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Mobilizing Bias in Europe

Lobbies, Democracy and EU Health Policy-Making

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ABSTRACT

What effects do interest groups have on the democratization and legitimacy of the European Union (EU)? Interest groups can democratize the EU only to the extent that they do not replicate inequalities. We use a newly constructed database to look for inequalities: Are the big organizations in Brussels the same as the ones in the EU member states? Are some member states' lobbies more active than others? And does the structure of EU lobbying create insiders and outsiders itself? We find representative biases in favor of powerful incumbents, groups from some member states and well-resourced groups.

KEY WORDS

- European Union
- health policy
- interest groups
- lobbying

Introduction

Could interest group politics address Europe's 'democratic deficit'? There certainly is interest in a remedy for that deficit: 'The volume of academic books on the "democratic deficit" in the European Union [EU] . . . is now huge and continues to grow, with ever-more convoluted opinion as to the symptoms, diagnoses, cures and even side-effects of any medication' (Føllesdal and Hix, 2005: 4).

One of the cures proposed is a healthy interest group ecology (Michalowitz, 2004). Despite public suspicions about interest groups, pluralist and corporatist theorists alike have over time argued that interest groups of various sorts are the key to understanding participation and decision-making in, and perhaps to, democracy itself (Baumgartner and Leech, 1998). And, more recently, those arguments have entered the larger debate about EU democracy. Even if the absence of a European demos and the structure of the institutions create a 'democratic deficit' by the standards of its member states, the strength and diversity of the interest groups at work in the EU might redeem its accountability and procedural legitimacy (e.g. Bellamy and Castiglione, 2004; Smismans, 2006).

This means that understanding the structure of interest representation in the European Union matters in order to understand whether interest groups can reduce the EU's 'democratic deficit', to understand their effects on politics, and to understand the resulting policy decisions. In the classic terminology of Schattschneider (1960 [1975]), the question would be: what does the structure of EU interest group politics do to the mobilization of bias in politics and policy-making? The democratic credentials of the EU, insofar as they rest on its pluralism, will depend on the kind and extent of biases in these groups. If there are systematic biases towards certain kinds of groups, owing to nationality or relations with the Commission, then there is cause to worry about the democratic credentials of the EU interest group system and perhaps the EU itself.

Since the first studies at the beginning of the 1990s (Mazey and Richardson, 1993), the volume of research trying to address this issue through the study of lobbying has grown considerably. From a relatively small number of overviews and case studies, the field of study has become large and diverse in topics and methods. We look at three major biases that are often attributed to the EU. We ask: Is any bias structured by existing power and, if so, does EU lobbying replicate the distribution of power in its member states, or do power and powerlessness not translate easily to Brussels? Second, is this bias national and are some countries better represented than others? And third, is the system marked by insider/outsider

distinctions and do some groups get a beneficial insider status that others lack?

In the health sector, we find that groups that are important at the member state level can and do bring significant resources to bear. Interest groups in Mediterranean and post-communist accession countries are less likely to lobby at the EU level (join EU-level interest groups) than groups from other countries. But insider groups show no clear signs of being chosen by the Commission as privileged interlocutors; instead, the well-known insider groups of Brussels appear to have achieved that status by joining every forum they could. That might reflect imbalances in resources, but does not suggest a corporatist agenda in the Commission.

Testing theories in the health sector

The standard approaches to understanding the development of EU interest group activity have been qualitative studies, quantitative analyses of the whole EU population of interest groups, or analysis of a certain kind of interest group – typically, business associations.¹ These previous studies tend to focus on areas where the EU is already active; they take an existing, established world of EU lobbying and analyze it cross-sectionally.

This article takes a slightly different approach. It combines analysis of the whole EU interest group ecology with, in some cases, closer examination of a single, 'new', field of EU policy activity, namely health policy, and uses quantitative analysis to test hypotheses about the mechanisms of EU interest politics. There are a number of reasons why this sectoral approach complements larger quantitative, as well as qualitative, studies. First, there is an argument for sectoral analysis in itself. In terms of sectoral variation, large-scale studies can pay a price for a large sample; differences between sectors and types of group can wash out and take useful information with them. There certainly are studies suggesting that EU policy sectors might have significant differences, perhaps so significant as to qualify any generalization (Eising, 2007; Schneider et al., 2007: 455).

Second, and more importantly, focusing on a sector can improve the quality of data interpretation. This is the main purpose of the discussion of the health sector here. The EU is a complicated and diverse world. Different Directorates-General (DGs), policy areas and forums have distinct roles that can be difficult to interpret. A sectoral study avoids this problem by including information about the status of different actors that is specific to a policy sector. For example, we test hypotheses that depend on information about the 'insiderness' of different institutional forums. They would be impossible

across the entire EU, because they would require not only an enormous amount of information but also an insuperably complicated coding (how do we compare the 'insiderness' of the Platform on Diet, Physical Activity and Health with an advisory committee in Agriculture or DG Trade's Civil Society Dialogue?). Likewise, we can use sources on health policy to identify important groups, information that would be very difficult to collect and code for the whole EU. This gain in information allows us to develop more nuanced indicators than would be possible across the EU as a whole.

The health sector is rich in important interest groups at the domestic level and rising interest in the EU; Coen (2007) suggests that health is the fastest-growing area of interest group engagement with the EU. It is also an interesting case to study, because it is a major area of the welfare state that has traditionally had little EU involvement and in which the 'Europeanization' of its policy area began only relatively recently.

There is a large and useful law and policy literature on this complicated topic (Hervey and McHale, 2004; Mossialos and McKee, 2004; Steffen, 2005; Mossialos et al., 2008; Greer, 2008a). The key points in the literature are that the creation of EU health service policies is not a response to major interest group pressures and that public health policy is only a slight response to these. In public health, the European institutions gained importance as a result of crisis response (to the BSE – 'mad cow' – crisis) (Clergeau, 2005; Farrell, 2005) and Commission use of funding to engage public health advocates (Greer, 2008b). There is no evidence that the member states wanted the EU to intervene in their health services (Greer, 2006), and hardly any evidence that they wanted the EU to intervene in the sphere of public health. In health services, the European Court of Justice started to apply internal market law to health services from 1998, services previously thought (for no obvious reason) to lie outside the internal market. Later, the European Commission would incorporate health into the proposed Services Directive (the 'Bolkestein directive'), although it would be stripped out after fierce lobbying. In other words, EU institutions and not domestic lobbies have been the main protagonists in the development of an EU health policy, and we should therefore safely expect health lobbying to be a reaction (one that need not take place equally quickly in all places).

Hypotheses

We test three broad hypotheses about who lobbies and the structure of interest representation. Our interest is structural biases, towards given groups, countries or interests, because these are the issues that have clear

consequences for democracy. These also support more elaborate work on tactics and access.

The *first* hypothesis derives from a long-standing debate that has focused on the relationship of influence at EU and member state level. It reflects the intuition of many frustrated activists: if you fail to get what you want in your member state, you might have better luck elsewhere. It also reflects the fear of incumbent groups that some EU activity might blindside them.

One argument is that the frustrated will remain frustrated and the incumbents need not worry much. This would mean that the EU offers advantages to the groups that are already powerful – in other words, that domestic power is fungible. This is what Beyers calls the ‘positive persistence’ hypothesis: the EU rewards established powers more than it creates new opportunities for the excluded or weakens established powers. It is easier to use member state access and the resources of the established powerful than it is for state-level outsiders to circumvent the problematic member state level and get what they want in EU politics (Beyers, 2002; Jeffery and Palmer, 2007). That would support the argument put forward, among others, by Stefano Bartolini when he referred to the EU as an ‘elite consolidation’ (Bartolini, 2005).

Students of EU lobbying have formulated two solid alternatives, however, that posit different relationships. One is what Beyers calls the ‘compensation thesis’: interest groups that are frozen out in domestic politics should have more incentive to engage with the EU (Beyers, 2002: 594). This compensatory strategy would mean that they would invest in EU politics as a way to compensate for their domestic weakness and create a correlation between outsider status in the member states and efforts in Brussels. The second alternative is that the conditions for success in member state politics might make a successful group ill-adapted to the different rules of EU politics (Coen and Dannreuther, 2003: 272; Cram, 2001: 613; Greenwood, 2003). This is Beyers’ ‘obstinacy thesis’, positing a negative correlation between integration on the member state level and integration into EU networks (Eising, 2003; Beyers and Kerremans, 2007). In a sustained analysis of professional representation in Europe, Greenwood argues convincingly that professions are poorly represented, with particularly weak and ill-adapted peak groups (Greenwood, 2003: 132). This would be just what partisans of the obstinacy thesis might expect: those organizations with substantial and successful investments in lobbying on the member state level will be unwilling or unable to invest in the new EU arena.

In the health sector, the key test of the ‘positive persistence’ hypothesis should be the power of professional organizations. In every country, professional organizations are crucial actors and often powerful lobbies, endowed with significant self-regulatory powers, economic influence and

long intertwining with the states that regulate the basis on which they have such powers, responsibilities and monopolies. Professions' 'participation in a set of relatively stable, closed policy networks has served to promote a close working relationship with their "sponsoring" ministries' (Lovecy, 1999: 143). So perhaps they could be 'obstinate': ineffective on the EU level because they are trapped, or lulled into sleep, by their close connections with member states. On the other hand, if groups with influence and success at the member state level can translate that power and those resources over to the EU level, then organized professions should become very influential actors in EU health policy.

H1: Existing inequalities of power are reproduced at the EU level and this should be especially visible for professional organizations.

The *second* hypothesis is that there will be systematic and predictable variations in the level of engagement by groups of countries. Van Schendelen complains that there are not enough studies of differences between countries and their engagement (van Schendelen, 2002: 132). Although this is hardly such a study (see e.g. Fairbrass, 2003; Schmidt, 2006), we can test, in the case of the health sector, a composite hypothesis from different ideas canvassed in the literature. First, the suggestion is that post-communist states (Estonia, Latvia, Lithuania, Poland, the Czech Republic, Slovakia, Hungary, Slovenia, Romania and Bulgaria) will have lower levels of participation. This will be owing to some combination of weakness in civil society and the recency of their accession. The second important idea in the literature is that Europe has a 'Southern question', which means that the structure and preoccupations of interest groups in Southern Europe (Portugal, Spain, Italy, Greece, Cyprus and arguably France and Malta) result in a lower participation in EU interest group politics than is the norm for 'Northern' (other EU-15) member states (Greenwood, 2002). The third is that the countries of North-west Europe developed a culture of independent lobbying earlier than the others, and so were able not just to translate their experience and approach to the EU level but also to gain first-mover advantages as effective lobbies (van Schendelen, 2002). These three ideas all suggest that groups of countries – Mediterranean, North-west, and post-communist – will have different levels of EU lobbying activity.

That concept is entrenched in Brussels folk wisdom, but there are some obvious alternative hypotheses. One is that richer countries lobby more because they can afford it, whereas poorer countries cannot; what looks like a British or Dutch culture of lobbying might turn out to be nothing more than a luxury of countries with a high per capita gross domestic product. The other is that lobbying is a function not so much of member state character or

region as of the stakes – the amount of money available. In that case, recipient countries should have more lobbies, because there is more for them to get out of the EU, as suggested by Zimmer et al. (2005) in the context of member states' political strategies.

H2: Southern and post-communist EU states will have lower levels of interest representation at the EU level than Northern EU states.

The *third* hypothesis is about who participates in what. Mazey and Richardson (2006) define the EU policy style as an adaptation to the complexity and turbulence of EU decision-making processes. The Commission will consult widely in the initial stages of a policy idea but narrow down its consultations to a small number of groups as well as the expert panels in which government-chosen experts dominate. There is a great deal of EU lobbying literature broadly finding support for this pattern, from a variety of theoretical perspectives other than Mazey and Richardson's. It argues that the Commission uses funding and closed forums (Mahoney, 2004) to select a subset of groups with which it will regularly communicate, using the promise of enhanced access to induce lobbyists to communicate useful information rather than their preferred and obviously tendentious arguments (Brodscheid and Coen, 2003, 2007). The key point is that, no matter which theory, this hypothesis postulates that the Commission should be actively structuring interest groups into insiders and outsiders, and a few groups will be reliable insiders across different issues.

H3: The Commission consults very widely but has a much narrower range of stable interlocutors, as seen in funds and structured consultation.

These hypotheses are mainly concerned with biases in EU lobbying, rather than the strategies that actors follow in established policy areas – the foundations rather than the edifice. This means that they operate one level beneath newer research that focuses on the ways that the EU is interpenetrated with other orders of government, and the ways interest groups and coalitions forum-shop and operate across multiple levels of government (Coen, 2007; Michalowitz, 2004; Woll, 2006, 2008).

Data and methods

Our main source of evidence is a quantitative database constructed from a number of sources. First, we worked with data from the CONECCS database maintained by the European Commission. CONECCS is a self-registration system of interest groups, in which they fill out a questionnaire and the

Commission exercises a gatekeeper role. The total number of organizations was around 700 for the full EU interest group ecology and around 70 for health organizations; slight variance in the totals reported below is due to dropping cases with relevant data missing. The data were coded, as far as possible, to be comparable with the databases of Wessels (2004) and Mahoney (2004).² The large size and interesting range of data in CONECCS have made it a popular base for the creation of data sets (Mahoney, 2004; Wessels, 2004).

But there are two limitations to CONECCS. First, the self-registration system means that there can be gaps when interest groups register with a DG's forum but not on CONECCS. Second, in CONECCS, groups can enter as many policy interests as they like, with no hierarchy among them. Most groups enter two to five policy interests, but a few enter 10 or more. Because entering an interest is costless, it is difficult to use it to identify their real priorities. Pragmatically, we culled groups that had 'environment' listed as an interest along with public health; this was to cope with the appearance of groups such as the European Association of Aquarium Curators in the set of health groups. Examination of the list of deleted organizations did not reveal any miscoding but did eliminate a large number of agribusiness associations, focused on food regulation, from the health list. We were then able to extract information from the database on their funding sources, headquarters location, date of founding and the country breakdown of membership.

To overcome these biases we complemented our CONECCS-derived database with a second one constructed from a wider range of sources. We refer to it as our 'participation database'. The first source of information in the database is the official representative forums organized by DG SANCO, which is responsible for health and consumer protection. Putting aside technical committees from comitology processes, which are concentrated in consumer protection rather than health services or public health, this means the European Health Forum (which has a 'Permanent' inner forum and a broader public forum) and the Platform on Diet, Physical Activity and Health. These forums are also what come up in a search of the Commission Secretariat's online register of organizations (which, irritatingly, replaces public access to the much more useful interactive CIRCA registry kept by DG SANCO). Including these forums is important for two reasons. First, not all groups in the DG databases are in CONECCS. Second, different forms of participation have different requirements and show different levels of commitment and access. We did not follow Mahoney's model and include the European Parliament registry of lobbyists (Mahoney, 2005: 52), principally because very few serious health lobbies (member state or EU) are included. The second source of information was the responses to DG SANCO's

consultation on possible EU health services legislation, which closed in January 2007. DG SANCO has since posted the responses online. Unlike the other sources we used, this does not require the contributor to be an EU-level group, or indeed a group, and individuals responded as well as a wide range of groups. This allows us to gauge interest in EU health policy beyond formally registered EU groups.

The use of these EU-derived databases is well established but, like any research technique, has its pitfalls. The principal hazard is that the use of the databases, which are kept by the Commission, produces an unjustified focus on European-level federations rather than (possibly more effective) efforts by individual organizations. The study of business groups, particularly, has found that individual firms are often just as effective as European groups, or even more effective (Coen, 1997; Eising, 2008), and, even if this finding is not replicated across all of the EU institutions, member-state-level associations (most germane for health) at least gain access to the European Parliament as successfully as EU-level groups (Bouwen, 2004). Furthermore, commercial consultancies make data 'noisier' – tobacco companies and some private healthcare providers, for example, usually rely on them and do not appear under their own names in most lists.

Two things mitigate these problems. One is that member state groups are included in some of our measures (they can submit consultation responses and join parts of the SANCO forums); this should reduce the bias towards a focus on EU-level organizations. Second, although EU groups are not the whole of Brussels lobbying, they are an important part of it and are thus particularly good for judging initial interest, because they are both the obvious, cheap 'entry-level' option and an arrow in the quiver of almost any organization, no matter how elaborate its other forms of representation.

To assess the first hypothesis, we also conducted a small survey of member state interest groups. The first step was to develop an initial list of major health organizations in the member states from online sources. We then reviewed the Health Systems in Transition (HiT) series of country profiles, substantial portraits of each European health system produced by the European Observatory on Health Systems and Policies, an organization supported by the World Health Organization, governments and universities. The peer-reviewed HiT profiles are written to a template and generally include lists of the major organizations.³ The second step was to send a short questionnaire to the member state organizations in each country by email, telephone and fax in March/April 2007, asking if they had an office in Brussels or other investment in EU policy or political capacity. We checked this information against the information in a well-established directory of public affairs (European Public Affairs Directory, 2007).

Finally, we complemented the analysis with semi-structured in-depth interviews: 51 interviews with EU officials ($N = 12$), member state and regional government officials from the UK, France, Germany and Spain ($N = 18$), and lobbyists, mostly of EU-level organizations ($N = 21$), between July 2003 and November 2006. The main waves were in the periods from October to December 2005 and March to July 2006. The qualitative evidence from these interviews is not the focus of this paper, but did allow us to structure and interpret quantitative data. Above all, it allowed us to benefit from information about how the EU health policy arena operates – for example, which forums are seen by the Commission and lobbyists as more and less important. It also gave us some confidence that the number of health lobbies working on their own or through consultancies is still relatively small; open-ended questions about who was active in Brussels typically elicited a list of EU-level groups. Tobacco companies and a few private hospital chains were the only groups that we found acting through consultancies rather than in their own names.

Results and discussion

So what answers does the health sector give? We started off by assessing the *first hypothesis*. Ideally, we would know the power of each health interest group in each member state and the size and influence of its EU representation. That would require unavailable data and pose coding problems, so instead we approached the question in three ways (triangulating).

The first takes off from the fact that dominant players in most countries' health policies include – and are sometimes restricted to – professional organizations. Furthermore, as Greenwood (2003) points out, professionals have traditionally been badly organized at the EU level. So choosing organized professions as a proxy for dominant incumbent coalitions in health is stacking the deck *against* confirmation of the hypothesis by choosing undeniably important (and often obstinate) players that might not be well equipped to engage with Brussels.

As a simple first test of professional groups' engagement, we compare their count of affiliations with EU health groups with the affiliations of other types of groups within each country, and with their involvement in EU policy generally. On both dimensions we find little evidence of weakness, as Figure 1 shows. In every country, professional organizations' connections to EU health groups outnumber those of trade unions, employer federations, service and production federations, and associations of public authorities *combined*; moreover, the share of professional group involvement in health is

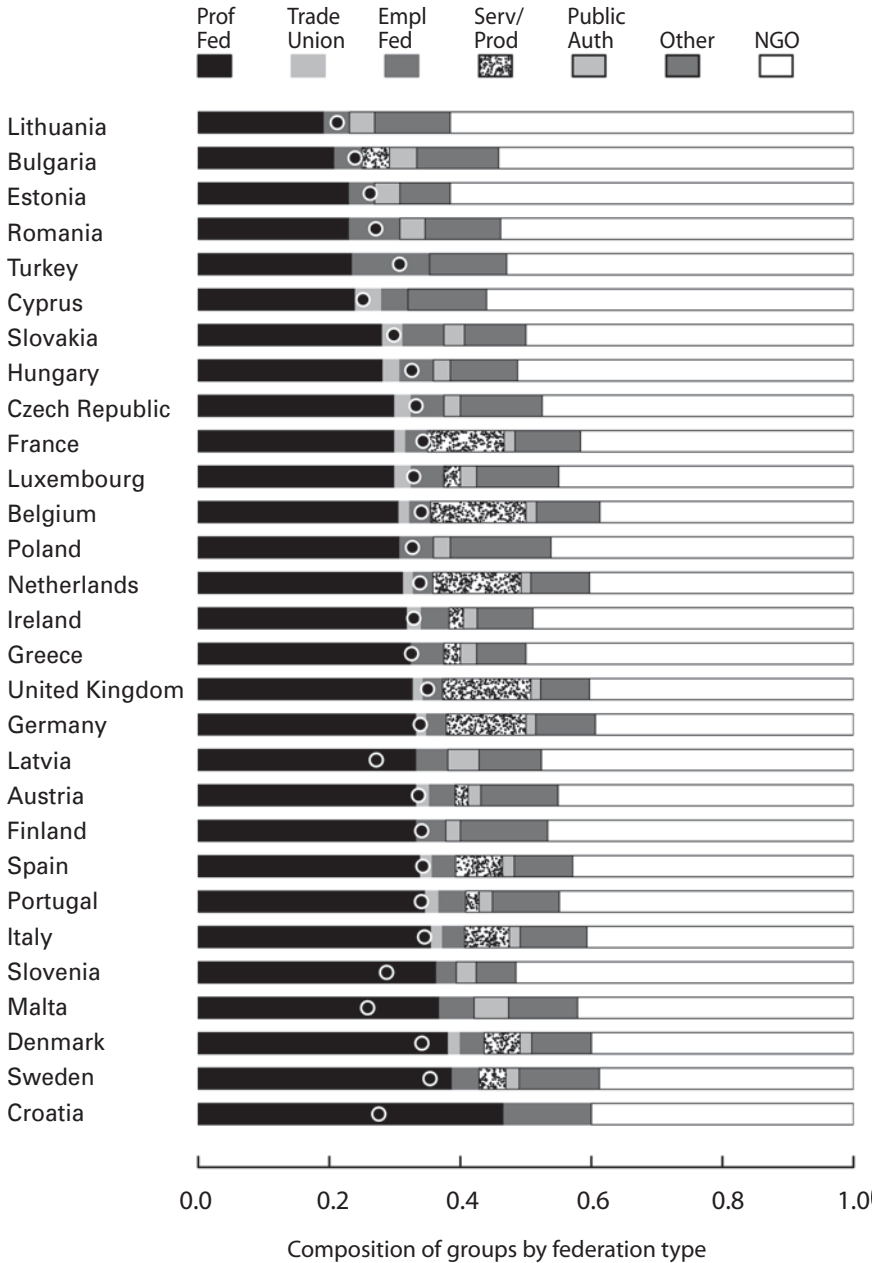


Figure 1 The country-level ecology of EU group membership. Bars show the proportion of a country's memberships in 72 EU health organizations involving professional federations, trade unions, employer federations, service and production federations, associations of public authorities, other groups, and NGOs. Black circles show professional federations' memberships in 646 EU organizations across all policy areas. Data: CONECCS (2007).

similar to professional groups' engagement over all policy areas. And, although there were more affiliates from non-governmental organizations (NGOs) than from professional groups (except in Croatia and Sweden), many are disease and patients' groups, which are numerous in many political systems and are often disregarded (or seen as front groups for the pharmaceutical industry). There is, so far, no obvious reason to worry about the fate of dominant health sector players. In fact, there is no obvious reason to worry about any of the relatively narrow interest groups (see also Schneider and Baltz, 2003). The groups overwhelmingly represent individual diseases, groups of patients, health organizations or professions.

A second test on the same theme considers whether associations locate their headquarters in Brussels or elsewhere. Greenwood argues that an association located outside Brussels is much less likely to be politically significant or well organized in order to engage in EU politics, in contrast to scientific or other debates (Greenwood, 2003: 14–15, 124). Low-cost airlines and fast trains reduce the importance of a physical office in Brussels, but opening an office in Brussels still sends a message and allows staff to spend more time attending relevant events.

We model the choice of 710 European interest groups to locate in Brussels or elsewhere using logistic regression, allowing the probability of a Brussels headquarters to vary across seven types of group. Our findings are summarized in Figure 2, which shows the probability for each group, along with a 95% confidence interval (Table 1 presents the logit estimates themselves). Overall, about 60% of the EU groups have their headquarters in Belgium, overwhelmingly in or very close to Brussels. NGOs (49%) and associations of public authorities (38%) are considerably less likely to locate in Brussels, whereas European trade unions seem more likely to do so (74%). Solidly in the middle, near the overall average, we find professional, trade and employer federations – a result that does not suggest the reluctance to engage with the EU that worried Greenwood in the discussion above.

So far, Hypothesis 1 stands. The power of professions persists positively. But it needs a third test. Professional organizations, powerful everywhere, are also prominent in Brussels. But are the groups in Brussels the *right* professional groups? Are they really representing the powerful organizations at member state level? There are always charlatans who are eager to make claims of representativeness that do not stand up, and they are especially plentiful in health (Greenwood, 2003: 136).

This question can be partially answered by turning it around. Instead of starting on the EU level, we started with the member state level, identifying the major member state professional organizations with our survey and then measuring their EU activity. The survey results show that the major

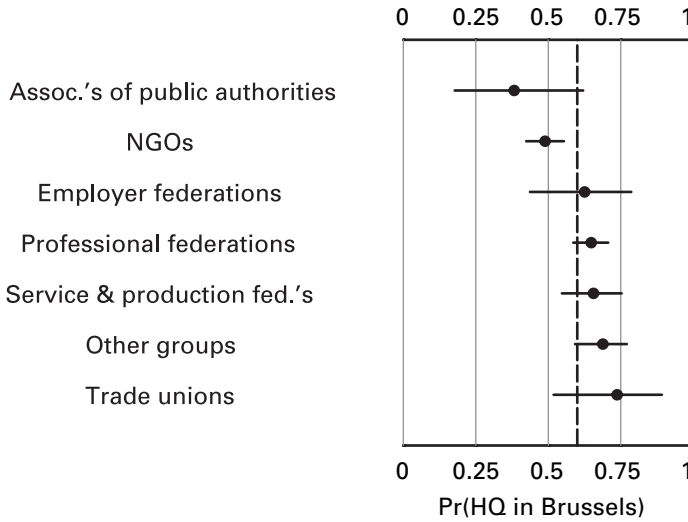


Figure 2 Probability of a Brussels headquarters by interest group category. Conditional expectations from the logistic regression in Table 1, with 95% confidence intervals for each estimate. The dashed vertical line indicates the average group had a 60% chance of a Brussels headquarters.

Table 1 Logit estimates of the probability of a Brussels headquarters

<i>Covariate</i>	<i>Estimates</i>
Associations of public authorities	-1.31* (0.56)
NGOs	-0.84* (0.25)
Employer federations	-0.27 (0.45)
Professional federations	-0.19 (0.26)
Service and production feds	-0.14 (0.32)
Trade unions	0.30 (0.56)
Constant	0.80* (0.22)
<i>N</i>	710
log-likelihood	-465.9
AIC	945.8

Entries are logit coefficients, with standard errors in parentheses. Political, religious, and other groups comprise the omitted category. Data: CONECCS (2007). * $p < 0.05$.

state-level associations identified in the HiT reports mostly join the same EU organizations: the list of major medical and nursing organizations is also the membership of the Standing Committee of European Doctors (CPME) and the European Federation of Nursing (EFN). They did not, however, all have

equal engagement with Brussels. There were three broad tiers among the member state associations. One tier had high levels of engagement, joining one or more EU associations and maintaining an office in Brussels or a commuting EU policy officer; there were four such organizations (not counting Belgian associations, which quite naturally had offices in Brussels). Those in the second tier joined one or more EU associations and had an identifiable international office but did not have a specific EU office. Groups in the final tier belong to one or more federations but do not have a Brussels office or an identifiable international policy division (and were extremely difficult to contact; the failures were the medical associations of Greece, Ireland, Latvia, Luxembourg, Romania and the Netherlands, and the nursing associations of Denmark, Estonia, Hungary, Ireland and Slovakia).

Hypothesis 1 is not refuted but is somewhat qualified. Professional organizations are powerful in member states and are well represented among EU groups. The qualification is that the level of engagement of the most important professional groups varies. The extent to which the positive persistence hypothesis holds appears to vary from country to country. But what about non-professional groups? We chose professions because we theoretically expected them to be the most rooted in member states and therefore least likely to be able to carry their influence across to the EU. But the first test – the representation of different types of group – shows no unexpected biases and the second test – location – showed that only public authorities and to a lesser extent NGOs locate outside Brussels. Repeating the third test for other groups would be most telling, except it would be close to impossible to identify the set of patients, or disease, or other groups across the EU that might be interested. So, although it is not hard to find people in EU health policy who are annoyed by the ubiquity of lobbyists for one disease or another, we cannot add support to that impression.

The *second hypothesis* was that there would be ‘regional’ variation – that North-western Europe would have stronger interest representation whereas Mediterranean and post-communist Europe would be weaker. To assess this hypothesis we take advantage of EU federation membership lists contained in our CONECCS-derived database for the full EU interest group ecology. We tally the groups in each member state affiliated with each EU federation; that is, for each EU-wide organization in the database, we count up affiliate groups in France, in Estonia, and so on. Summing these tallies by country gives us a measure of interest representation for each EU member, allowing us to assess differences in participation across four broad country groups: the Mediterranean states (Portugal, Spain, Italy, Greece, Cyprus, France and Malta), the post-communist accession states (Estonia, Latvia, Lithuania, Poland, the Czech Republic, Slovakia, Hungary, Romania, Bulgaria and

Slovenia), 'North-west' European states (Sweden, Denmark, Ireland, the UK, the Netherlands and Finland), and other countries in Western Europe (Germany, Belgium, Luxembourg and Austria).

Not surprisingly, we find big differences among these regions. On average, post-communist and Mediterranean states have 264 and 391 affiliates to EU groups per country, respectively, whereas North-western and 'Other' countries have 473 and 481. But because these four groups of countries differ on a variety of dimensions that might influence participation in EU interest group politics, we must go beyond simple descriptive statistics if we are to have any confidence that differences across regions really reflect their shared history of interest representation, rather than the confounding influence of other covariates. Our data consist of counts by country and show strong evidence of over-dispersion, which suggests negative binomial regression as a clear modeling choice.⁴

We begin with a baseline set of controls correlated with regions but likely independently to influence countries' ability and desire to affiliate with EU groups and to lobby the EU itself. First, larger states should have both greater resources to field large numbers of groups and greater demand for diversity or regional subdivisions among those groups, leading to more affiliates; hence we control for 2006 population size (CIA World Factbook, 2007). Second, to the extent that interest group formation is coincident with economic development, more affluent countries should be able to support a greater number of interest groups and thus have the opportunity to form more affiliations with EU groups. To capture this possibility, we control for per capita gross domestic product (GDP), measured at purchasing power parity in 2004, using data from the Penn World Tables (Heston et al., 2006). We log both population and per capita GDP to allow for the possibility of diminishing marginal returns, which is especially important because even small or underdeveloped countries may have a minimum basic set of interest groups. Finally, we control for the net contributions of each country to the EU in 2006. Larger spoils should attract greater lobbying activity, so countries with high net contributions should have fewer EU affiliates. Including all three controls results in three missing cases (Latvia, Bulgaria and Romania); however, alternate specifications suggest our main results are insensitive to their omission.

Our baseline model, without regional effects, produces results matching our expectations. Interpreting the coefficients in the first column of Table 2 as elasticities, we find that a 1% increase in population corresponds to a 0.23% increase in group affiliations, and a 1% increase in per capita GDP corresponds to a 0.55% increase in EU group memberships. Conversely, we expect countries with high net contributions to the EU to have somewhat fewer affiliations than net recipients, though this result is not quite

Table 2 Negative binomial estimates of EU group affiliates per country

<i>Covariate</i>	<i>Expected Sign</i>	<i>Baseline Model</i>	<i>Model with Region Effects</i>
In(Population)	+	0.23* (0.02)	0.23* (0.02)
In(per capita GDP)	+	0.55* (0.13)	0.42* (0.12)
Net EU Contribution	-	-0.021 (0.013)	-0.031 (0.011)
Post-Communist	-		0.07 (0.08)
Northwest	+		0.23* (0.06)
Other Countries	+		0.21* (0.08)
Constant		-3.33* (0.86)	-2.13 (1.33)
θ		76.5* (26.9)	135.6* (52.8)
<i>N</i>		24	24
log-likelihood		-126.3	-120.7
AIC		262.7	257.4

Entries are negative binomial coefficients, with standard errors in parentheses. θ is the dispersion parameter. Mediterranean countries are the omitted region in the second model. Data: CONECCS (2007). * $p < 0.01$.

significant. Adding controls for region to the model, we find persistent regional differences. The coefficients listed in the second column of Table 2 suggest that North-western and 'Other' countries should have, all else equal, over 20% more affiliations with EU federations than Mediterranean states, and at least 15% more affiliations than post-communist ones; both comparisons are statistically significant. Moreover, with regional effects controlled, net EU contributions emerge as a statistically significant correlate of group memberships.

To assess the relative importance of regional and economic covariates of affiliations, we plot in Figure 3 the expected number of affiliations for a comprehensive set of hypothetical countries. In each graph, we fix two controls at their means (e.g. GDP per capita and net EU contributions), allowing the third control (e.g. population) to vary across the full spectrum seen in the data. We plot out the expected participation rates resulting from the full model for each of our four country groups, taking care to show through dashed lines where our predictions stray into extrapolation. We can see, for instance, the strong pull of population and economic development: over the wide ranges of each seen in the EU-27, these variables are clearly strong correlates of group affiliations. Nevertheless, the effects of region are sizable, persistent and often cumulative, especially with GDP. In essence, we find a border bisecting Europe: to the East and South, we find post-communist and Mediterranean states lagging behind; to the North and West,

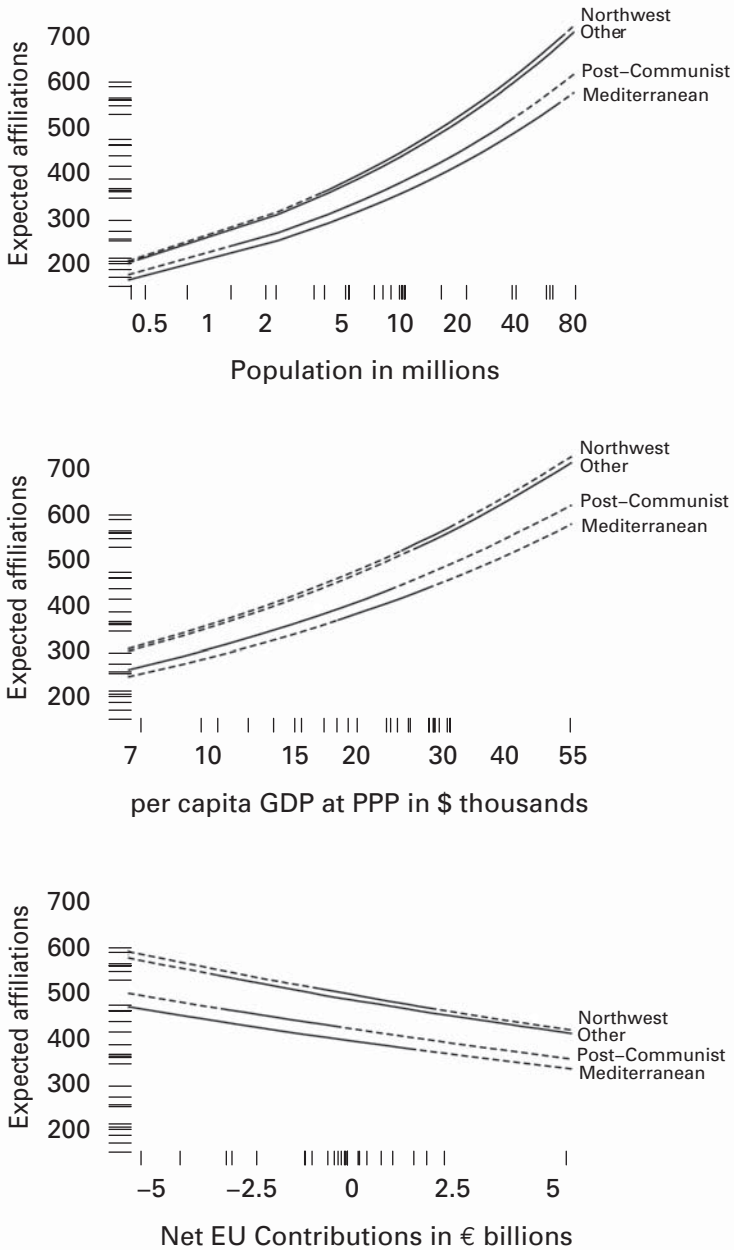


Figure 3 Country-level affiliations with EU federations as a function of region, population, development, and net EU contributions. Conditional expectations from Table 2, Model 2. Covariates not plotted held at means (population at 18 million, per capita GDP at 23 thousand dollars, and net EU contributions at 407 million euros). Dashed lines indicate extrapolation beyond the range observed in the region. Hash marks on axes show the observed data. Population and GDP per capita axes are log-scaled.

we find states more integrated in the interest group politics of the EU, even controlling for their economic and demographic muscle.

The *third hypothesis* is that the EU does not just replicate member-state-level biases, but also creates its own, with access strongly influenced by the Commission's habit of picking partners. In our reading of the literature, the Commission has two principal ways of picking its interlocutors: funding them and listening to them. For the time being, the budget does not allow DG SANCO to core fund groups to work on health issues. Our interviews showed this to be a running political debate in EU health politics, with DG SANCO internally split between health officials who would like to core fund health groups, and consumer protection officials who prefer to control the DG's core funding for their clients. Because there is no specific budgetary provision for core funding health groups, there is no direct test of the hypothesis's discussion of funding. Yet groups funded on other budget lines may work on health issues as well, so Commission funding may have an indirect effect on health lobbies.

We provide a picture of the sources of funding of EU health groups (Figure 4). Most groups rely heavily on membership fees. Most associations of public authorities, service and production federations, trade unions and employer federations rely on them exclusively. Although most NGOs get most of their funds from fees, half also draw on the EU for considerable funding. These NGOs are from adjacent policy areas, such as the European ageing platform AGE, which is core funded by DG Employment and Social Affairs and participates in the Permanent Forum ('in close consultation with DG Employment', grumped a DG SANCO official in a May 2006 interview).

Nevertheless, those receiving funding are not in the center of the consultative machinery. Most of the organizations receiving funds from the European Commission are engaged in only one or two forums. The most likely reason is that they are not funded by DG SANCO, or if they have SANCO funding it is for consumer protection; EU organizations funded by a different part of the Commission are likely to focus on the activities of their sponsoring DG.

We can also test the structure of advice given to the Commission, a measure unaffected by the problems affecting core funding. To work this out, we used our participation database, which includes information about participation in the various forums surrounding DG SANCO. We look for two separate but potentially reinforcing patterns: the presence of a small set of insider groups that are systematically more likely to participate in multiple health forums, and the existence of elite forums drawing their membership primarily from these repeat players. If an insider/outsider divide is evidence of elitism in the structure of EU lobbying, then a convergence of insiders and elite forums suggests the Commission uses its power as a gatekeeper to

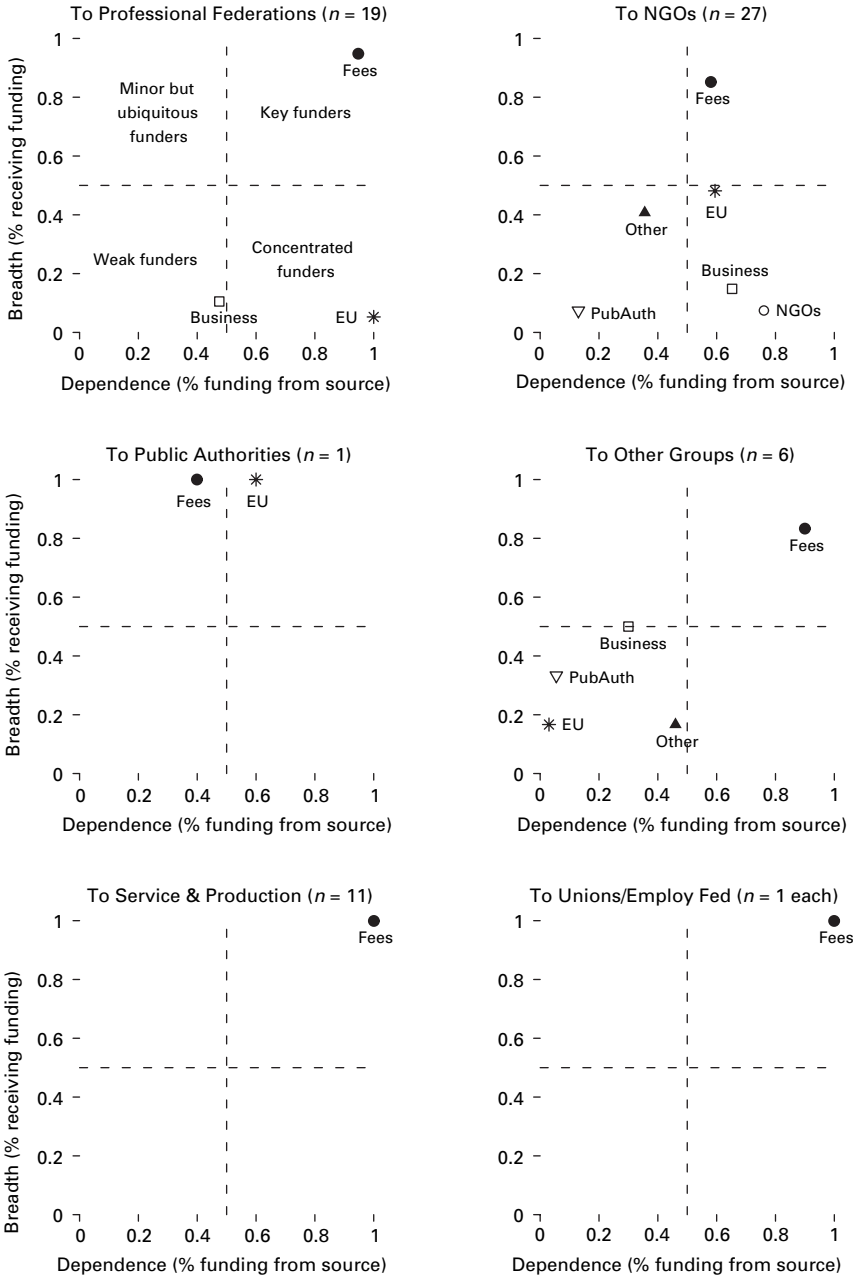


Figure 4 Finances of EU health organizations, by type of recipient. Vertical axes shows the percentage of groups in a category (e.g. professional federations) receiving any funds from a given source (e.g. membership fees). Horizontal axes shows the degree to which recipients depend on those funds. Funding sources not used by any organizations omitted. Data: most recent reports from 66 health organizations in CONECCS (2007).

produce this structure. Our interviews and the formal membership requirements suggest a tiered structure among the different health forums.⁵

Based on membership requirements, the least selective mode of engagement is responding to DG SANCO's 'open consultation' on health services, a precursor to legislation that ran from late 2006 until the end of January 2007, receiving submissions from 234 groups. There were no barriers to participation, and respondents include governments, individuals, Euro-regions, groups of doctors and all manner of EU and member state interest groups. Because DG SANCO worked to elicit responses from as many groups as possible, this should present a large part of the total number of groups interested in the EU's health services policy.

The second-most selective interaction, also available to groups that are not EU-level federations, is participation in the Platform on Diet, Nutrition and Physical Activity organized by DG SANCO. This is open to any organization and includes member state and EU lobbies, companies, governments and a range of health professions. If the DG SANCO consultations had a substantive bias towards those interested in health services, the Platform has a bias towards public health (participants included McDonald's, which is naturally interested in public health politics, as well as public health advocates, governments and others).

The third form of interaction is also within the Platform: making a 'commitment' to an action for the Platform. Groups then report their activity and progress back to the Platform and the other members. Commitments can be small or unfulfilled, but they are a statement of intent and failing in them presumably looks bad. A group need not even join the Platform to make a commitment but, unlike merely joining, a commitment can create a cost.

Next in terms of difficulty come the groups that bothered to be listed in CONECCS. This requires that a group be an EU-level organization and gain the approval of the Commission Secretariat gatekeepers for the database. But it is easy for EU groups that focus their energies elsewhere to add 'health' as an issue in their CONECCS sign-up without participating more actively in health lobbying.

The remaining forums require that a group have a specific interest in health, that the group be an EU-level group and that DG SANCO agree that it is a serious health actor. The easiest of these forums to join, and the least influential, is the European Health Forum (EHF) Open Forum. Joining the EHF Open Forum is approximately as open as gaining a listing in CONECCS (an online form and Commission approval), but is specific to health. Registration for the forum requires the group to care about health and DG SANCO to agree it is a serious EU health lobbyist.

Last come the groups in the EHF Permanent group (also known as EUPHF, European Union Public Health Forum), which are selected by the Commission. The elite status of this particular group is documented. One of the creators of the EUPHF, an official of DG SANCO, is on record explaining the EHF two-tier structure in terms that could almost have been written by Mazey and Richardson (Mazey and Richardson, 1995; Baer, 2001). Casting it as an exercise in democratic theory, he explained its structure as a balance between democratic participation – the Open Forum to which any EU group can contribute – and reliable interest representation, seen in the stable EU-level organizations of the Permanent EUPHF (there is also supposed to be a Virtual Forum, which has not happened). In other words, the Permanent Forum was designed to be a forum for insiders. Tellingly, he gave this talk at the European Health Forum Gastein, one of the regular events at which the ‘European health policy community’, such as it is, meets.

To test quantitatively whether some forums are more elite than others, we show in Figure 5 the percentage of groups with one, two, three or more forum memberships belonging to each forum; elite forums should have a

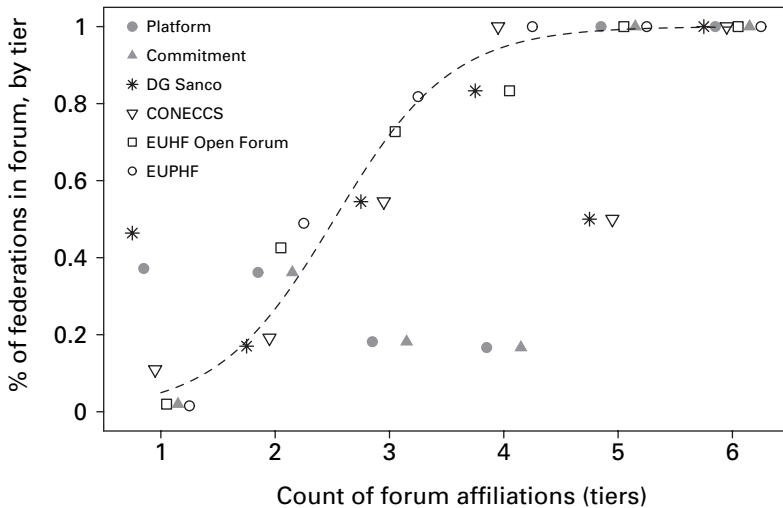


Figure 5 Health federations' preferred mechanisms of engagement.

Plot divides health organizations by the number of affiliated fora, showing the percentage of health organizations within each level belonging to a given forum. Dashed line shows the best fit from a robust and resistant bivariate regression on the logit scale. The number of groups at each level match Figure 6, with the addition of 343 non-EU federations belonging to just one forum, for a total of 457 single-forum groups. Data: EUPHF (2006); EUHF Open Forum (2006); EU Platform For Action On Diet, Physical Activity And Health (2007); Commitment to EU Platform For Action On Diet, Physical Activity And Health (2006); DG SANCO Consultation (2006); CONECCS (2007).

smaller and more select membership consisting mostly of groups that already participate in the other forums. The data reveal the expected ranking of forums by cost of admission, yet a surprising degree of randomness in forum membership among moderately involved lobbies. Consistent with expectations, the EHF Open Forum and EUPHF are poorly attended by groups with only one membership; instead, these groups tend to choose SANCO's open consultation or the Platform. On the other hand, all groups with four or more affiliations are members of the EUPHF, the forum most often mentioned in interviews; moreover, these groups overlap strongly with the answers interviewees gave when asked to list major groups. Yet, although the Permanent Forum appears to be the essential forum, it is not as selective as we expected: even groups with just two memberships are *more* likely to join either EUPHF or the EHF Open Forum than they are to take the simpler actions of listing in CONECCS or participating in SANCO's open consultation.

Finally, the choice to join or make commitments to the Platform appears idiosyncratic, and is usually made by groups with no other involvement in health forums. These forums draw a large number of food-oriented groups that are not interested in the health service issues of the EHF or SANCO consultation, and thus constitute a different point of entry to health policy. Conversely, most groups with three or four forum memberships seem to be interested only in health services policy, rather than the nutrition and physical exercise components of public health.

We can take a different look at whether there is a hierarchy of forums, and gain a useful tool for assessing whether groups can be divided into insiders and outsiders, by estimating a simple model of forum engagement. We make two assumptions: first, that each group decides whether to engage in a given forum independently of its choices to join other forums, and, second, that the probability of engagement in a particular forum is the same for every group. We refer to this baseline as the 'independence' model. Estimation is complicated by the fact that our sample omits all groups that failed to join a single forum, as some would surely do by chance under the model. Fortunately, we can infer the number of missing participants under the independence assumptions, and correct our estimates accordingly (see the methods appendix). Our estimates are presented in Table 3. Groups were twice as likely to be listed in CONECCS as to join the Permanent Forum (a statistically significant difference), with participation in DG SANCO's open consultation and the EHF Open Forum falling in the middle, as expected. We also find much smaller rates of participation in the Platform, suggesting again that it draws a different crowd from other health forums. Notably, no forum drew more than one-third of our adjusted pool of groups, suggesting no single forum encompasses the entire interest group ecology.

Table 3 Probability of forum membership under independence

<i>Forum</i>	<i>Uncorrected Probability of Membership</i>	<i>Corrected Probability of Membership</i>
CONECCS	0.40 [0.33, 0.47]	0.29 [0.21, 0.37]
DG Sanco	0.35 [0.28, 0.42]	0.25 [0.18, 0.32]
EUHF Open Forum	0.27 [0.21, 0.34]	0.19 [0.14, 0.26]
EUPHF	0.21 [0.15, 0.27]	0.15 [0.10, 0.20]
Commitment	0.18 [0.12, 0.23]	0.13 [0.08, 0.18]
Platform	0.16 [0.11, 0.21]	0.12 [0.07, 0.16]
Observed groups (<i>n</i>)	181	
Non-participants ($n^* - n$)		72.9 [46.4, 114.7]
Total groups (n^*)		253.9 [227.4, 295.7]

Entries in the first column are the Bernoulli MLEs of the probability an EU-level federation joins the listed forum, assuming all federations make this choice independently and identically. The second column corrects these estimates for the bias caused by omitting of federations with no forum memberships. 95% confidence intervals in brackets. Groups which are not EU-level federations excluded from the analysis. Data: See Figure 5.

Turning to the question of whether forum participants can be classed as insiders or outsiders, in Figure 6 we rank the groups by total forum memberships and find a pronounced participation gradient. (We include only EU-level federations in this test because only they are eligible to join all six forums.) The distribution tails off sharply as most groups participate in only one activity. On its face, the pattern is exactly what we would expect from the authors who developed this hypothesis: many groups interact once or twice, but only a few are insiders that routinely engage. However, this participation ski slope is convincing evidence of an insider/outsider divide only if rates of forum membership differ significantly from the distribution that would emerge from random activity. For example, if the independence model holds, through random chance alone we would see some groups with greater engagement than others, yet these differences would not indicate any *systematic* differences in the tendency to engage. Only if some groups have a higher probability of engagement than others can we infer a meaningful insider/outsider divide.

Using the estimates from Table 3, we calculate the expected number of groups at each level of participation under the assumption that groups join forums randomly and independently (see the methods appendix). We plot these estimates, along with a 95% predictive interval, in Figure 6. At first glance, this new distribution appears to match observed group behavior: the

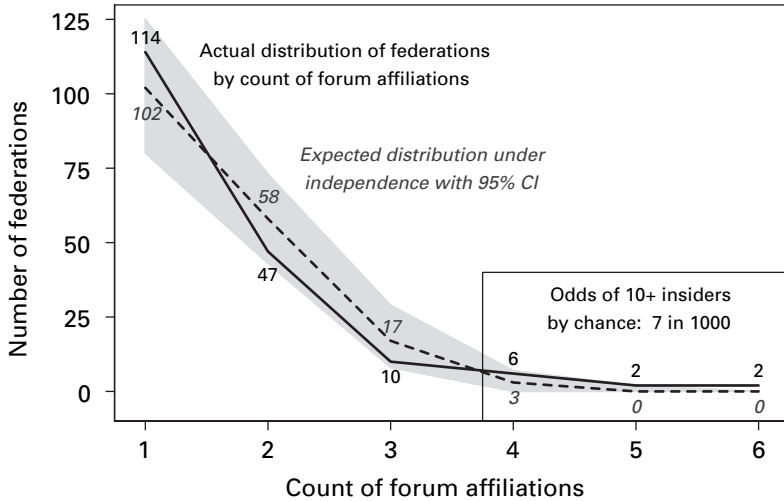


Figure 6 Insiders and outsiders among EU-level health federations.

The plot shows EU-level health federations grouped by the number of forums joined (solid black line), compared to the distribution they would follow if they chose to join or refrain from each forum independently with probabilities given in Table 3, column 2 (dashed gray line). See note 8 for methods details. Data: See Figure 5.

steep drop-off in participation turns out to be not dramatically different from random behavior. Closer examination, however, reveals significant deviations from independence: we observe 10 groups engaged in four or more arenas, whereas under random participation we would expect only three – and none at the highest levels of engagement. Indeed, without systematic differences in groups' tendency to engage, the odds are a mere 7 in 1000 that we would see 10 or more such insiders. Conversely, too few groups have a foot in the door. Only 57 groups belong to two or three forums, a total so low we would see it in only 1 out of every 25 draws from a random distribution. The divide between insiders and outsiders has re-emerged, though the decisive evidence is not the statistically unremarkable appearance of dozens of groups with limited engagement, but the statistically improbable (if not substantively surprising) presence of 10 widely engaged lobbies.⁶

Those 10 elite groups, the 'inner circle' of Jarman (2008: 31), should be well known to anybody who frequents EU health events. The Association Internationale de la Mutualité, which represents social insurance funds; the professional group European Union of Medical Specialists (UEMS); the industry-funded Pharmaceutical Group of the European Union; the industry-funded European Patients' Forum; the European Hospital and Healthcare

Federation, which represents providers; the European Health Management Association; the NGO-dominated European Public Health Alliance; the EU-supported consumer federation BEUC; the European Heart Network, which is funded mostly from industry and otherwise by the Commission; the Standing Committee of European Doctors; and the enterprising Euro-HealthNet – they are distinctive for participating in many different forums, including both the more public-health-oriented Platform and the more health-services-oriented EHF and SANCO consultation.

Hypothesis 3 appears to miss the mark. Although formal interest representation has a pronounced insider/outsider dimension, it is not a simple story of exclusion by the Commission. What distinguishes the insiders listed by interviewees is not that they belong to particular insider forums but that they engage with many different forums. Their interests in different forums appear to dictate whether they join, rather than the Commission deciding on a hierarchy.

Conclusion

EU interest representation in health is biased in favor of those who are already powerful in the member states and the Commission, and against poor, post-communist or Mediterranean states. Our data bear out the views of some scholars and the folk wisdom of the EU institutions that find post-communist and Mediterranean states less prone to lobby. It is not clear whether it is reassuring to find that they do lobby when there are large absolute sums of EU money to be had. This suggests that the contribution of interest group politics to EU democracy can be overstated, even if defenders of Europe's incumbent health system elites might feel relieved. Replicating state-level biases is closer to Bartolini's 'elite consolidation' rather than an advanced form of pluralism or deliberative democracy.

The surprise was in the fate of Hypothesis 3. EU lobbying is often presented as a story of many transients who pass through Brussels and a small core of really influential groups. In health, we found a small but diverse group of insiders and modest but statistically significant variation in the probability that groups join one or another health services forum.

This might be a validation of our sectoral approach, of delving into one sector, because it allowed us to count the many groups that are engaged in health politics without listing in CONECCS and grade their engagement based on knowledge of the forums, and thereby led us to a surprising conclusion. It also makes a point about measurement and raises questions about work based on CONECCS alone. CONECCS is a small part of the

all-forum database, with a membership that does not fully overlap the other health forums. The reason is the costlessness of adding extra interests in a CONECCS registration. To take one example, EUROPATAT, the European Union of the Potato Trade, is in CONECCS and added health to its interests in CONECCS. But it did not care enough to join the Platform, let alone other forums.

Substantively, the findings suggest a story about resources. Wealth, population size and a country comfortable with lobbying all predict engagement with EU interest representation. So does a good record in drawing resources from the EU. Incumbent lobby groups do well at the EU level and do not seem to have been outflanked by any intrepid but under-resourced outsiders. And when we look at the structure of interest representation itself, it suggests that 'insiders' are simply the groups that expend the time and energy necessary to participate in multiple forums. Each of these findings suggests the same thing: EU interest representation favors the energetic and well financed. It is a pluralist choir, but as Schattschneider might have noted, it has a suspiciously upper-class (and Dutch, German or British) accent.

Democracy aside, the findings are satisfying, by and large, for the literature. But they raise some obvious questions (Dür and De Bièvre, 2007; Michalowitz, 2007). For example, are those 10 elite groups getting their money's worth by joining all those forums? Are there some other insiders doing something we cannot pick up in the formal channels? These, however, would require different studies.

Methods appendix

This appendix details the estimation of the marginal probability a group will join a given forum, as well as the expected number of forums joined by a group under independence. Obtaining these estimates would be straightforward, except that our sample includes only groups that belong to at least one forum. One common strategy for dealing with this problem, the truncated binomial distribution, would exclude our knowledge of the differing marginal probabilities of joining each forum, and thus bias our results against finding independence. Instead, we use the available information to impute the missing data, then treat the data on the six forums as separate, independent and identically distributed Bernoulli draws.

For observed groups $i = 1, \dots, n$, let y_{ij} indicate whether group i is a member of forum j , and let Y_i record the sum of group i 's forum memberships. To find \hat{Y}_i , the expected number of forum memberships per group

under independence, we must first estimate the probability that a group joins forum j , which we denote p_j . We might use the maximum likelihood estimator (MLE), $\hat{p}_j = \sum_i y_{ij} / n$, but, because our data are truncated to exclude groups that joined no forums, this estimator is biased upwards. However, we can recover these missing observations and construct an unbiased estimator, \hat{p}_j^* , by noting that, under independence, the number of groups with no forum memberships must equal the (unobserved) total number of groups, n^* , times the probability that a group belongs to no forums, $\prod_j (1 - p_j)$. Formally, the implied total number of groups under independence is

$$n^* = n / \left[1 - \prod_j (1 - \hat{p}_j^*) \right].$$

Substituting this corrected n^* into the MLE yields six conditions that the corrected probabilities must satisfy:

$$\hat{p}_j^* = \frac{\sum_i y_{ij}}{n} \left[1 - \prod_j (1 - \hat{p}_j^*) \right], j = 1, \dots, 6.$$

We obtain \hat{p}_j^* by substituting in the uncorrected MLEs and solving the resulting system of six equations. Now we can simulate the predicted total memberships \hat{Y}_i of our \hat{n}^* groups under independence, taking care to incorporate both the estimation uncertainty in \hat{p}_j^* and the fundamental uncertainty in \hat{Y}_i (Gelman and Hill, 2007, Ch. 7, provide an overview of the relevant simulation principles).

Notes

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- 1 The best reviews are Beyers et al. (2007) and Coen (2007).
- 2 The database is posted online at <http://www.sph.umich.edu/iscr/faculty/profile.cfm?uniqname=slgreer>, as are a series of tables illuminating various points in this text (including a descriptive table that compares the total with the health subset).
- 3 Data available at <http://www.euro.who.int/observatory>.
- 4 See Cameron and Trivedi (1998) for an extensive review of count models and the negative binomial.

- 5 These groups were in place in late 2007, but a legislative proposal promised for late 2007 and still unpublished would be likely to change them.
- 6 This result does not appear to be an artifact of the six forums chosen. We find similarly improbable concentrations of insiders even if we exclude the Platform and Commitment to the Platform from the model (on the concern that these groups draw from a systematically different pool of participants), or if we exclude the EHF Open Forum and the Platform (on the grounds that membership of these forums is strongly correlated with the EUPHF and Commitment, respectively).

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