setting.

However when applying conflict expansion to the European Union some important notes are needed. EU decision-makers are much less likely to be vulnerable to public mobilization than respective national decision makers. This has to do with lack of direct accountability to citizens from the EU level, and the lack of an integrated public sphere at the EU level. Citizens of the European Union primarily identify themselves with their respective nations rather than with the EU (*Scmidt, 2003*). *"As a result, the member state level dominates the European level as a focal point for citizens' political loyalty and interests"* (*Princen, 2004 p.31).*

When actors shift an issue to the EU level, this could contribute to increased conflict expansion, in the sense that participation from other member states becomes involved in the issue. This could contribute to a change of how the discussion is framed. It could also contribute to a decrease in conflict expansion, in the sense that public mobilization is weaker on the EU level and less relevant, for certain actors, could this be advantageous because decision makers at the EU level is often divided among functional lines. For example environmental policies are decided by the Environmental Council, which is made up of environment ministers, so the result of shifting an issue to the EU level can result in the exclusion of certain industrial interests that are represented through ministers of economic affairs (*Ibid p.32).* For instance it makes quite a difference whether energy policy issues are discussed by environmental policy makers, or by economic policy makers, or by foreign policy makers. Every policy maker will hold a unique perspective on the issue at hand (*Princen 2011 p.929).*

The European Union is also unique in the sense that it has many access points and quite demanding decision making rules. This results in a situation where getting an issue on the agenda is fairly easy, because there are many actors that may take up the issue. For example, a party group in the European parliament. But the difficulty lies in spreading the issue to several actors in the EU, because it has a multitude of veto players who may veto the proposal. Connecting this to the policy process, the main problem lies often in the decision making step, and the implementation step. In order to have successful agenda setting in the European Union, the actor needs to form a high degree of consensus among important players. Princen outlines three ways such a consensus could arise:

1. "*The views of policy making from different member states may converge around a given approach. Such a convergence can be aided by the strategic framing or issue in ways that make them more attractive to a wider range of actors"*

2. *"An issue may affect a wide range of member states, making it more salient for a larger number of actors"*

3. *"Some external event with transnational repercussions may focus the attention of policy making in a range of member states and EU institutions. In the absence of such factors, however the, issues will usually linger in the lower range of political agenda"*

(*2004, p.33-34*)

In Princens article entitled *Agenda- setting strategies in EU policy processes*, (*2011)* Princen develops the four strategies that can be used to put an issue on the EU agenda: mobilizing supporters, arousing interests, capacity building, and claiming authority I will briefly describe these four strategies.

Mobilizing supporters:
Here two main strategies can be identified according to Princen, venue shopping and venue modification. Two types of venue shopping can also be described: horizontal venue shopping between EU institutions, or vertical venue shopping between different levels in a multilevel system in which the EU exists (*Princen, 2011* p.931).

Horizontal venue shopping is helpful here, especially given that the institutions are divided along functional lines. There are for instance certain Directors General at the Commission, different groupings in the Council of Ministers etc. This enables actors to put an issue in a special context that excludes potential competitors or interests. Vertical venue shopping is another way to bypass the opposition in the member state. To take it up on the EU level, for example, companies and firms send complaints to the European Commission about barriers to trade, this resulting in important implications for the internal market project. Another way to put an issue on to the EU agenda is to appeal to an international organization first, in order to put pressure on the EU in a later phase of agenda setting. The World Health Organization has for instances played an important role in putting issues that are connected to public health, such as alcoholism and mental health on the agenda (*Kelly 2008 p. 60*).

Another way to go about is to create suitable venues for the issue, or at least modify the venue. An example of this is when presidencies in the EU sometimes change the configuration of the Council of ministers in order to discuss other issues (*Tallberg 2003 p.8*). Other important considerations the presidency must consider, include how frequently meetings should occur, what policy making actors should be included in the decision making process, etc. (*Ibid p.10)*

Arousing interests:
Another important factor for an agenda setter is to frame the issue so it attracts wide interest. This can mainly occur in two ways according to the literature, through using uncommon, complex terms, and through moving in small steps. Using uncommon and complex key terms can express an issue that is related to EU values and "identity" for example human rights and democracy. Another way to approach it is to connect the issue to policy priorities and action plans. For example, the Lisbon agenda has been used to advance several issues, because the importance given to Jose Manuel Barroso as the Commission president.

Another strategy is to build up the issue slowly using small steps. One popular way to do this is to conduct a study that highlights a possible need for an initiative at the EU level or at least start a debate (*Princen 2011 p.934).* The presidency can hold conferences on special topics, or hold informal meetings to start arousing interest in a given area. This applies to other EU actors also (*Tallberg 2003, p.6-7*). The final element in this strategy is to focus on small non-controversial aspects of an issue, in order to build up more support for the area. One example that Cisneros Örnberg discusses is alcoholism. Several of the proponents for combating this issue wish to delimit the availability of alcohol. However, this is too controversial to present a viable option. Instead, the proponents use small steps such as highlighting drunk driving, and hope that this will form a stepping stone towards a broader discussion about alcohol Abuse and policy (*2009, p.769*).

Capacity building:
Often when the issue is new to the EU agenda, the proponents need to assure all parties that sufficient organizational capacity exists, in order to motivate involvement by the EU. This capacity building exists both inside the EU and outside the EU (*Princen, 2011 p.935).* One way to do this is to send national experts to the Commission, who can help with the process and increase the capacity of EU institutions in the given area. In the European Parliament, different informal interest groups are formed around a specific issue such as aging that involves different MEPs; NGOs that share the same interest about an issue can work as networks in promoting a special issue to the EU agenda. Over time these networks can develop into EU level policy communities that organize the receptiveness to issues once they have been introduced to the EU agenda. The Commission helps in this process by subsidizing different interests groups. It especially subsidizes those groups which are especially constrained financially. The Commission together with interest groups tries to develop expert networks that can give expert knowledge in a given issue area. Closely related to this is so called networks of exchange of best practice. In areas were binding legislation is politically or legally not available, this could contribute to the development of "European-wide consensus on best practices, which can be used as a basis for further discussion at the EU level" (*Ibid*, 936).

Claiming Authority:
Claiming authority can be separated into two categories: linking an issue to existing policies within the EU, and identifying common ground. In order to link new issues with old ones, new issues are typically advanced using old issues as their base or as examples. One common way to do this is to advance the issue to the internal market as a basis. One example is the obligation of an EU-wide ban on tobacco advertisements, which was publicly justified because referencing possible barriers to free trade if differences in regulatory rules between member states were allowed to stand (*Princen and Rhinard 2006 p.1124).* This is also reflected at the European Court of Justice, which has ruled in favour for arguments such as this (*Hilderbrand 2002 p.22).* This strategy can also be used in more general claims, for instance that the EU should promote economic development and therefore a particular issue being advanced could help in this objective. The final method of linking an issue is to argue that an existing policy area in the EU affects the issue the agenda setter is trying to promote, and it therefore needs to be dealt with the EU level. One example is existing EU policies that affect cities. Instead of creating an independent urban policy area, other policies have been modified to become more "urban sensitive" in order to avoid a debate about new EU competences which would be too controversial. (*Atkinson 2001 p. 387*).

The other dimension here is when an issue cannot be linked to an existing policy. One way to approach the problem is to try to find a common ground among different actors in the EU. For example, the Commission has argued that since most member states need to deal with similar problems, such as aging, it make sense to develop common approaches to problems. By doing this the Commission opens up for debate issues which can possibly trigger policy initiative in the future. To sum up, the following table may help to see the different strategies that can be used.

	Venues	*Frames*
Gaining attention	Mobilizing supporters	Arousing interests
Building credibility	Capacity building	Claiming authority

It is argued, using agenda setting theory that analyzing the public health process could help in identifying relevant actors and driving forces behind the evolution of public health. By using the modified *Venue shopping* theory, a greater understanding of the public health process will be acquired. The framework is also built on Princen's typology of four different strategies that can be used in bringing an issue onto the agenda. The two key concepts which are reflected in the literature that are needed to successfully place an issue on to the agenda are gaining attention and building credibility. They work through two analytical instruments, venues and frames. These concepts will be investigated further in relation to the public health process, in order to gain a greater understanding of it. Potential venues in the public health process will be identified, and the concept of framing will be applied to different issues in the public health process. The different strategies described in this section will also be investigated within the public health process, to identify if they can be applied properly. As already discussed earlier, much of the output in public health is more prone to the use of soft legal instruments such as recommendations and benchmarks. Therefore a discussion of the Open method of coordination (OMC) is needed to further the understanding.

2.2 Open Method of Coordination (OMC)

Social policy and public health in the European Union sometimes use soft legal instruments such as declarations and the new mode called open method of coordination (OMC). The legal instrument OMC was introduced during the European Council in Lisbon 2000, and aims to fix guidelines and timetables for short, medium, and long term goals. To do this indicators and benchmarks were created to compare best practices. By translating European guidelines into national and regional policies, specific measures, targets, and periodic monitoring could be achieved of the progress achieved in order to put in place mutual learning processes between member states. [9] The OMC collects all the old "soft law" instruments under one name, such as collective recommendations, review and monitoring (*The OMC and the new governance patterns).*

Scholars in this area are for example: Sandra Kröger (see "*The Open Method of Coordination: Underconceptualisation, overdetermination, de-politicisation and beyond"),* and Luc Tholoniat with his article "*The Career of the Open Method of Coordination: Lessons from a 'Soft' EU Instrument"*. This debate could be described to have two sides, scholars that define OMC as a useful legal instrument, and opposing this view, researchers who claim that this instrument is not useful. It is therefore important to analyze this debate in order to draw useful conclusions that can be used in the EU public health context[10]. Milena Buchs explores the debate surrounding OMC, and the difference that distinguishes the two sides. There are the "optimists" and the "pessimists," which according to her concentrate on different questions. "Optimists" are more interested with the question of whether OMC exerts influence at the national level, and through which mechanisms. "Pessimists" according to her concentrate on

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[9] http://ec.europa.eu/invest-in-research/coordination/coordination01_en.htm#1

the question of whether the OMC can strengthen EU social policy, and therefore the European welfare state. In the words of Milena Buchs:

> *"They regard the introduction of the OMC as a political compromise that aims to strengthen EU social policy against the EU's economic objective but has to rely on soft coordination due to a range of barriers to the adoption of legally binding social policy framework at the EU level"*

However this is seen by pessimists as a second best solution, which is too weak to be able to influence national governments and social policy, against the dominant and prevailing policy focus of the EU which is market integration.

The "optimist" on their hand highlighting the effectiveness of soft law, because it is not binding, contributing to policy experimentation and a better problem formulation on the ground. In their opinion, soft law contributes to decentralized policy making, and the involvement of a magnitude of policy actors in the policy making discussion. This understanding is also reflected in the agenda setting literature, were so called "hard law" is not necessarily the most effective if the actors are attempting to introduce a new issue on the agenda and break a deadlock. This could be a starting point, in order to discuss an issue that may in the future contribute to something with more substance.

"Optimists therefore regard soft law as more suitable than hard law for operations within a context of diversity in which different policy solutions are required in different member states"

The optimists continue to claim that soft law could be more effective than hard law because it induces long-lasting policy learning, and because it has the potential to influence deep-seated values and attitudes (*Buchs, 2009 p. 3*). The key mechanism for optimists is policy learning. "Pessimists" are sceptical about the ability of soft law to influence member states, mainly because sanctions do not exist for member states that do not follow the EU's advice and thus break soft law principles. Also the question of path dependency stresses that OMC recommendations and targets are unlikely to have a significant influence on national policies if large "misfits" exist between them and national institutions.

OMC could be described as a multi-level tool involving many actors, which is also related to the notion of understanding multi level governance. OMC is also connected to public health, and the following is stated in the Lisbon Treaty paragraph 2 article 168 TFEU:

> *"The Union shall encourage cooperation between the Member States in the areas referred to in this article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the member states to improve the complementarity of their health services in cross- border areas.*
>
> *Member states shall in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the member states, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organization of exchange of best practice and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed"*

As highlighted here, the picture in the literature is fragmented and varies between different scholars. My argument follows along the lines of agenda setting theories; that in order to bring new issues, and especially sensitive ones onto the EU agenda, it could be easier if the issue is set out as non binding. If it is binding, there could be a risk that member states are reluctant to discuss sensitive issues, and therefore the issue will not be brought up in the first place. It is left to see if this applies to public health.

2.3 Multilevel- Governance (MLG)

The theory of Multi-level Governance will assist an understanding of the overall elements of the European Union, and the overall policy making system contained within it. It is argued that this theory accurately reflects the policy making process of public health. Therefore is it important to note that MLG works as a theoretical frame, to acknowledge that there are several levels affecting the policy making process, and rejecting the traditional notion that the member states are the only important actors. MLG should not be understood as an explicit tool, but rather a choice argument for agenda-setting theory and policy network analysis. It can also be said that all three of these theories, in some ways, are reasoning in similar ways and can be described as governance perspectives. Scholars defending a more state-centric approach can of course criticize this choice of theory. As with all the other theories used in this thesis, the aim is not to discuss the integration aspects of Europe because that topic has already been covered extensively in the literature, but instead to understand why the public health process occurred as it did. To explain an outcome and to acknowledge the importance of other actors besides just the member states is important. Although member states can be seen as *"gate keepers," they are not the only important actors today in the European public health process*. So a combination of these three theories will help in the quest to develop potential explanations for the public health process developing as it did, and also to acquire a deeper understanding of the theory and practice of public health at the EU level. With the evolution of the European integration process, European governance has become more complex, and can be described well as a "*complex web of interconnected institutions, and sub national levels of government"* (*Hooghe and Marks, 2001 p.282.)*They outline that member states governments do not always get their way. This can for instance occur when they are outvoted at the Council of Ministers, or bypassed by their own local governments, by interest groups etc (*Ibid).* MLG can be described as another way to describe the EU system, compared to the intergovernmental perspective which would describe it a different way. European integration is instead understood as a policy creating process, in which authority and policy making are shared across multiple levels of government, sub-national, national, and supranational (*Ibid, p.283*). Multi-level governance is reflected within many EU institutions, for instance, increased power for the European Parliament, the influence of supranational institutions like the Commission, and the change of decision rules with more qualified majority voting. (*Ibid p.290*). The tipping point for this evolution could be said to be the Single European Act, where more issue areas grow, and where more domestic groups were active in the EU arena. This resulted in the kind of political competition that the national states are used to, and which has now been introduced to the European Arena (*Ibid p. 291*).

“Multilevel governance has opened up opportunities for public and private interests of all kinds to enter the policy-making process, thus gently, almost imperceptibly, undermining the state sovereignty” (Ibid. p.282).

Multilevel governance can, by and large, be said to be more descriptive than theoretical, especially in the way that it changes how we look at the EU, and encourages scholars to search for theories with domestic elements rather than international politics which can contribute to explain policy outcomes. For instance the Commission is seen as holding the pen but it is affected by many actors, EU institutions and also interest groups when it comes to policy initiation. This relates to my thesis and my underlying argument, too often, so called “Integration theories” are used to explain or simplify the policy process in the European Union. However, here, more traditional concepts such as agenda setting will be used instead. MLG has also highlighted new regional entities with the member states, which can help in legitimizing the EU and coming closer to the people. In addition to this, social and political groups which have received little attention in other situations may acquire influence through this (*Peterson 2009, p. 105).*

The overall understanding is thus that the nation state is no longer the only exclusive focal point between domestic politics and international relations. The policy making system in the European Union consists of a multilayered architecture, in which several actors affect the policy process. Another dimension is the importance of networks and the influence they hold. This aspect will be discussed in the next section namely Policy Networks.

2.4 Policy- Networks

As described at the outset, it can be said that policy networks are of special importance in the policy formulation phase, where potential alternatives to decisions need to be narrowed down in order to arrive at a decision. Networks can be defined in the following way: *“the term network is frequently used to describe clusters of different kinds of actors, who are linked together in political, social or economic lives. Networks may be loosely structured but still capable of spreading information or engaging in collective action”* (*Ibid p.105).* Importance under network theory is placed on the linkages between organizations, rather than on the organization themselves. Policy networks can be defined as “*clusters of actors, each of which has an interest, or “stake” in a given policy sector and the capacity to help determine policy success or failure” (Ibid).* Or alternatively, institutions that are a*“Set of formal institutional and informal linkages between governmental and other actors structured around shared if endlessly negotiated beliefs and interests in public policy-making and implementation”* (*R. Rhodes 2006 p.526).* One broad characterization of networks is the policy community, which has stable membership, and excludes outsiders. Members rely heavily on each other, and are often also heavily influential in policy formulation and in pushing for their own members’ issues. The issue network is the second group, which is a more loosely organized, open membership grouping which usually has unbalanced membership that can lead to more competing rather than unified policy preferences (*Young 2010 p. 54).* It is very rare to find policy communities in the European Union, because of the complexity of several member states and actors with competing preferences. (*Ibid).*

Three important actors can be identified within the sphere of policy networks, namely: producers, epistemic communities and advocacy coalitions. *Producers* are often important because of the resources and the contacts they have. Often, they are required for an issue to be successful. *Epistemic communities* are important because they can contribute to identifying solutions to policy problems. Finally, *advocacy coalitions* could be described as networks within networks, which compete to push for their preferred policy solutions. Policy networks tend to contain between one or four coalitions. They can be described in the following way according to Sabatier and Jenkins- Smith:

They share a set of normative and causal beliefs
They engage in a non- trivial degree of co-coordinated activity over time
Many scholars, using policy networks, seek to explain policy outcomes. For instance, they investigate how network, that facilitate bargaining between stakeholders over policy design and detail, are structured in a particular policy area. One example of this is Falkner's description of the *social policy regime that can be explained in part as the product of collective action on the part of an emergent social policy network to create a more favorable environment for EU intervention. (Peterson, 2009 p.108).* It is especially relevant to use policy networks in an EU context because of the dependency of officials and experts on "apolitical" committees that help push the policy agenda forward (*Ibid p.107*). Policies in the European Union are fundamentally shaped and closely examined by experts and officials in the EU's committee system, both before a decision is taken and after. The EU can be described as a very powerful community, but in another sense it is very weak when it comes to resources. It often relies heavily on resources and experts held at the national level, including the private sector (*Ibid*). However this approach to networks has been criticized for merely being descriptive and lacking explanatory power. Therefore, network theory should be considered in conjunction with agenda setting theory. The different strategies that actors can pursue will bring in a deeper understanding to the process instead of only identifying networks. One proposition regarding this theory is that the way in which networks are structured in any policy area will decide and help to explain and predict policy outcomes. The aim here is to discover how the networks in the public health process are structured, and what impact they have over the process. Another argument for using policy networks is the increased technical difficulties in the policy making process. More experts are therefore needed, and they in one way "depoliticize" the issue. Policy networks can narrow alternatives and shift the agenda by pursuing different strategies that generate new political and economic forces (*Ibid 106*)". *The main contribution of EU policy network analysis to theorizing about European integration is that it empathizes the Union's inescapable diversity and complexity"* (*Ibid p. 120*).
*"To try and describe how the EU works without the metaphor of a network is a challenge, on par with seeking to explain, under the same injunction, how international terrorists operate" (*Ibid).

The theory of policy networks works "best" when it is used together with other theoretical perspectives on EU politics and policy making(*Peterson, 2009 p.* 110). This thesis will achieve this. More broadly, this perspective looks at the ways *in which network structures affect selected aspects such as the spread of information, strategies of actors, exchange amongst them and policy outcomes" (Ibid p.11). The* EU is especially interesting for scholars using policy network theory because of its quasi-federal elements, where the policy network is used as a method to manage negotiations, diverging opinions, and the exchange of resources and ideas. Policy network theory will merely be used in order to analyze the

importance of networks in the public health process, and possibly constitute an explanation of why public health was introduced onto the agenda, and what impact networks have on the public health process.

3 Case study design & Process-Tracing

Case study is going to be my research design. The public health policy area within the European Union will serve as the case study for this thesis. Below, a more detailed description of choice of case, research design and research methods will be discussed.

One prevailing argument among different scholars is that the Union has an economic dimension that is the most important one of all. Instead, the argument of this thesis is that this perception is partly incorrect, and we can identify other dimensions such as the social dimension of the cooperation which also hold importance. Therefore, I advance scholars describing this part of European cooperation. Even though this dimension is not that far developed in the literature, it is still an important and perhaps surprising element of the functioning of the European Union.

Public health has established itself on the EU agenda recently, and that is surprising because this has taken place despite public health being a sensitive topic with a close connection to the welfare system. The European Union has traditionally been concerned with economics and markets, therefore the case for public health could be said form an *deviant or anomalous case* that needs to be investigated further to identify the policy process.

The aim of this thesis is not to generalize the result to policy areas in the European Union as a whole. However the possibility does exist, in the future, to compare public health with different policy areas in the European Union. Sometimes, scholars especially the ones dealing with European Integration theories, tend to generalize all policymaking and the logic to all policy areas in the European Union, and they simplify it often. This is something that is unfortunate, and this thesis acknowledges scholars such as Falkner, Wallace, Pollack, Kingdon and Loui[11] who have studied this area more specifically, and avoid this mistake. This thesis argues that different policy areas are surrounded with their own politics and elements; therefore it is feasible to investigate public health deeper with its own contextual concepts.

In order to structure the research a theoretical connection to the case of public health is needed. What phenomena is public health characterized by? *"The Unique historical event cannot be ignored Verba notes "but it must be considered as one of a class of events even if it happened only once" (In George and Bennet 2009 p. 114).* Another task used by researchers, is to divide the causal process into different component theories that can explain the process. Below I will shortly describe these three theories and how they connect to public health. It is argued that these theories can explain the logic of the public health process, and help in the quest to develop explanations for the public health process.

[11] *Politics makes policies*, it's almost impossible to separate policymaking from politics, a more traditional political science concept, actors are involved in all stages of policymaking.

Public health as a case of multilevel governance: As with many processes in the European Union, public health constitutes a multilayered system with multiple actors that influence the process on the local, national, regional, supranational and international levels. The fact that many of the decisions are taken with novel methods such as the open method of coordination introduces new actors into the policy process and encourages new issues to be put on the decision agenda. Both the trends within each member state, and those within other international organizations such as the World Health Organization, determine partly if issues are brought up on the EU's agenda. Therefore in order to understand the public health process it needs to be viewed as a multi level process.

Public health as a case of policy networks: The Public health process includes actors such as NGOs, companies, the alcohol industry, the tobacco industry, the public health alliance, the Brewers of Europe, and policy experts. These different actors create different competing networks, which try to influence as much policy as they can. Also, the Commission picks up issues from the different networks for which to advocate.

Public health as a case of agenda setting strategies: Public health is surrounded by different actors, who try to influence a multilayered process, through framing issues, promoting the issues to different venues (arenas), and employing different strategies.

This thesis will now continue to be advanced, and later research design and method will be discussed, along with the possible limitations of my choices.

3.1 Why study public health in the European Union?

Four main reasons can be mentioned, till why it is interesting to study public health:

1. Public health has become an important policy area, with increasing obesity, cardiovascular diseases and an increasing older European population.

2. Public health highlights a new dimension compared to the dominant economical dimension, were a focus on health aspects are important. It also highlights the possible tensions between the goal of a free market and the goal of protecting health.

3. Public health is a policy area with different perceptions and some parts of the area are highly politicized which highlights interesting clashes and opinions.

4. Public health can be considered as a cross border issue that all European states deal with.

3.2 Case study design

The most important step in a case study is of course to identify the case as has been done in the introduction. Bennet and George define a case in the following way, "*We define a case as an instance of a class of events. The term "class of events" refers here to phenomena of scientific interest" (Bennet and George, 2009 p 17).* Policy areas in the European Union are the classes of events that this thesis argues are different from each other, while public health represents the case. Bennet and George continues to define case study in the following way *"A case study is thus a well- defined aspect of a historical episode that the investigator selects for analysis rather than a historical event itself" (Bennet and George, 2009 p 18).* I will now turn to both the positive aspects of the case study method, and also the drawbacks with this design.

The case study method could be said to shine were statistical studies are weak or not possible (*Bennet and George, 2009 p.* 19). Therefore I argue that case study design is the most feasible in the case of EU public health. It would be quite difficult to utilize statistical analysis conduct a study in this case. By choosing the statistical method, the research question of this thesis would have to be re-formulated, and the study would be more method-driven rather than knowledge driven *(*a weakness pointed out by *Flyvbjerg, 2006 p. 242).* The case study also captures well the contextual factors related to public health. Public health as a policy area has its own set of dynamics and merits. By using the case study, I capture these dynamics and the possibility is opened up for further comparisons between different policy areas in the future. By building on the research of this thesis with more cases in the future, a greater understanding of policy areas in the European Union may be acquired. Also the problem of *conceptual stretching* could be avoided using the case study method. The concepts and definitions that will be used in this particular case and the context it covers may not be applicable in other cases. By using case study method, it can be assured that this case will be judged based on its own context and not against another benchmark *(Bennet and George, 2009 p.19).* Statistics could have helped this thesis to measure the outputs of public health in, for example, measuring the effectiveness of recommendations and directives in this area. However has this already been investigated somewhat, and a pattern of increased action in this area can be identified nonetheless. Therefore is it more interesting to state this fact and continue instead to analyzing in depth the reasons and factors behind this evolution by using case study as my research design.

Therefore the focus in this thesis is on qualitative research, with the awareness that quantitative methods can also be used in the case study method. One weakness that is highlighted in the method literature is the issue of generalizing the result of one case to other cases. In this thesis this problem does not arise because the aim is not to generalize the result to a higher level, but instead just to the issue of public health as a unique case which is not a "typical" case for policy areas in the European Union. It is instead better, as mentioned earlier, to compare this case with other cases in order to acknowledge similarities and differences and not to create a class. *"Even when a plausible argument can be made that a factor is necessary to the outcome in a particular case, this does not automatically translate into a general claim for its causal role in other cases" (Bennet and George 2009, p.27).* The aim here, put simply, is to gain knowledge about the public health process and not translate this result to other policy areas in the European Union. (*Flyvbjerg, 2006 p. 227)*

"It is simply that the very value of the case study, the contextual and interpenetrating nature of forces, is lost when one tries to sum up in large and mutually exclusive concepts" (Peattie 2001 p. 260).

Another downside with the case study method, and with other methods, is the issue of causality, and especially in predicting the effect of causality. It is important to be careful when analyzing the result, so as not to attribute causation to any set of circumstances. The aim here is instead to identify possible explanations for the process of public health, utilizing the theoretical tools and research paths taken. It is also reflected in the literature, that many students use quantifying language when they use non statistical research methods, for example words such as "many" or "how much" which are used to measure quantifiable amounts. This is something that will be taken into consideration. The aim here is instead to form a theoretical framework and method to find possible explanations, without comparing these explanations with each other in order. This is of course a challenge, and the aim will rather be to find complementary explanations rather than competing explanations. By choosing other theories and concepts, the conclusions of this research may differ in a way that does not answer my research question. The most important part is instead to use concepts and tools that can be related to reality, and to have an open approach to the research. Case study is instead strong in assessing whatever and how a variable matters to the outcome, but does not measure how much it matters (*Bennet and George 2009, p. 27).* The case study method could also be described as an open ended process, and in this case will be applied to explain a process rather than to test a theory. The aim is to explain the process with the help of theory. Another important note is the issue of equifinality, which does not only concern the case study method but others also. The author requires awareness that an outcome can have several explanations, and that by choosing different theories, almost the same answer may be acquired (*Ibid p.161).*

3.3 Process tracing

Inspiration from process tracing could be helpful in identifying the chain of events that leads forward to the outcome. However it should be stated that this research does not aim to find strict causality, even though it would constitute a bonus for the research. Instead, it can be said that *connections* are more important here than strict causality. More important for the aim here is that the method should focus on the process rather than the outcome of EU public health. As stated before, the interest here is to formulate an explanation as to why public health is on the EU agenda. Therefore there will be a focus on the process leading to the outcome as the important element. George and Bennet state that process tracing is especially useful in deviant cases. *"Process- tracing of deviant cases offers an opportunity to differentiate and enrich the general theory" (Ibid p.215)*
Other interesting aspects that would assist are the analysis of how different actors acted during the process leading to the outcome. One way of conducting research using this method is to start with decisions that are close in time and then work backward until something interesting is found that can be shown to affect the process. In this way, it can be possible to identify so called formative moments, where the process locks itself, or in other words, path dependency. With process tracing, the researcher can delimit potential explanations, but it is of course always difficult to limit all different potentials (*Bennet and George 2009, p.207).*
Process tracing can be conducted in several different ways, but as George and Bennet state *"The challenge in using process tracing is to choose a variant of it that fits the nature of the causal process being investigated" (213)*

More broadly, process tracing can help the researcher to identify single or different paths to an outcome. This dimension is more interrelated to my overarching research aim, to find potential explanations for the public health process. I also argue that using process tracing to generate more general explanations would be more helpful than focusing on every detailed step of the process. This also because there is the aim of finding explanations rather than finding the dominant causal explanation. I will identify the public health process and from that process apply theories to explain the process (*Bennet and George, 2009 p. 215*). Another important reason for using this method is the ability to use other methods to complement the results if needed (*Bennet and George, 2009 p 6)*. The following statement from George and Bennet sums up the scope of process tracing in a good way. It is the *"Attempt to trace the links between possible causes and observed outcomes"*. This is an aim of the thesis. Following both the research aim and the scientific problem, the question should guide my method and not the other way around. If I for instance wanted to use statistical methods I had to reformulate my question, and in that sense be more method driven (*Ekengren and Hinnfors 2006)*. Bennet and George also state that process tracing can be a powerful tool to explain outcomes, which clearly reflects the ambition of this thesis (*Bennet and George, 2009 p*. 7).

Another important focus is how to use theories in the research. Should it be theory development or theory testing that is used? The argument here is that a theoretical discussion of the public health process in the European Union is mostly missing and therefore, theories will be used that can be translated to the empirical material in order to support possible explanations. This is also more related to my aim and scientific problem. Instead of testing existing theories to the material, material will be presented that can be tested against theories. The downside, as Esaiasson, Gilljam, Oscarsson and Wängnerud acknowledge, is the risk that by just having a bit of imagination, the material that has been collected could be transformed to fit the existing theories; this of course needs to be done carefully when analyzing the material. Another important point to make is that traditional process tracing, hypotheses are created from theories in order to predict the process. It is argued that the existing theories are not that strong in predicting the outcome of the process and thereby cannot create a strong hypothesis for my process. Therefore it could be said in strictly meaning that I take a step differently and instead use theories to indentify the elements of my case, Multilevel governance, agenda setting theory and network approaches are used as starting models to understand the elements of the public health case. These theories assist in outlining the process and finally identifying potential explanations for the process. Put simply, the public health policy process will be outlined, from 1980 until early 2012, in order to find potential explanations for why public health exists on the EU agenda using more general explanations (*Bennet and George 2009 p. 211*).

3.4 Delimitations

In order to acquire a concrete result and not include excessive information, delimitation in time is needed. The research will start from 1980. In this year there was still no referral to public health in the EU treaties. However, in the Maastricht Treaty of 1992, for the first time there appeared in the treaties references to EU powers. The process will be followed in detail until early 2012. The year 1980 was chosen because it is a reference point just before public health found its way in an EU treaty. Therefore, the actors and processes behind this appearance could be studied. This time period also saw a relatively small number of actors

pushing for public health to be recognized as an EU issue. Over time, this changed and the change can be studied in actor behaviour if this time period is used. This research follows along the lines of Sebastian Princen, who outlines that the shift in wording of public health changed when it began to be seen as a goal in itself rather than simply a topic for internal market discussions. In this process formative moments will be identified, such as the different treaties (e.g. Single European Act, Maastricht, Amsterdam, Nice and Lisbon). Using these treaties as reference points help to structure the research process, and also are excellent examples of the "formalization" of decisions on the public health topic. Another important point to mention is that the focus here is only on public health, and not other social policies such as labour rights etc. The aim is concerned with the study of the process, how it came to be on the agenda in the European Union, rather than being concerned with the actual decisions made. Thus, implementation of decisions will not be analyzed. Implementation is a whole new concern, which has its own implications that will not contribute to answering the research question of this thesis. Material will be collected, and from that material analysis of the process will take place using different theories in order to prove the possible explanations that have been set out as a hypothesis. Also, with theoretical assistance, Different categories can also be utilized afterward, under which material can be more easily sorted.

3.5 Material

With the above mentioned delimitations, I can instead include more documents in the analysis, including official EU documents. These will be analyzed from all EU institutions dealing with public health. Newspaper articles and statements from different actors concerning public health will be analyzed to capture the whole spectrum of EU action on public health since 1980. Second hand sources will also be used, when needed, mostly to confirm first hand sources and increase their validity. One weakness that can be mentioned in the research design is that no interviews will be conducted. There are several reasons for this, including that time is limited, and that interviews need to capture the whole spectrum of opinions from different actors such as NGOs, member states and EU institutions, which would be difficult given the time and financial constraints of this study. However, some interviews have been conducted by other scholars concerning the public health process, which can serve as secondary sources for this study. These may confirm or deny the evidence found in the different documents. In this way I believe that the result will be satisfactory and easy to follow. In the next two chapters will the research be presented and analyzed.

4 Public Health on the EU agenda

This section outlines a historical overview of the public health process, and attempts to discuss how public health appeared on the EU agenda from 1980-2002

1980- 1986:
Key documents:

Europe against Cancer Programme 1986:

This is the first real document considering smoking, and eating habits as a reason for cancer in Europe. It was created by the Committee of senior public health officials (1980): This is a concrete example of how the public health process works, using a committee of experts who discuss public health, and later propose concrete issues that should be discussed. Actions taken in the program are prevention, informing the general public, training health workers, and research. Here the importance of experts is highlighted. This report later contributed to new discussions on public health in the European Union.

"Striving to reduce tobacco consumption and improve eating habits. These new areas of work are important because smoking and diet are each thought to be involved in about one-third of cancer fatalities. From 1987 onwards, the European Community will help support national activities in the context of the internal market, the common agricultural policy and consumer protection in particular (upward alignment of taxation arrangements for manufactured tobaccos, harmonization of the labelling of manufactured tobaccos and foodstuffs, redirection of production towards varieties least harmful to health, bans or restrictions on certain types of advertising, etc."

WHO The charter Against Tobacco, 1988:

"*3. Outlaw the advertising and promotion of tobacco products and sponsorship by the tobacco industry"*

"*10. Build alliances between all sections of the community that want to promote good health."* As with the European Union, the WHO also promotes networks and alliances around different issues.

Here it can be identified that both the European Commission and the WHO are considering the same issues and the dangers of smoking. This is because the same experts often meet each other in different settings, and after a while converge in their opinions. In this case, these organizations agree that smoking kills, and therefore highlight the problem for policymakers, who can then decide to act or not. Even if these documents are only statements and "nice words," this does contribute to discussion and may later on be added to the agenda. However this discussion about cancer did not only exist in these two organizations, but also in several countries around the world, for instance the US and Canada have discussed them. All

these different venues contributed to the spotlight focusing on the issue, which then led to the experts starting to converge their opinions about the increase in cancer.

Policies:

However during this time, when many of the policies about food harmonization and inspections for example, *the model of the public health certificate, in respect of meat products from Argentina and Uruguay was also developed (*1986). Although that development was more likely motivated by the functioning of the internal market, rather than by purely public health concerns despite WHO reports, and the European *charter on environment and health* (1989). Public health by itself did not constitute any major policy. Instead what can be said is that expert committees and research programmes were established. For example, a report was released entitled "*Adopting a sectoral research and development programme of the European Economic Community," in the field of medical and public health research* (1982). That would later develop into possible results, but the role of expert advice was established by this kind of report, this could be seen as a way for experts to give input to the Commission on different issues and narrow down potential alternatives.

1987-1997: Maastricht Treaty and Amsterdam Treaty

Key documents:

Here, we can see an increase of documents concerned with public health, compared to before. Both written questions from MEP's (*Written Question E-3726/97*), and questions other institutions contributed to such documents. They are mostly concerned with different action programmes on certain issues like cancer, and health monitoring. These so called action programmes involved a multitude of actors both NGO's pushing for more public health, but also industry pushing for pharmaceutical, alcohol and tobacco regulatory leniency.
In the *Treaty on the European Union: 1992 (93) art 129,* lie the voting rules, which were changed to *Qualified majority voting* for the first time, and the following provision appeared for the first time in the treaty:

"1. The Community shall contribute towards ensuring a high level of human health protection by encouraging co-operation between the Member States and, if necessary, lending support to their action. Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education. Health protection requirements shall form a constituent part of the Community's other policies".

While in a legal sense this article set public health in the treaty for the first time, this provision continued in the Treaty of Amsterdam (1997) with the following provision:

"1. A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs related health damage, including information and prevention". (art. 152)

This article, it is argued, firmly sets public health on to the agenda. It states when public health needs to be considered (in all community policies and activities). However considering that public health still is regarded as mostly a national competence, this article does still ensure that public health remains on the agenda, at least theoretically in all policies and activities.

Policies:

The WHO published an important report called *Health 21, health for all in the 21st century an introduction* (1998), which outlined different strategies and goals in order to promote and improve public health in Europe. For instance goal 20: "*A multisectoral strategy for sustainable health"* which has the aim "*to create sustainable health through more health-promoting physical, economic, social and cultural environments for people"* This later on led into concrete action from the European Union, namely with the report *Decision No 647/96/EC Of the European Parliament and of the Council of 29 March 1996, adopting a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health (1996 to 2000).* This is another example of how experts at the WHO and other groupings draft opinions and reports about possible actions in order to improve public health, and it is then implemented both at the WHO and in the European Union. Other examples from the report include target 19 *"Research and knowledge for health".* This example clearly reflects policies of the EU in this area, for instance with research on different topics, or one concrete example, *Adopting a programme of Community action on health monitoring within the framework for action in the field of public health (1997 to 2001)(* Decisions No 1400/97/ (1997).

During these years more action plans were released on several issues, such as *Decision No 647/96/EC (1996), which adopted a programme of Community action on the prevention of AIDS and certain other communicable diseases within the framework for action in the field of public health (1996 to 2000).* Or, *Decision No 647/96/EC (1996) adopted an action plan to combat cancer within the framework for action in the field of public health (1996 to 2000).* And *Decision N0 102/97/EC (1996) adopted a programme of Community action on the prevention of drug dependence within the framework for action in the field of public health (1996-2000).* Until now, there have been almost no documents concerning alcohol, obesity, and the exception being smoking. The Commission, together with the EU Irish Presidency, tried to push for more anti-smoking policies at the EU level (*for more information see Princen, Agenda setting in the European Union 2009).* Instead there are more so called "non-controversial" issues been handled, such as cancer prevention, where there is no clear opposition against the issue. Such questions are not very "politicized," and therefore do not trigger the same debate and conflict expansion as food, tobacco and alcohol policy does. Scientists and experts within the different networks highlight the risks of cancer and AIDS, and a consensus is established about the risks, and the European Commission decided to initiate action plans; it was put on the agenda as a result. Here more concrete policies are developed than were before, and its action programmes, the expert networks and the member states have arrived on common positions that may be dealt with.

Networks: The European Public Health Alliance (EPHA) was founded[12], which reflects the increased importance for public health in the European Union. Networks such as the EPHA are created in order to promote public health issues at the European level. This organization to some extent can be said to take up the fight against industry, which has been established for a long time, in the European sphere. The public health proponents also want a say in the policy making process.

1998-2002:

Policies:

Preparation of a first public health program, took places under "*Decision No 1786/2002/EC, adopting a programme of Community action in the field of public health (2003-2008).* One integrated program instead of eight different health programs[13] was instituted, which aims to create more coherence and transparency in EU public health.

"The public health framework was reviewed within the Commission, with a communication of 15 April 1998 on the development of public health policy in the European Community.,This indicated that a new health strategy and programme were needed, in view of the new Treaty provision on public healths, and the new challenges and experience that Europe was facing at the time".

So here we see the Union responding to the new treaty provisions in the Amsterdam Treaty, and now as a result of all these actions, this policy area is not as fragmented as it was before.

"EU actions will be refocused along three strands: Improving health information to citizens, professionals and policymakers, strengthening the rapid response capacity for coordinated reactions to major public health threats, and targeting actions to promote health and prevent diseases" (Health and Consumer Protection Commissioner David Byrne[14])

During this time it can be said that Alcohol started to appear more in the discussions at the EU level. This has to do in one way with the Swedish presidency in 2001, and the admission of Finland and Sweden into the EU in 1995. Sweden put alcohol, for the first time, onto the discussion table at the EU level.

"The EU's approach to alcohol policy has changed during the Swedish presidency", says Lars Enquist former Swedish Minister, responsible for public health. "Previously, alcohol-related issues were primarily regarded as an integrated market, or agriculture concern., However, all the member states now agree that alcohol should be regarded as a public concern issue as well[15]".

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[12] *"EPHA is the European Platform bringing together public health organizations representing health professionals, patients groups, health promotion and disease specific NGOs, academic groupings and other health associations".* http://www.epha.org/IMG/pdf/epha_Leaflet_2011.pdf

[13] http://euobserver.com/9/2518

[14] http://www.euractiv.com/health/conciliation-agreement-new-eu-public-health-programme/article-113138

[15] http://euobserver.com/9/2518

Another possible reason for this was the increased discussion on alcohol at the international level, which triggered action simultaneously at a European level. *The European charter on alcohol (1995), the Declaration on young people and alcohol (2001),* were two reports that were also issued by the WHO *around that time (For more information regarding alcohol in EU see Cisneros Örnberg, 2008), which raised awareness of the issue***.** As stated before, the Commission does not act in a vacuum, and many of the proposals and issues have been long discussed in networks of experts who highlight new issues and actions. Often by following a debate, at the WHO for instance, one can see a response on the European Union level. This often happens because many of these experts and networks are active at both levels of advocacy, and a consensus is then established. Also by following how member states perceive public health affect what actions are taken at the EU level on this issue. So the combination of the Swedish presidency and WHO pushing for more discussion around alcohol abuse among young people are potential reasons for why the discussion ended up on a European agenda. For instance the Union issued a recommendation for the candidate countries to work with alcohol abuse among young people, and also issued a recommendation and proposed a future common strategy on alcohol. Note that those are soft legal instruments, which may be used as tools for EU agenda setting action.

Networks: Now a clearer conflict line has been established between the industry, with for instance the Brewers of Europe[16], and on the other side the European Public Health Alliance that tries to influence the agenda as much as they can. It makes it easier when the Commission arranges different conferences and hearings on issues, for instance the alcohol and Health forum[17]**.** And both industry and public health experts are involved when policies are formed such as the alcohol strategy and the green book of a smoke free Europe.

• Concluding discussion

Next will a conclusion follow with a discussion over important factors that affected the public health policymaking process.

The role of the WHO:
The World Health Organization Europe plays an important role in agenda setting. This organization works in close cooperation with the Commission, where ministers in Europe meet in high level groups. Even if the decisions are recommendations and declarations that are not legally binding, the issues are discussed, and sometimes a consensus can be achieved over certain issues. WHO Europe consists of public health experts, scientific, and technical experts, whose aim is to promote health in the European region. They work in close cooperation with the Commission. For instance, this co-operation is described in the first Public Health programme (2003-2008).

"Cooperation with third countries and the competent international organisations in the sphere of health, such as the WHO, the Council of Europe and the OECD, should be fostered, not only in the field of collecting and analysing data (including indicators) but also in the

[16] http://www.brewersofeurope.org/ founded 1958
[17] http://ec.europa.eu/health/alcohol/forum/index_en.htm

field of intersectoral health promotion, in order to ensure cost effectiveness, avoid overlapping of activities and programmes and enforce synergy and interaction, taking particular account of specific arrangements for cooperation such as that between the WHO and the Commission".

Examples of action from the WHO are *the Charter against Tobacco* (1988). And the *European Charter on Environment and Health (1989). The Copenhagen Declaration on Health Policy (1994),* the *Health 21 – health for all in the 21st century and introduction (1998), Warsaw Declaration for a Tobacco-free Europe (2002)*

The role of expert networks:
In public health, is it especially important that risk assessment methods are able to identify the harm that certain products have on individuals. Scientific evidence from expert is required in order to legitimize an intervention at the national level and especially at the EU level. For instance, it would be unlikely that smoking would be brought up on the agenda if the scientific evidence did not point to the same direction, that it is harmful. When a consensus is reached among the expert networks, it is easier to promote an issue on the agenda. This happens often when experts meet at different conferences at different levels, for instance when the European Union or the WHO arrange different conferences or meetings. For example, the charter against tobacco (1988) written by the WHO and Europe regarding cancer put smoking for the first time on the agenda at the international level, and European level with help from the Irish presidency. Member states began to initiate concrete measures against smoking after this point. Thalidomide, AIDS, cancer, and tobacco are all examples of what is often discussed on several levels at the same time.

Important players in the process: The public health process can best be understood as a multi level dimension were action both happens often, and simultaneously at national, EU, and international levels. It often reinforces itself, and with the Commission acting and pushing for issues that are "hot". An example is this statement about tobacco, from an official in the Commission, highlights this very well.

"It's in the air(....) At that time, we had got the tobacco file from another unit, so we didn't yet know what to do with it(...) The first member states had also started to put in place smoke-free legislation. Ireland had already done it. Then we thought: we might push it at EU level to get more member states on board. Often, these ideas don't drop from heaven, but they are somewhere here. They are like a flower that grows and that gets a new blossom. It is organic, it develops from something that is in the air, that has been on the ground". (In princen Moving issues onto the EU agenda p. 99)

In this section I established the importance of a multilevel perspective of the process, by both looking at the international level with for instance the WHO, the domestic level and the convergence of experts in different transnational networks, contributing to and forming issues. In this environment are the Commission, and different countries such as Sweden (alcohol) Ireland (Smoking) which help in this process by also pushing for action at the EU level. These parties help in the initiation and drafting of certain reports. Even if it is hard to pinpoint the exact driver of a particular EU agenda, the combination of these activities is important and necessary for issues to appear on the EU agenda. This kind of activity can be identified in alcohol, tobacco, and pharmaceuticals, which can trigger attention at the EU level. The interests of this paper will focus on the surprising evolution of public health onto the EU agenda.

The area of public health can no longer be said to hide in the shadows of other policy areas, as was the case before. This follows along the lines of Princen and Cisneros Örnberg. As many scholars state, is it fairly easy to put issues onto the EU agenda, since it has multiple access points, but that does not mean that any particular issue will be brought up higher onto the agenda. For instance, there are many veto players which exist, and can make any issue such as that of public health, disappear quickly from the agenda. Some issues are harder, and the focus in next section is on the dynamics of agenda setting. The aim of the next section is to illustrate this, by applying different agenda strategies to the public health process, to see how different issues are getting on the public agenda and some issues are not brought up onto the agenda. However is not the aim of this paper to evaluate how successful actors have been in getting decisions implemented and transferred to EU law. It is also worth noting that applying these strategies can be considered to be one of many explanations of how an issue may arrive onto the agenda. This will be further discussed at the paper's end.

5 Putting issues on the Public health agenda

Now, public health as a policy area that is on the agenda, at least according to the view of this thesis's author. Different health strategies, alcohol strategies and a new public health division exists. This report continues by illustrating how different actors pursue different strategies in order to put an issue onto the agenda, or take it off the agenda. As mentioned before four strategies can be outlined: mobilizing supporters, arousing interests, capacity building and claiming authority. These four strategies will be described, and concrete examples will be given that can be applied to the public health process. These categories have interrelationships, they can work alongside each other without affecting each other. They can also reinforce each other and make a particular issue stronger. And they can also be in conflict with each other. These strategies are tools that can help to create an understanding of how different actors try to put issues onto the agenda, and therefore are considered as an open ended processes. Two broad challenges exist for an actor to put an issue onto the agenda, gaining attention and building credibility. These are key factors, which can affect venues and frames.

	Venues	*Frames*
Gaining attention	Mobilizing supporters	Arousing interests
Building credibility	Capacity building	Claiming authority

• Gaining Attention

"Strategies of gaining attention involve directing issues toward the 'right' venue in order to mobilize (potential) supporters, and framing the issue in the 'right' way in order to arouse interest in it". (Princen 2011 p.929)

1. **Mobilizing supporters:**

Venue modification: A new committee in the European Parliament was formed, just to deal with health issues. Before, the committee also handled environmental questions. According to many NGO's, other, non-traditional issues have taken over the EU agenda. Could this mean that health has gained more, or less attention recently? Also the fact that environment has become a very important area, may mean that public health has temporarily taken a back seat[18].Another example is the European Public Health Alliance, which has tried to change

[18] http://www.euractiv.com/health/cautious-welcome-proposed-ep-health-committee/article-179750

policy so that pharmaceuticals are dealt with at the Commission's Director General, SANCO, instead of at the current industry directorate[19]. This means that much of the interest in public health has in the past come from industry rather than public health. Pharmaceutical companies, of course, do not want to change the configuration, as they see health products as an industry issue and not a health one. By only dealing with industry interests, other interest such as public health may be excluded. In effect, the interests of the industry are the dominant if kept at the DG ,Industry. On the other hand, if public health were to switch to the DG, SANCO, the opposite may occur. In a way, could this be seen as an attempt by both sides to achieve greater influence. Pharmaceutical interests were later moved to DG, SANCO, instead of remaining with the DG, Enterprise[20], and in that way some industry interests may be excluded, while more public health interests are prioritized compared to the former configuration. Can the EPHA, and other public health proponents be successful in shifting the arena of an issue, which can result in a increased mobilization of public health proponents compared to the industry that is more excluded? These two examples reflect the increased importance for public health in the European Union and the higher priority it has achieved. If it is not possible to modify a venue, a shift in venue can help in mobilizing more supporters. The Swedish retail industry bypassed the Swedish government and mobilized with the Brewers of Europe, because they wanted to change the rules in Sweden. This for instance included companies sending complains to the Commission about barriers to trade, and questioning the Swedish alcohol monopoly, (Case C-170/04 *Klas Rosengren and Others*). One example is when opponents of the Swedish alcohol restrictions succeeded in suing Sweden at the European Court of Justice, which ruled against Sweden which previously banned Swedish citizens from importing alcohol into the country. In that way, they did bypass the Swedish government, and by changing venue, the opponents did force the Swedish rules to change[21].This has also been apparent from an international level. The WHO has for instance launched certain statements which often make the EU, start discussing certain issues. These include for instance obesity[22], alcohol, tobacco and mental health[23].

The issue of obesity is one example of this. *The Obesity charter signed in Istanbul 2006* (*European Charter on counteracting obesity, EUR/06/5062700/8)* was created after different health and consumer groups tried in combination with this charter to mobilize supporters to push for more action across all government departments so all policies are shaped to encourage and enable healthy lifestyles. In this context, the *(GREEN PAPER "Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases" 2005)* can be mentioned. These documents reflect the increased awareness of obesity and action taken on several levels in this regard. This often happens when expert networks converge in potential proposals for action, by starting to discuss issues on the international level such as the WHO. This can result in action at an EU level, because the receptiveness for the EU venue can be greater than the international level. One concrete try for action at the EU level, where the proposal of so called "traffic lights" on food package, that according to the aim would help to identify products that are high, medium or low in salt, sugar and fat in order to guide consumers when buying food products. This proposal was strongly supported by the public health NGOs ,and strongly opposed by the

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[19] http://www.euractiv.com/health/ngos-want-medicines-removed-eu-industry-policy/article-183296
[20] http://www.euractiv.com/future-eu/eu-officials-slalom-through-power-overlap-news-496956
[21] http://euobserver.com/851/24196
[22] http://www.euractiv.com/health/ministers-agree-obesity-charter/article-159718
[23] http://www.euractiv.com/health/mental-health-strategy-focus-prevention/article-160268

industry. It later did not end up as a proposal, after several MEPs rejected the proposal. In that respect, the industry did help to keep the issue off the agenda[24], or at least helped to put it lower on the agenda despite the initial proposal[25]. This step was seen by many actors as too bold and therefore it was rejected.

The presidency: With the agenda setting power, the EU Presidency has contributed too, as different presidencies prioritize public health more frequently. For example, Sweden, the Netherlands, and Finland have the power to set the agenda from the outset, and they can also decide more how many meetings and what priority they should have. Thus a Presidency is thought to have so called structured power, together with the Commission (Tallberg). *Sweden:* Both during the presidency 2001 and 2009 Sweden did try to push for a discussion of the harms of alcohol. *Finland*: Health in all policies,[26] Finnish priorities during their presidency[27] (*2006: Health in All Policies Prospects and potentials*). During the Finnish presidency they did promote the objective of health in all polices and helped to strengthen the treaty provision that a high level of public health should be ensured in all policies. And they also emphasized other policy goals, which did not necessarily coincide with public health. Finland also helped to push for a new public health program together with the Commission. *The Netherlands* started to discuss the issue of healthy ageing, and the need for preventive measures[28]. *Ireland* too highlighted cardiovascular diseases that arise from alcohol, smoking and unhealthy foods[29] that are a big problems in Europe.

As seen in this section, there are several actors trying to mobilize supporters. This strategy is especially important in an EU context because there are a lot of veto players, who can stop issues from advancing if there is a lack of public pressure on them not to do so, a next strategy is to arouse interests, that of course is fundamentally important in order for a issue to be discussed.

2. **Arousing interests:**

Use of big words: The EU's 2020 goal[30] can be considered an important action plan for the future, where health is included as a factor to reaching a better economy. By connecting health to a bigger goals or strategies of the Union, health can be pushed higher up onto the agenda. Another example is the upcoming health strategy[31] (2014-2020), which is framed in

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[24] http://www.euractiv.com/health/industry-bashes-commission-proposals-food-labelling/article-169973
[25] http://www.euractiv.com/health/traffic-lights-food-packages/article-159721
[26] http://www.euractiv.com/health/economic-trade-policies-need-take-better-account-health/article-158078 Published 25 September 2006
http://www.euractiv.com/health/finns-warn-health-ambitions-clashing-eu-policies/article-157914
http://www.euractiv.com/health/robert-madelin-business-case-healthy-citizens/article-156857 Published 21 July 2006
[27] http://www.euractiv.com/health/finland-push-stricter-eu-measures-alcohol/article-155968

[28] :http://www.euractiv.com/future-eu/healthcare-dutch-presidency-tackle-ageing-populations-problem/article-128685

[29] http://www.euractiv.com/health/irish-presidency-sets-forth-ambitious-schedule-public-health/article-114036
[30] http://ec.europa.eu/health/europe_2020_en.htm
[31] Proposal for a Regulation of The European Parliament and of The Council on establishing a Health for Growth Programme, the third multi-annual programme of EUaction in the field of health for the period 2014-2020.

order to connect to the bigger goal of economic growth, and is therefore called Health for Growth, in which the focus is to advance health in economic terms, the merits of having healthy citizens, that health contributes to more economic growth. Another example is that members of the public health committee of the European Parliament warned governments to cut health spending due to the financial crisis, because that can worsen the disparities seen around the Union[32].

There are also opposing actors who want to put issues of the agenda by using complex language. For. Example, with tobacco, when the Commission planned to restrict the tobacco industry further, the tobacco industry released a report that indicated that the crime rate would increase if these measures were implemented[33]. Another report stated that more restrictive regulatory measures will threaten the EU's Roma inclusion strategy, and will contribute to increased mafia activity due to increased illegal smuggling activities[34]. However, in the end, the Commission rejected the reports. Another example is the industry's attempt to hand out reports showing how important the alcohol industry is for the economy, and how many jobs would be lost if further restrictions were imposed. This was done in order to connect this to the financial crisis. The industry, both tobacco and alcohol, try to connect their products with employment connected to those products, to try to show that by implementing policies, jobs [35]will be lost. These reports and statements attempt to arouse certain interests among different actors. When it comes to alcohol, the alcohol industry in this case, the international centre for alcohol policy releases reports about the dangers arising from alcohol taxes, and minimum prices, that the amount of unrecorded alcohol will increase, and that will increase the health risks.[36] This is done in order to keep the alcohol regulation question far from the EU agenda. Another report was about the Swedish alcohol monopoly, that it is not effective. These reports were launched before the Commission proposed a new alcohol strategy. The Commission avoided, later on in the strategy, discussing tax or pricing[37], which reflected the industry's aim, despite the Commission raising the issue of binge drinking, and the conclusion that minimum taxes could be a tool in reducing harm before the strategy was launched[38],[39]. This was also apparent in the strategy of 2006, where a lot of restrictive measures were proposed, such as age limits, and warning labels, but in the end this did not end up in the strategy. This failure can be seen as a successful framing by the industry involved, to highlight the loss of jobs instead of the harm alcohol contributes to[40]. During the Swedish presidency 2009, the industry also tried to undermine the Swedish attempt to put alcohol onto the agenda. For instance, there was a report launched by the industry about Sweden's domestic alcohol policy, which blamed Sweden for failing to keep down consumption (this report was written by the Brewers of Europe[41].

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[32] http://www.euractiv.com/health/meps-warn-governments-cut-health-spending-news-501588
[33] http://www.euractiv.com/health/tobacco-rule-changes-boost-crime-industry-warns-news-511917
[34] http://www.euractiv.com/health/lobbyists-link-eu-tobacco-curbs-rising-crime-roma-news-506560
[35] http://www.euractiv.com/health/battle-brewing-alcohol-restrictions/article-184935
[36] http://www.euractiv.com/specialreport-reviewing-europes-alcohol-harm-strategy/policymakers-weigh-drawbacks-alcohol-tax-hikes
[37] http://www.euractiv.com/specialreport-reviewing-europes-alcohol-harm-strategy/europeans-diverge-alcohol-taste-tax-marketing-
[38] http://euobserver.com/9/22352
[39] http://www.euractiv.com/health/commission-prefers-higher-alcohol-tax-combat-binge-drinking-news-511799
[40] http://euobserver.com/851/22718
[41] :http://www.euractiv.com/health/swedes-put-alcohol-pricing-eu-health-agenda/article-185929

The above mentioned examples aim at connecting the issues to the larger goal of economic growth and progress. The industry claims for instance that by imposing restrictions on food, tobacco and alcohol, of the economy will lose many steady jobs, and by extension economic growth. And on the other hand, public health proponents argue that by imposing these measures, the public are going to be more healthy and thereby can contribute further to the economy. Another part of this strategy is to take, so called "small steps " in order to put the issue higher onto the agenda.

Small steps: One way to do this is, for instance, to highlight the growing elderly population in Europe and to advocate that the EU needs to implement more health policies now. Another example is obesity. Many reports have publicized the increased obesity in Europe, and these reports can be used to put obesity on the agenda[42]. However are the Commission focuses on vulnerable groups such as children, and pregnant women,[43] both in its alcohol strategy, and in its discussions about obesity. This is also a strategy used by other public health proponents, because starting to discuss the risk with alcohol and unhealthy food in these groups can later on expand to a broader discussion of lifestyle choices by the European population. To give a concrete example, when an agreement was formed under which Europe's eight largest alcohol manufactures were going to work with the World federation of adversities, the European Commission and national associations to create concrete measures to protect young and vulnerable groups from targeted advertising[44]. This shows that by taking small steps, even the industry and opponents to more regulation can be participants in the system. Another way to approach it is to arrange different conferences about issues, such as on the topics of alcohol or healthy food. This occurs with, for instance, different networks and presidencies[45], when they use the Open Method of Coordination and different settings such as stakeholder's forums on different issues. The different health strategies use different forums to get input to the strategy, including the alcohol strategy[46].

As seen so far in the analysis, actors are trying to arouse interests for their own issues, and the different actors often succeed in doing this. Public health promoters are especially good at this, and this awareness is reflected in the different health strategies and policy documents which the Commission launches. But in order for the European Union to deal with the issue, they need also to build credibility for the issue, in order to be highly prioritized on the agenda. The next two strategies covers this aspect.

- ## Building credibility

"In terms of venues, building credibility requires a strategy of 'capacity-building' at the EU-level in order to arrive at venues that are sufficiently capable of dealing with the issue. In

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[42] http://www.euractiv.com/health/traffic-lights-food-packages/article-159721
[43] http://www.euractiv.com/specialreport-reviewing-europes-alcohol-harm-strategy/health-chief-wanted-drinking-kills-labels-news
[44] http://www.euractiv.com/specialreport-reviewing-europes-alcohol-harm-strategy/alcohol-industry-unites-advert-abuse-clampdown
[45] http://www.euractiv.com/health/chronic-diseases-pull-economy/article-159484
[46] http://www.euractiv.com/health/lifestyle-health/article-154425

terms of framing, it implies the construction of a convincing argument about why the issue is European in scope and, hence, is legitimately dealt with at the EU-level. This strategy can be called 'claiming authority"'(Princen 2011 p. 930)

3. **Capacity building:**

Here, different networks have an important role to play. For example, the European Public health Alliance on one hand, the other hand the industry. Both are very active in promoting certain issues, and these actors often clash depending on the issue at hand, and how politicized the issues are etc. Networks have a prominent role to play in coming up with opinions for different strategies, and especially with the open method of coordination that involves a multitude of actors. The Commission for instance, arranges different forums were public health is discussed. For example, an alcohol forum has been held in the past, where different stakeholders take part to discuss certain issues. Another example is the forming of the European Health Forum[47], which was created when the first health program was launched. Here, different public health actors are given the chance to address their issues. Various committees have been established, and various experts are also consulted when different policies are formed. When the Commission formed its alcohol strategy in 2006 for example, public health experts from different NGOs were involved in the drafting of the text.[48]. This increased the leverage and the capacity of the Commission to deal with public health issues. The Commission has, in the past, also been accused of using excessive numbers of consultants who have connections to the industry, when certain public health issues are formed[49]. So both the industry and public health actors try their best to create capacity for their issues. To give another example, the European Consumers Organization (BEUC) chaired a multi-stakeholder discussion group. The group, composed of national authorities, food manufacturers, retailers, and academics discussed problems related to obesity and unhealthy food[50]. At this forum, it was agreed that to combat obesity, it "*must be tackled across policies with a special focus on children and the young".* Another example is when all member states agreed on health determinants, in order to build capacity and strength for the EU in public health[51]. As mentioned before, the role of experts is especially important in public health, because public health policies deal with potential harm to human's beings, so the risks need to be considered by experts before an issue is presented. Another way for the Commission to build capacity is to conduct evaluations on certain programs. For instance, the Commission arranged a reflection process on future health strategies in 2004, where different stakeholders were given the opportunity to present input and feedback for the future. This helps the Commission to build more capacity, and include more opinions in order to establish a stronger health policy for the future[52].

When the European Commission increases its capacity and expertise in the public health area, the receptiveness for public health issues increases. For instance, the Director General, SANCO is considered to have achieved greater capacity than before, but for the issue to be

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[47] http://www.euractiv.com/general/health-ministers-adopt-new-public-health-programme/article-112447
[48] http://euobserver.com/851/20264
[49] http://euobserver.com/9/27600
http://euobserver.com/18/29038
[50] http://www.euractiv.com/health/traffic-lights-food-packages/article-159721
[51] http://ec.europa.eu/health/indicators/echi/index_en.htm
[52] http://www.euractiv.com/health/health-expenditure-economy/article-153271

dealt with at the EU level, it needs to be advanced first. But why on an EU level, and why not at the national level? The final strategy is claiming authority.

4. Claiming Authority:

One way of claiming authority is to link public health to another policy area. Health groups for instance to link climate change with health. Climate change is a very important topic on the agenda, and thus climate change advocacy groups attempt to connect the issue to health in order to discus certain new policies[53]. *"People think climate change is now about economics, but health should be the bottom line… That any policy that is good for the environment is good for health too"(* Dr Michael Gill of the climate health council). Different networks tried, for instance, at the Copenhagen world climate change summit of 2009 to connect health to climate change, and stated that we need to implement more health policies. Another example where a connection did succeed is in regard to the Environment and Health Strategy (SCALE) (2003). That strategy was concerned with the effects of pollution on the environment and human health. The strategy was jointly designed by three Commission Directorates General: Environment, Research and Health. Another way to connect issues is to find common ground. For example, with active healthy aging, the Commission stated that 2012 will be the European Year for active aging, identifying good practices and encouraging policymakers and stakeholders to promote active ageing[54]. This can be seen as a tactic to put aging on the agenda, because it is an issue that every member state is experiencing, or will in future. By doing agenda-setting via small measures such as this, the discussion may increase in the future, and the Commission may be able to claim authority over the issue. Here again, the EU 2020 goal can be mentioned, where health is linked to economic growth in order to claim authority over the issue. When the connection between health and economic development is constructed, it is easier for actors to argue for an action at the EU level.

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[53] http://www.euractiv.com/health/health-forgotten-climate-talks/article-186161
[54] http://www.euractiv.com/innovation/ministers-back-innovation-alliance-healthy-ageing-news-502972

6 Conclusion

The aim is to investigate and develop potential explanations for the process of public health policy making in the European Union.

This thesis has illustrated Public health increased importance, and can be said to be an increasing important policy area, in both the European Union and the rest of the member states. With a growing elderly population is public health even more important in order to prevent high pressure on the healthcare in the future. However with the ongoing financial crisis and the sensitive nature of public health with a close connection to the welfare state, complicates the picture and highlights the difficulties to put public health higher onto the agenda, therefore is it important to note that putting public health on the agenda is one thing, but to get public health higher on the agenda is more difficult. Case study design and process tracing have been used as tools in conducting the research. Now will the thesis initial research questions bee presented and discussed.

What actors are the drivers behind the public health process?

This thesis highlighted the importance of transnational expert networks. Expert networks are of importance in various policy areas. The argument here is that expert networks are even more important when it comes to public health, because the aim with public health is to protect the health of the citizens. To be able to formulate an issue in public health, expert needs to agree on the harm of the proposed issue, at least present strong evidence for the harm. For the issue to be highlighted in the starting phase, expert needs to draw attention to the risks, the next phases induce new actors and factors. The goal of public health can clash with the goal of market integration and economic growth, therefore needs the experts to agree on the risk, for example the case with smoking. In one respect needs the expert in these transnational networks agree with each other before an issue can be brought up at any venue, including the EU venue.

This thesis has also acknowledged the important role of The World Health Organization (WHO) especially pursuing issues before it arrives on the EU agenda. WHO work closely with The Commission, were ministers in Europe meet frequently on high level groups. Even if the decisions are recommendations and declarations that are not legally binding, the issues are discussed and sometimes can a consensus be achieved over certain issues and as stated in the theoretical framework can sometimes more sensitive issues be easier to discuss if it is not legally binding. One reason for this, are the capacity and expertise, the WHO induce. WHO consists of public health experts, scientific and technical experts and the aim is to promote health in the European region, they work in close cooperation with The Commission and this highlights once again the importance of experts on several levels, both on the national level, EU level and the international level. However it is hard to pinpoint the exact driver/drivers, the combination of these activities are important and necessary for issues to appear on the

public health agenda and once again reflects the multilevel dimension, EU policymaking are operating in.

The underlying argument, is that the process should be considered as a multilevel process with The Commission as the chief operator, were different actors try to influence via different forums like the Health and Alcohol forum, both EU institutions with the EU presidency and the European Parliament and networks like Brewers of Europe and European Public Health Alliance are important players.

How do different actors affect the public health process?

The use of four agenda setting strategies (Mobilizing supporters, Arouse Interests, Capacity building and Claiming authority) with two broad overlaying challenges, (Gaining attention and Building credibility), have illustrated, how different actors try to put issues on the agenda or of the agenda in the public health policymaking process. To best influence the process, both of the challenges needs to be fulfilled this in order to increase the possibility to put issues higher on the agenda. To be able to motivate why the EU should act, or construct a story till why the issue is EU in scope, are often lacking, when issues do not appear on the public health agenda.

Proponents that want more EU action on public health, have often failed to claim authority over the policy area, despite try. Actors often agree with the problems that are acknowledged but disagree that EU should be the actor that should handle the issue, as Princen states in his article, is it even more crucial for policy areas that are relatively new on the agenda to build credibility and capacity, not only gain attention for the issue. Public health can be considered to be relatively new, compared to other policy areas. That has built up capacity. Those policy areas often have an easier time putting issues onto the agenda by just gaining attention for an issue. This can depend on the public health article in the Lisbon Treaty and the subsidiary principle that exist, that from the out start sets boundaries which means that this point is even more important in the public health area.

The broader challenge of gaining attention, have the public health proponents often succeeded with, however building credibility takes time to build up, there are of course exceptions for instance smoking, that already came up to discussion with the European against cancer programme (1986) and from the mid 90:ths have occupied the agenda, but as the thesis has illustrated with the empirical material, are issues often weakened by for instance the industry and often ends up relatively weak compared to the initial proposal from The Commission. Once again need it to be stated that there are other factors that can explain if an issue appear onto the public health agenda and the result may have differ if other concepts and theories were used, however have this thesis contributed to one part of the explanation. Next question deals more with potential factors that can affect the public health process.

How do diverging perceptions about public health affect the public health policymaking process?

The issue at hand:
Alcohol and smoking represent two cases of successful agenda setting and lack of putting issues high on the agenda they are also two highly politicized products. Alcohol can be considered to be on the agenda, but the issues of such are not very strong, and disagreements

exist between member states and other actors. Alcohol is also considered to be a part of the culture. In Germany, beer is for instance considered to only a simple beverage, compared to Sweden and Finland which restrict alcohol strictly in order to cut down on excessive alcohol consumption.

Smoking on the other hand is more commonly accepted to be deadly, and scientists have come to a consensus as to this activity's impact. Also, the fact that smoking directly affects people, via the smoke, which makes the harm even greater, is easy to see. The fact that other countries such as the US, Canada and other actors have imposed restrictions on smoking also changes the perception. When EU countries such as Ireland started to ban public smoking, other EU countries followed afterward, and tackling smoking became a "hot" issue which made it easier to push handle by politicians.

What factors affect the public health policymaking process?

There are other factors that affect if an issue appears onto the agenda and not only how successful actors are, or how politicized the issue is.

External events:
An important consideration that needs to be addressed is the affect of external events. The financial crisis has, for instance, occupied the whole EU agenda, and will likely continue to do so. However this domination limits discussion of public health and other social issues. Another example is when so called new diseases spread between member states. During the 1980s, HIV/AIDS did contribute to action on the public health area. The swine flu epidemic (also known as H1N1) is another example that forced the EU, to some extent, to discuss public health more frequently.

Market harmonization:
In the start of the 80: s and 90: s with the creation of the internal market and the four freedoms, did trigger action on the public health area, mainly with harmonization of food inspections and the banning of certain dangerous chemicals and substances, this seen more as a functionalist logic. The European Court of Justice did also rule in favour for the goal of public health and against public health in certain cases for instance against Sweden's restriction of alcohol import from other EU countries, which trigged action, but however were the argument merely to have a functioning internal market and public health by itself did not constitute the main reason.

Why Public health on the EU agenda?
As stated here are there several potential explanations till why public health has appeared onto the agenda. Expert Networks have often highlighted the risk with certain issues, one central document in this, was the Europe against cancer program(1986) which later contributed to several action programmes, that acknowledged the risk with cancer, and the raised awareness were reflected on several levels, in WHO and the member states. Other reasons have been external events, market harmonization; the combination of these activities can be stated as potential explanations till why public health has appeared on the public health agenda. However hasn't public health, achieved the same priority as other more "important" policy areas such as economical matters, if this will change, will the future predict.

Future research

With the creeping expansion of public health in the European Union, academics need to acknowledge this policy area more closely compared to other policy areas. Public health is here to stay with the last decade increase of welfare diseases around Europe, combined with a growing elderly population that will severely constrain the European welfare systems.

One way of doing this is to build on this study, with other policy areas and closely compare different areas with each other in order to identify driving forces and similarities/differences between policy areas in the European Union. Another focus can be on the implementation part of the policymaking process in the public health process.

7 Executive Summary

Research Problem and Aim of the Study

The European population is aging, and people are suffering from more welfare diseases such as obesity and cardiovascular disease. Heavy consumption of food, alcohol and tobacco are three products contributing to the risk of health complications. To give one example, by the year 2050, the number of people in the EU aged 65 and older will grow by 70%. The 80+ age group will grow by 170%[55], which clearly reflects the challenges the EU faces, with high demands on health care. To combat such health risks, more public health[56] policies could be implemented in the European Union. In that way, certain diseases could be prevented, relieving some pressures on the welfare systems of EU member states. Public health could also be seen as a cross border issue, because Europe is a common internal market where harmful substances such as alcohol and tobacco flow free. Surprisingly can it be acknowledged an increased action on an EU level, despite the sensitivity with the close connection to the welfare- system. The EU has been traditionally concerned with issues related to the economy and market integration, yet has recently increased its cooperation in the public health area. How can this be explained?

Research formulation

> *The aim is to investigate and develop potential explanations for the process of public health policy making in the European Union.*

Research questions

1. What actors are the drivers behind the public health policymaking process?

2. How do different actors affect the public health policymaking process?

3. What factors affect the public health policymaking process?

4. How do diverging perceptions about public health affect the public health policymaking-process?

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[55] http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf

[56] "*Public health is the science and art of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for diseases and injury prevention… Public health works to prevent health problem before they occur*" http://www.whatispublichealth.org/

Theoretical Framework

Policymaking

The argument in this thesis is that policy making and the surrounding logics in the European Union differ depending on which policy is in focus. Each area attracts different actors and the institutional elements are different etc. To understand the public health process, an understanding of the policy process in general is required as a basis. Policy coordination as a policy mode is used in order to understand the policymaking process in public health:

Policy coordination: Policy coordination is characterized by the following elements according to Helen Wallace:

- *The Commission as the developer of networks of experts or epistemic communities or of stakeholders and/or civil society, and accumulating technical arguments in favour of developing a shared approach to promote modernization and innovation;*
- *The involvement of "independent" experts as promoters of ideas and techniques;*
- *The convening of high- level groups of national experts and sometimes ministers in the Council and occasionally the European Council, in brainstorming or deliberative rather than negotiating mode;*
- *The development of techniques of peer pressure, "benchmarking", and systematic policy comparisons in order to encourage policy learning;*
- *Dialogue (sometimes) with specialist committees in the EP as the advocates of particular approaches; and*
- *Outputs in the form of "soft law" and declaratory commitments rather than "hard law" and binding commitments oriented at gradual changes in behaviour within the member states.*

This mode is the one most closely related to the public health process, and captures key dynamics of the process.

Multilevel governance, Policy networks and Agenda setting theory, constitutes the thesis theoretical framework.

Public health as a case of multilevel governance: As with many processes in the European Union, public health constitutes a multilayered system with multiple actors that influence the process on the local, national, regional, supranational and international levels. The fact that many of the decisions are taken with novel methods such as the open method of coordination introduces new actors into the policy process and encourages new issues to be put on the decision agenda. Both the trends within each member state, and those within other international organizations such as the World Health Organization, determine partly if issues are brought up on the EU's agenda. Therefore in order to understand the public health process it needs to be viewed as a multi level process.

Public health as a case of policy networks: The Public health process includes actors such as NGOs, companies, the alcohol industry, the tobacco industry, the public health alliance, the Brewers of Europe, and policy experts. These different actors create different competing networks, which try to influence as much policy as they can. Also, the Commission picks up issues from the different networks for which to advocate.

Public health as a case of agenda setting strategies: Public health is surrounded by different actors, who try to influence a multilayered process, through framing issues, promoting the issues to different venues (arenas), and employing different strategies.
Following model is applied in the thesis in order to understand the public health process better:

	Venues	*Frames*
Gaining attention	Mobilizing supporters	Arousing interests
Building credibility	Capacity building	Claiming authority

Methodology

Case study is the thesis research design. The public health policy area within the European Union serves as the case for this thesis. Inspiration from process tracing is used in order to identify the chain of events that leads forward to the outcome. This research did not aim to find strict causality. Instead, it can be said that *connections* were more important here than strict causality. The focus on the method was on the process rather than the outcome of EU public health. The thesis identifies the public health process and from that process applies theories to explain the process (*Bennet and George, 2009 p. 215*).A important reason for using this method is the ability to use other methods to complement the results if needed and the ability to trace the process from 1980-2012 (*Bennet and George, 2009 p 6).*

Analysis

The analysis consist of two chapters one dealing with the evolvement of public health onto the EU agenda the other chapter deals with the issue of putting issues higher onto the agenda. The result from the conducted analyse will now follow, answering the research questions.

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