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A European Social Citizenship? Some Reflections on the Recent Case-Law of the European Court of Justice

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When the rules on the citizenship of the Union appeared in the Maastricht Treaty, most commentators received them very lukewarmly. The European citizenship was built as a complementary institution and a mere addition to national citizenship – as unnecessarily specified by Article 2 of the Amsterdam Treaty. Even the most well-disposed observers saw it as a simple consolidation of subjective legal positions, which were already recognised by Community legislation. Most of them saw Union citizenship as a status summarizing rights that already existed in the system, even though with little practical relevance; and few were confident that this status could strengthen the dimmed legitimacy of Community institutions, even though only symbolically, as was the intention of the revisers of the treaties (see e.g. Weiler 1996).

The criticism most frequently made of the notion of citizenship of the Union is that it could not free itself of its mercantile legacy and of the ‘market citizen’ model that has always dominated the Community construction (See *ex plurimis* Everson 1995; and for a retrospective insight

Bell 2007, especially at p. 313). The citizenship of the Union was weakened since its inception on the very grounds that should have been its strength. It was deprived, in fact, of true political meaning and content, thus ending up reaffirming the central position of the paradigm of the economic player, the ‘market citizen’, without even promising an authentic universalization of the freedom of movement and residence within member states. And even though the European Commission tried to instil some optimism about its potential, only few believed that the limitations posed by secondary legislation – as expressly reaffirmed by the EC Treaty in what currently is Article 18(1) – could make it possible to overcome the traditional and clear-cut functional demarcations (between economically active and inactive individuals) for accessing free movement and related-rights in the host State.

Today, if we look retrospectively at the powerful interpretative innovations that have been introduced by the Court of Justice’s case-law since the end of the 1990s, it is hard to understand why the potential of Articles

17 and 18 of the EC Treaty was so underestimated. By now, the Court of Justice has accustomed us to its role of 'judge-as-artist', a moulder of a truly European social dimension, which can open 'des horizons meilleurs aux citoyens, sans tourner les dos aux réalités et aux situations concrètes', as Advocate General Ruiz-Jarabo Colomer has recently written¹. In fact, it is now difficult to account for the amount of caution and scepticism expressed when the rules on citizenship of the Union were read for the first time.

Beyond any reasonable expectation, the Court of Justice upheld the views of those (few, to be honest) who believed that the capacity for institutional self-regeneration and change were implicit in those weak provisions (see for this terminology Kostakopoulou 2005). The transformative potential of the institution that was cautiously designed by these rules was perceived to be marginal at the beginning of the 1990s, but then took centre-stage later. Nowadays, one can well argue that the 'European citizenship constitutes a unique experiment for stretching social and political bonds beyond national boundaries' (Kostakopoulou 2007, 624).

Thus, since the Court recognized the citizenship of the Union as a 'fundamental status of nationals of the member states, enabling those who find themselves in the same situation to enjoy the same treatment in law irrespective of their nationality, subject to such exceptions as are expressly provided for'², the effects of Articles 12 and 18 EC in the form of cross-border access to social protection systems have expanded to the extent that the traditional boundaries of these systems have been questioned and perhaps irreversibly undermined. The status of citizen of the Union requires, as reaffirmed by the Court in *Grzelczyk*, 'a certain degree of financial solidarity between nationals of a host member state and nationals of other member states, particularly if the difficulties which a beneficiary of the right of residence encounters are temporary'³.

A critical overview of the Court's case-law – from the famous *Martínez Sala* decision⁴ to the latest judgements – provides food for thought about the spectacular and controversial outcome of a long season of renewed judicial activism (see Giubboni 2008). Some commentators have even stated that a new paradigm of social solidarity has at last emerged on a pan-European scale, which has redefined the boundaries of domestic welfare systems and the requirements for belonging to the resulting redistribution communities (Golyner 2005;

Dougan and Spaventa 2005; Verschuere 2007).

I am not arguing that the Community project was alien to forms of solidarity among member states nationals before the case-law reached this turning point. It is fair to recall that at least some of the 'existing accounts of European Union citizenship do not adequately capture its origins and growth', and that 'European rights have political origins' (Maas 2005, 1009). The rules on the free movement of workers – established in 1968 with a well-known provision in Regulation No 1612 on social advantages – rested on the association between free access to labour market and full equality of treatment in host member states in almost all spheres of social and economic life. However, in the last decade the case-law on Articles 12 and 18 EC has undoubtedly extended the scope of application of this association between equal treatment and solidarity, far beyond what could be expected from the wording of Community primary and secondary rules, to include all nationals of the Union simply on account of their sharing this 'fundamental

status'. This new paradigm of social solidarity is supposed to have an innovative element: inclusiveness. Social solidarity is projected beyond the traditional beneficiaries of the economic freedoms established in the Treaty. For this reason, attention must be devoted to the rights of movement and residence, and the relevant entitlements to social protection recognized by the Court's

case-law to the persons who do not play, or have ceased to play, an active role on the labour or service market.

This case-law, which Community legislators have only partially codified in a revision of the main instruments of secondary legislation in this area⁵, is a source of unresolved interpretative tensions. The relationships between the outcomes of interpretations reached by the Court's case-law and the explicit contents of secondary legislation – Directive 2004/38/EC and Regulations No 1408/71 and No 1612/68 in particular – are far from being clear and final. Above all, the case-law of the Luxembourg judges seems to have a strong tendency to go beyond the boundaries of the current EU regulatory framework. The interplay between the role of the Court of Justice and that of European and domestic legislatures generates mounting tension. From this perspective, this case-law has a constitutional dimension, anticipating the establishment of a more incisive role to be played by the Court of Justice, together with new paradigms of European social solidarity (Dougan 2006). And the Court

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seems resolute to defend the prerogatives afforded to citizens of the Union by the Treaty, much further than Community legislature seems ready to grant. The sensitive issues raised by this interplay must be tackled.

In sum, the boundaries of membership to the communities of solidarity-based redistribution laid down by the national welfare schemes have certainly become – especially thanks to the case-law of the Court of Justice – more open and permeable, and hence more inclusive, at least for European citizens. Union citizenship, from being a complementary and secondary institution as it was considered in the Maastricht’s revision, has become the epicentre of deep constitutional transformations and a sound anchor point of new bonds of ‘mutual social responsibility’ among member states’ citizens (Weiler 1998, 1095). The cross-border opening of welfare schemes to economically inactive Community citizens who can prove a certain degree of integration with the society of the host country may rightly be considered as the founding act of a new and more advanced notion of European solidarity.

However, the apparent conquest of this strong social dimension for the European citizenship is not devoid of limits and contradictions. The most blatant limit is that the inclusive and solidarity based approach of the European citizenship is offset by a symmetric closure vis-à-vis of those who are excluded from the membership. If one considers the situation from the point of view of third-country migrants, one must indeed conclude that a ‘process of equalisation co-exists with processes of exclusion, and the relativisation of the member states’ borders is accompanied by the reinforcement of the external frontiers of the Union and the relocation of migration controls in third countries’ (Kostakopoulou 2007, 634). Thus, it may be observed that whilst a comprehensive de-nationalisation and a de-territorialisation trend in the welfare systems is currently empowering Union citizens, for third-country migrants the functional status is becoming increasingly significant. And ‘it is particularly ironic that whilst union citizenship is transitioning away from the market citizenship model, this is being reconstructed in respect of third country nationals’ (Bell 2007, 329). The goal of overcoming this limit that is intrinsic to the ‘dual’ nature of the European citizenship will only be attained by replacing nationality with residence as a pre requisite for cross-border

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membership, something which is unrealistic today, especially for third-country nationals⁶.

Yet even the area of European solidarity, whose new boundaries have been traced by the Court of Justice, is not exempt from significant constraints and contradictions. Even though, admittedly, (as of today) there is no conclusive empirical evidence, the risk that the erosion of forms of domestic control by member states over the access to welfare schemes may in turn cause a reduction in the supply of social benefits, thus triggering dynamics of ‘social levelling-down’, cannot be by any means neglected (Ferrera and Sacchi 2007; Besson and Utzinger 2007). Indeed, it is an only apparent paradox that the progresses of a case-law that is inspired by a genuine ethos of integration may bring about negative social disintegration.

Such a risk may be intrinsic to the position that the Court of Justice was forced to adopt, which inevitably is individualistic as it is tailored on the single case heard

by the Court (see Newdick 2006). The outstanding prominence acquired by the provisions on Union citizenship actually rests on the same ratio that allowed the Court to model the constituent traits of the European economic constitution on the market freedoms. Yet, an approach based on the rights of individuals – even of Union citizens in need claiming a form of social assistance in the host member state – defies the necessarily collective dimension of solidarity. Financial solidarity among member states’ citizens thus becomes the piecemeal, individualistic, atomistic solidarity uprooted from a collective context: the dominant dimension of the European cross-border solidarity sanctioned by the Court of Justice in the individual case examined turns to be the fragmented one which is individually and sometimes opportunistically accessed by European citizens who have exercised their freedom of movement. From this perspective, a recovery of the truly collective dimension of social solidarity may be traced in those Court’s rulings in which, by balancing the State’s interest in keeping public spending under control and the individual exercise of a fundamental freedom, the Court emphasises a limit such as the ‘unreasonable burden’ that is also considered by the 2004 Directive.

It then becomes hard to identify a collective, political cement for European solidarity in the ECJ’s case-law: the reference model, if not the market citizen, would in any

case remain the rational player who takes advantage of the opportunities offered by the opening, or in any case the easier access to national welfare schemes. A sort of counter-argument supporting *a contrario* this conclusion can be extracted from the very recent case-law that de-values the meaning and European potential of the classic form of 'mechanic solidarity' which underlies industrial action at national and transnational level. The infamous *Viking* and *Laval* cases⁷ at least demonstrate that the Court of Justice is not (yet) prepared to recognise the constructive potential for the European political project of social solidarity which truly originates from transnational collective action at Community level (see Barnard 2008). By subjecting these forms of collective solidarity to a still dominant market-integration rationale, the judges in Luxembourg, quite apart from a correct balancing exercise between fundamental social rights and market freedom, vividly demonstrate a total absorption within this individualistic and quite paradoxical paradigm of 'European solidarity'. Trade unions are asked to incorporate, in their evaluations of the options at stake for defending the workers' interests, the 'objective' interest of market integration, that is to say the very interests of the counterparts they are acting against. The concrete collective solidarity which is at the core of industrial action (also at transnational level) is *ex ante* limited by this new duty to take into consideration the employers' economic freedom as protected by Articles 43 and 49 of the Treaty (see especially Wedderburn 2007 and Joerges 2007).

This is why criticism of the Court's excessive activism seems, at least partly, justified⁸. No matter how clever and appropriate the balancing of interests at stake performed by the Court under the principle of proportionality is in practice, there is still an 'ontological' gap between the complexity of the issues raised by the re-modelling of the boundaries of social solidarity in Europe and the – cognitive and legitimacy – resources that the Luxembourg Court has to tackle them. Hence, the Court should rather refrain from excessively interfering with the powers attributed to the legislature (European in the first place) with reference to the fundamental rules and procedures that are instrumental to the definition of those boundaries.

At the same time, the European legislature should exercise this role with greater awareness and efficacy. For instance, many have voiced the need to return to a more

active and far sighted use of the co-ordination technique, which has always provided the basis for Community social security law. The relevant regulations – which in the 2004 reformed version already have a general personal scope – should widen their material scope also. For example, it should be of the utmost importance to extend to social assistance and, notably, to the general minimum income schemes that are in force in many Union member states but are nonetheless excluded, as the former, from the substantive scope of Regulation No 883/2004, co-ordination criteria similar to those that have been in force for quite some time for special non-contributory benefits.

Bolder action is needed in the field of export of unemployment benefits, which are still burdened by the constraints of an anachronistic view of the European labour market. And if one wants to avoid the case by case approach of the Luxembourg Court to the very sensitive issues raised by the exportability of healthcare benefits and students maintenance aid, the European legislature must clearly lay down appropriate rules even for this matter, which are capable of balancing, on a necessarily general level, considerations of control over public spending (and elimination of forms of free riding) with those of individual freedoms.

However, one must be aware that the institutionalisation of a properly European form of social solidarity presses the Community legislature to overcome the mere logic of co-ordination of national welfare systems. The rooting of a form of 'organic' solidarity 'among strangers' in the enlarged Europe – to take up the evocative terminology used by Rainer Zoll (2003) – requires a minimum core of citizenship social benefits that are governed, and at least in part financed, at the Community level⁹. The idea of a European minimum income, which has been discussed for some time, as that recent notion of 'a civic remuneration in return for social, ecological and cultural services' (Zoll 2003, 189) go exactly in this direction, and yet they point to reform objectives that may be too far away on the Union's horizon. However, the first positive experiences of mobilisation of the European Globalisation Adjustment Fund (EGF) demonstrate that the Union is now ready to give its practical contribution to the governance of the processes of economic restructuring that are currently under way in Europe and to act as a buffer for their social consequences. The Fund – which does not replace the measures

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for which companies are competent under national legislation and collective agreements – has already co-financed customised service packages whose aim is to provide re-training and, hopefully, new jobs to workers who have been dismissed by European companies as a consequence of the delocalisation of productive activities, mainly to China (Nowaczek 2007). If the scope of the EGF were enlarged, for instance, one may think of an active, truly Community-based protection scheme against unemployment as a first stage of an incremental construction of a 'pan-European welfare scheme' (Ferrera and Sacchi 2007), capable of shaping that bond of organic solidarity among member states' citizens that currently only rests on their finances. Also a Community framework legislation on social services of general interest could help strengthen – in this optimistic, wishful picture – a true political dimension of European social solidarity (see essentially Ross 2007).

Yet, beyond the examples that have already been suggested or that can be imagined, the re-definition of the boundaries of the welfare systems of the 'Old Europe' certainly requires new and suitable *political* answers. As already observed, it is an integral part of a new social question that directly affects the European Union and its scope and capability to contribute to steering the complex processes of economic and social restructuring. And it is difficult to imagine that the Court of Justice, inspired as it may be by the best intentions, may alone give the answers that are needed.

* This article summarizes the Introduction and Conclusion of a paper forthcoming in *Modern Law Review*.

¹ Opinion delivered on 20 March 2007 in Joined Cases C-11/06 and C-12/06, *Rhiannon Morgan v. Bezirksregierung Köln and Iris Bucher v. Landrat des Kreises Düren* [2007] ECR-00000, point 1.

² Case C-184/99, paragraph 31, *Rudy Grzelczyk v Centre public d'aide sociale d'Ottignies-Louvain-la-Neuve* [2001] ECR I-06193.

³ *Ibid.*, paragraph 44.

⁴ Case C-85/96, *Martinez Sala v Freistaat Bayern* [1988] ECR I-02691.

⁵ Directive 2004/38/CE and Regulation No 833/2004. The latter is not yet in force, since the relevant implementation provisions are still missing.

⁶ For the overview of the recent EU legislative initiative aiming at the improvement of the status of third-country nationals see Nowaczek (2008)

⁷ Case C-438/05 and Case C-341/05 respectively.

⁸ For a newest example of this activism see the Judgment of the Court (Grand Chamber) 20 May 2008 in Case C-352/06, *Brigitte Bosmann v. Bundesagentur für Arbeit - Familienkasse Aachen*.

⁹ Of course, these European social rights to a decent level of living should be modeled according to a true universalistic paradigm of 'civic citizenship', encompassing third country residents

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Towards an EU Care Area without Borders? The New Commission Proposal for a Directive on Patient Mobility

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Introduction

Patient mobility is not a new phenomenon¹. Thousands of US patients have had their hips replaced in other countries in a quick, cheap and, last but not least, relatively safe mode. Yet the one aspect that makes the situation within the European Union different is the possibility of reimbursement by public healthcare authorities after receiving medical treatment in another member state.

While following the 2004 enlargement, free movement of workers triggered an intensive debate across the whole EU, the issue of free mobility of patients was a topic of rather anecdotal evidence and media reports and has so far attracted little attention on the policy agenda. One of the reasons for such a limited academic and public interest in this phenomenon might be its limited scale. In the documents attached to the new Proposal on patient mobility (European Commission 2008a and 2008b), the European Commission stipulated that the current volume of the entire phenomenon of patient mobility within the EU has been relatively low, estimated at around 1% (approximately € 9.7 billion) of overall public expenditure on healthcare². Around 4% of EU citizens travelled abroad to receive medical treatment; the number ranges slightly

between 2% to 8% across the EU with the exception of Luxembourg where 1/5 of population went to another member state to look for a medical care (Eurobarometer 2008: 7). The picture on patient mobility is blurred since most health systems in the European Union do not provide necessary data. It is symbolic that in spite of the fact that Regulation 1408/71 regulating so far patient mobility (Council 1971) was adopted over 35 years ago, member states still have not developed a comprehensive data system at the EU level regarding patient mobility and the financial implications of this phenomenon.

To codify patients' rights and procedures related to patient mobility and to improve information exchange in that respect, the European Commission tabled on July 2, 2008 a Proposal for a Directive on the application of patients' rights in cross-border healthcare (hereinafter a Proposal for a Directive on patient mobility). The Proposal took account of the ECJ jurisprudence in this field, concerns of member states of losing their independence in deciding on their own healthservice systems and a great variety of domestic solutions existing currently in the EU.

The main goal of this paper is to present the new Commission Proposal on patient mobility in the context

of relevant legal, social, institutional and political factors. After sketching currently existing rules regulating cross-border healthcare and socio-economic factors influencing patient mobility within the European Union, this article turns to a quantitative account of the phenomenon. How the EU decides to govern patient mobility is presented in the subsequent section giving an overview of key principles envisaged in the Proposal for a Directive on patient mobility. Finally some remarks related to some likely clashes between stakeholders during the negotiations and concluding comments are introduced.

Currently existing rules regulating patient mobility

The foundation for the current system regulating patient mobility was laid in the Regulation 1408/71. Due to the absence of further legislative steps and as a consequence of far reaching judgments on patient mobility, the European Court of Justice acted as a *de facto* legislator. For the last ten years it has ruled on several cases in which it stretched the Community understanding of application of internal market rules to health services.

The ECJ substantially challenged the legal status quo in 1998 with two landmark rulings. The *Decker*³ and *Kohll*⁴ judgements caused somewhat alarming response from national health ministries. The Court decided that patients could freely choose a health provider abroad without obtaining a prior authorisation. Afterwards they can claim for reimbursement 'as if they had received treatment in their home country'. A right to go to another member state to receive medical treatment was deemed to be linked with fundamental provisions related to the freedom to provide services (C-Kohll, par 35-36). As Ferrera (2005, 129) put it, patients could 'sneak out' of domestic schemes of affiliation, then re-enter them and 'voice' for compensation. The lack of guarantee to being reimbursed for medical costs related to treatment abroad up to the amount envisaged in a home state (i.e. a state of affiliation) stands against the freedom to provide services within the meaning of Article 49 EC⁵. Further cases⁶ clarified to what extent and in which circumstances governments could invoke the grounds of 'public security, public policy and public health' for the sake of mobility's limitation. The Court agreed that public health services were based on a fragile supply and demand balance. Capacity planning would be impossible if patients were totally free in choosing their health providers. To this end when stability of social security systems and maintenance

of medical and hospital services open to all are shaken, member states could justify the existence of 'overriding reasons relating to the public interest' (Ferrera 2005, 128-131; McKee, MacLehose and Albrecht 2004, 165).

The ECJ judgement from 2006 in the *Watts* case introduced also some further interesting changes in the Community legal regime⁷. Because of a long waiting time, Yvonne Watts asked the UK National Health Service for the permission to be treated abroad. The National Health Service did not accept her application, yet she decided for the treatment in France paying out of her pocket. Upon return, she claimed for reimbursement. Three years after an unfavourable ruling of the High Court in England and Wales⁸, on May 16, 2006, the European Court of Justice ruled in the case of Yvonne Watts that such a claim cannot be refused unless it is established by competent authorities that the waiting time for treatment 'does not exceed the period which is acceptable on the basis of an objective medical assessment of the clinical needs of the person concerned' (C-Watts, par 79). Since the *Watts* ruling, national healthcare authorities have become preoccupied that longer waiting lines may lead to an increase in the outflow of patients abroad. What is more,

the ECJ strengthened the position of the European patient by providing a structure and judicial procedures through which one could bypass the national system or challenge its decisions (Martinsen 2007, 18-19).

The EU legislation and subsequent ECJ rulings created a dual system of social coverage for healthcare received abroad⁹. The first system, related to the

E112 procedure requires that patients secure prior authorisation and offer conditions as if they were insured in a state where the service was received. In the second, more recent system (created by the *Decker* and the *Kohll* rulings) a patient pays for a treatment but claims refund as if he or she received service in his home country. Symbolically, the UK Department of Health 'warns' on its website against proceeding with the second scheme without consultation with a local health commissioner and without a legal advice. The ambiguity due to existence of dual systems creates confusion among patients, healthcare professionals and policy-makers (Palm and Nickless 2001, 13).

The scope of patient mobility is influenced not only by the legal system but also other factors related to a facilitated access to information, lower costs of travelling, public perception, citizens' willingness to go abroad in their quest for medical care and domestic institutional

"The EU legislation and subsequent ECJ rulings created a dual system of social coverage for healthcare received abroad".

arrangements. A full list of factors facilitating or hindering patient mobility could be very long; the below paragraphs gives the overview of those most relevant.

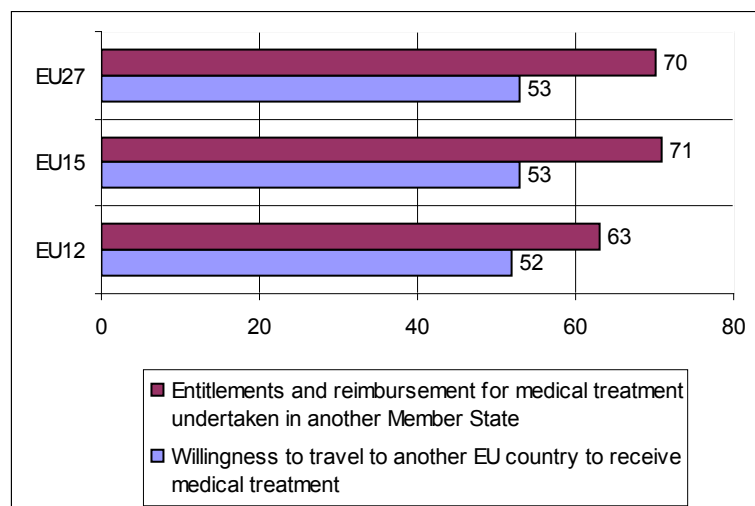
An ever increasing access to information and smaller costs of travelling have boosted medical tourism. Media, info-points, or internationally-oriented health care premises¹⁰ provide information about possibilities for obtaining medical service abroad. In the digital era, citizens are not dependent on the government and mainstream media as for the access to information¹¹. Several clinics' websites offer even review of testimonials and press articles with stories covering patients' experience in receiving medical treatment abroad¹². After screening media coverage on this phenomenon it becomes clear that press articles from British newspapers are flooded with product placements trying smartly to ease potential customers' worries about obtaining health service in foreign clinics and to encourage UK citizens to travel abroad. The latter, with the emergence of budget airlines operating to destinations located in new member states, has become more affordable than ever¹³.

The key finding of a recent Eurobarometer survey on patient mobility (Eurobarometer 2008) is that 30% of citizens are still unaware that they have a right to receive healthcare outside their country of affiliation (see figure 1). While nearly 90% of Dutch, Slovenians and Danes think that they have a right for a treatment abroad and

are likely to receive reimbursement, only around fifty percent of the Hungarians, Portuguese and Latvians believe so. The difference between the average among respondents from EU15 and from new member states is 8%. On the other hand every second citizen would be willing to travel to another EU country to receive medical treatment. Significant differences exist between various countries with 88% of Cypriots, 82% of Maltese and 79% of Irish prepared to travel, and just 26% respondents from Finland, 29% from Estonia and 33% from Latvia willing to go abroad. There is only a minimal, almost nonexistent positive correlation between the perception whether or not a health authority of a country of affiliation provides coverage for treatments abroad and the willingness to obtain such a service (Eurobarometer 2008, 10).

Conversely a variety of factors may lead to a decreasing outflow of patients and their growing reluctance for a treatment abroad. Authorities may decide to counteract the reasons for health tourism by increasing financial and technical capacity of local providers and effectively reducing waiting lists and waiting times (the UK National Health Service's target is to treat every patient within 18 weeks). One of the consequences of the High Court (2003) and the European Court of Justice (2006) rulings in the case of Yvonne Watts was government's determination to reduce the waiting times. Being concerned about the possibility of outflow of patients abroad, claiming their

Figure 1: Proportion of those giving a positive answer to the questions below



Notes: The following questions were asked: Q1. I am entitled to receive medical treatment in another EU country and be reimbursed for that treatment by my national health authority or health care insurer; Q2. Would you be willing to travel to another EU country to receive medical treatment?

Source: Eurobarometer (2008)

money back on the grounds of 'undue delays', a spokesman for the Department of Health stated that 'our objective is to reduce the length of time that people wait. Waiting times are falling and we are committed to continuing this progress' (BBC 2003b). The above mechanism might have been the reason why a number of E112 forms issued in UK declined throughout the last decade.

Lack of trust in bureaucracy and perceived inefficiency of international arrangements might be another reason. Foubister (2006) stipulated also that it is also the particular attitude of medical doctors that might have, at least in the UK, strong influence on patient mobility. 'Pride factor' not to send patients overseas, combined with the fear of the declining income can constitute major reasons why cross-border contracting may decrease. Instead of referring patients to clinics abroad, medical doctors who work privately and are contracted by the National Health Service might encourage their patients to 'go private' in the case of long waiting lists. In facing the dilemma between sending patients abroad or encouraging the NHS to contract more services, they usually opt for the latter one.

Institutional arrangements or habits existing across the EU can also halt or boost outflow of patients. For instance, as reported by Bertinato *et al.* (2005, 15), according to the pre-2004 system in Spain financial resources from abroad were not allocated to the regions. This led to underreporting of foreign treatment. Reforming the system and creating incentives for reporting made some regions drastically increase the number of reported patients. Until mid-1990s, Italian doctors quite eagerly referred their patients to foreign clinics justifying their opinion on the insufficient quality of services. In addition, 'institutionally arranged' mobility did not have direct consequences for the budgeting of regional health authorities since money was transferred directly from the Ministry of Health. The number of authorisation dropped significantly once, following the changes introduced in 1998, expenditure has been subtracted from resources allocated to the regions (Busse, Drews and Wismar 2002). The number of E112 issued to Italian patients dropped significantly from 16,280 in 1999 to 3,547 authorisations in 2004 (Busse *et al.* 2006).

Quantitative overview of patient mobility

Discussing the scope of patient mobility in the context of the new Proposal, the two procedures mentioned above have to be taken into account. The first

one relates to the situation when the health care is not provided in the given state and a patient is sent abroad (so called E112 procedure established under Regulation 1408/71). Domestic authorities apply this scheme when due to long waiting lines (e.g. UK) or a limited scope of domestic offer (e.g. Malta) they cannot provide treatment to their patients. The second procedure is applied when a patient decides to go abroad on his/her own without a prior authorisation from authorities (so called 'Kohll/Decker procedure').

The scale of planned treatment abroad has been relatively small accounting in the 1990s for between 0.3% and 0.5% (that is barely € 2.00 per inhabitant) of total expenditure on health care (Palm *et al.* 2000, 6). In this period, France (followed by Spain) was the most attractive destination country for planned treatment. After an increase for that kind of expenditure in 1993 (€ 1103 million), the total cost in the EU was declining throughout the 1990s to the level of € 758 million in 1998.

The most widely used data covering the decade of the 1990s (Hermesse, Lewalle and Palm 1997; Palm *et al.* 2000) suggest that, in spite of growing awareness on possibilities related to free mobility, per-capita expenditure declined in most countries (see figure 2).

The graph below (see figure 3), drawn on the basis of figures presented in the recent Commission document (European Commission 2008b, 70) provides only a partial, greatly underestimated, picture¹⁴. Nevertheless it gives an interesting overview of this phenomenon in EU member states. In 2004 the most popular state of treatment was France that wrote out a bill to other states worth of nearly 350 million Euros. The second most famous medical premises were located in Spain claiming 156 million Euros from other countries and owing 37 million. On the other hand Germany owed almost twice more (295 million Euros) to other EU states than it received from them. The ratio between claiming and owing is even more significant in the UK (almost 4:1). Such comprehensive data are lacking for later years and therefore it is difficult to argue if the states that joined the EU in May 2004 are becoming more popular countries of medical treatment for foreign patients (or if they would send more citizens abroad). Back in 2004 they represented only a tiny portion of the picture and it was basically Slovenia that attracted a great majority of foreign patients among all new member states.

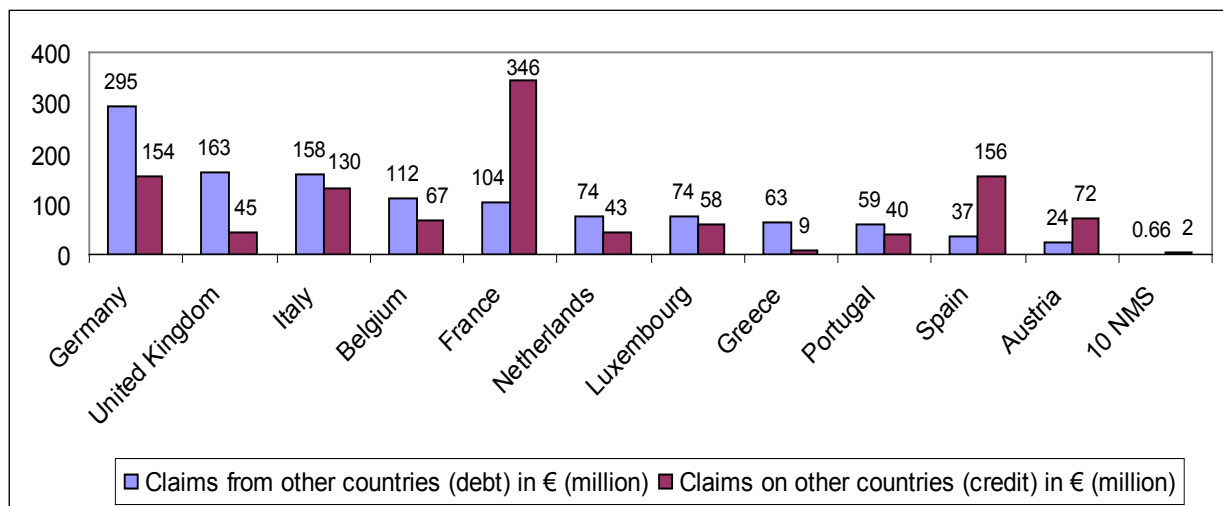
Back in 2004, the European Commission sought

Figure 2: Per capita expenditure (in €) on patients receiving healthcare services in other EU countries

	1989	1993	1997	1998
Belgium	3.62	8.93	8.93	4.38
Denmark	–	0.16	0.83	0.63
France	0.79	1.87	1.21	1.05
Germany	1.77	1.83	2.08	2.21
Greece	0.95	2.51	2.68	3.15
Ireland	0.18	0.65	1.68	0.93
Italy	2.99	8.36	3.52	2.89
Luxembourg	58.01	149.55	135.29	116.00
Netherlands	1.95	0.26	1.98	2.85
Portugal	0.82	3.76	6.81	7.00
Spain	0.33	1.48	1.03	1.11
UK	0.33	1.61	1.92	0.36
Austria	–	–	0.48	1.87
Finland	–	–	0.49	0.52
Sweden	–	–	0.65	0.96
Average	1.31	2.95	2.37	1.99

Source: Palm *et al.* (2000)

Figure 3: Claims under Regulation 1408/71 in € millions in selected states for 2004, emergency and planned treatment



Source: European Commission (2008b, 70)

to collect data on claims for reimbursements *without* prior authorisations (i.e. 'Kohll/Decker procedure'). Although questionnaires were sent to all EU15 member states only four governments provided a reply. France indicated that data of that kind was unavailable as it is collected by regional sickness insurance funds, and the UK government mentioned that it was aware of some cases but could not deliver any detailed information. Against this background, any conclusive remarks can hardly be made. Besides the cases of Austria and Belgium, it seems that at the beginning of the century the phenomenon of 'self-managed mobility' combined with reimbursement application hardly ever occurred. The Austrian government informed that most of the financial

resources allocated for these claims (€ 3,445,470) were distributed among patients using non-hospital services (mainly dental services) provided in Hungary. In Belgium expenditure linked to 'Kohll/Decker applications' grew from € 87,284 in 1999 to € 224,639 in 2001 (Busse *et al.* 2006).

Overview of key rules envisaged in the Proposal

Patient mobility has always been a politically difficult issue mainly because of the question whether a new legislation will lead to 'liberalisation of health services', as anticipated by some, or simply codify already existing rules, as in the end tabled in the draft. After a few years of pre-legislative debate and a few months of very serious

controversies within the European Commission about the content of the draft (see for instance Euractiv 2008a and 2008b), the Commission decided to include the revised Proposal in the package of 19 documents composing the Renewed Social Agenda and adopt it on July 2, 2008.

The legal basis for the Proposal is Article 95 of the Treaty calling for measures that should have as their object the establishment and functioning of the internal market. The Directive will establish a framework for cross-border healthcare but will not substitute rules under Regulation 1408/71 but rather complement them. It will specify and clarify the entitlements of patients to have healthcare in another EU member state. The Commission decided for a directive as the most appropriate legal instrument for such a scope of intervention although during the public consultation, several contributors informed the Commission that they would prefer to include changes within the already existing Regulations on the coordination of social security systems (European Commission 2007, 5).

The Proposal is based on the main principle that patients will be reimbursed to the amount that would have been paid had they obtained that treatment in their country of affiliation. As the Commission warns, patients going abroad would 'bear the financial risk of any additional costs arising' (European Commission 2008a, 5). The reasoning behind this principle is explained by the Commission in the Proposal. The limited level of reimbursement has been introduced to avoid 'health-care shopping' or as worded by the Commission to create a system wherein 'the patient should not derive a financial advantage from the healthcare provided in another member state' (European Commission 2008a, 27, preamble 24).

Against this background, it is a valid concern to what extent the Directive would not provide solutions for only rich and mobile patients from old member states who could afford seeking medical treatment abroad. On the other hand, poorer residents (in particular from new member states) would not be able to pay additional costs of medical treatment, let alone costs related to travelling. The Commission must have been aware of consequences of such a provision since already during the consultation process several stakeholders (i.e. providers, health care professionals) had informed about such side-effects. The Commission argued however that inequalities remain even if no action is taken and that other Community

instruments (e.g. structural funds for health infrastructure) contribute already to bridging the gap between more and less developed member states (European Commission 2008b, 46).

To find a proof for the validity of this criticism however, one needs to look no further than the very Eurobarometer report mentioned in the Explanatory Memorandum to the Proposal (Eurobarometer 2008, 23). Among factors that discourage citizens to obtain treatment elsewhere in the EU, 47 per cent indicated the factor that 'medical treatment abroad is not affordable'. However the number differs significantly between residents of old member states and those that joined the EU in 2004 and 2007. While the EU 15 average is 40 per cent with only 19 per cent of respondents from Belgium and Luxembourg indicating this factor, 70 per cent of citizens from 12 new member states said that they could not afford travelling abroad to receive medical treatment (the highest being 82 per cent in Latvia and 77 per cent in Slovakia). The impact of this financial aspect is enormously different across the individual countries and it will surely play a significant role in terms of the scope of application of new patient mobility rules.

The Commission claims that there is no evidence that patient mobility in the case of non-hospital care 'will undermine either the financial sustainability of health and social security systems overall or the organisation, planning and delivery of health services'. It is because 'the reimbursement of such care remains within the limits of the cover guaranteed by the sickness insurance scheme of the member state of affiliation, the absence of prior authorisation requirement will not undermine the financial equilibrium of social security systems' (European Commission 2008a, 15). Therefore, Member States will be unable to require prior authorisations from patients going abroad.

Slightly different rules have been envisaged for hospital care¹⁵ wherein the Directive would give national governments a possibility to introduce a system of a prior authorisation. Member states can however apply this safeguard clause only in situations where 'there is evidence that the outflow of patients due to cross-border hospital care undermines or is likely to undermine the financial sustainability of health and social security systems overall or the organisation, planning and delivery of health services and that prior authorisation is necessary and proportionate to maintain the financial and

"The Proposal is based on the main principle that patients will be reimbursed to the amount that would have been paid had they obtained that treatment in their country of affiliation".

organisational balance of the health and social security system in question' (European Commission 2008a, 16). Patients should normally receive a decision regarding an authorisation for a cross-border healthcare within fifteen calendar days. In more urgent cases evaluated on the basis of factors such as the specific medical condition, the patient's degree of pain, the nature of the patient's disability, and the patient's ability to carry out a professional activity, that period should be shorter (European Commission 2008a, preamble 33 and Article 9).

The Commission clarifies that the Directive will *not* modify the existing framework for coordination of social security schemes (i.e. scenario 1 in figure 4); it would rather put in place an alternative mechanism based on the principles of free movement and building on the principles underlying decisions of the ECJ (European Commission 2008a, 4-5). From patients' perspective, these two systems are 'coherent' (European Commission 2008a, Preamble 22); 'the patient may choose which mechanism they prefer, but in any case, where the application of Regulation 1408/71 is more beneficial for the patients, the patient should not be deprived of the rights guaranteed by that Regulation' (European Commission 2008a, Preamble 23). As a matter of fact, when the treatment cannot be given within the time medically justifiable, taking account patient's current state of health and the probable course of the disease, patients could still follow a path envisaged in Regulation 1408/71 (i.e. scenario 1)

rather than the one codified in the Directive (i.e. scenario 4 in the case of hospital treatment). However, in practice, if patient is mobile, entrepreneurial and willing to cover a difference in costs of treatment in his home country and costs arising in a relation to treatment abroad, he could still opt for a faster and less bureaucratic scenario under the Directive (however such an exit option is a reasonable only in the third scenario, i.e. going abroad with no authorisation required).

What would happen, under the new Directive, if patients, although being required to apply for authorisation (i.e. scenario 4), go abroad for *unauthorised* hospital care treatment? Could they still invoke rights enshrined throughout *Decker* and *Kohll* rulings¹⁶ and apply for reimbursement after coming back home? If a member state wants to introduce a system of a prior authorisation, it must be able to prove that 'there is evidence that the outflow of patients due to cross-border hospital care undermines or is likely to undermine the financial sustainability of health and social security systems overall or the organisation, planning and delivery of health services and that prior authorisation is necessary and proportionate to maintain the financial and organisational balance of the health and social security system in question' (European Commission 2008, 16). Only by doing so, national rules would comply with rulings of the ECJ that list cases where a system of authorisation can be introduced (in particular *Smits* and *Peerbooms*,

Figure 4: Cross-border healthcare provided under the existing and future systems

		Applied procedure	Means of payment	Amount of reimbursement
Existing systems	1	E112 procedure (authorisation obtained)	Domestic social security institutions cover the costs	Costs of treatment and any additional costs covered by public funds
	2	"Kohll/Decker procedure" (unauthorised treatment)	Patients meet the costs themselves	In the case of hospital care no guarantee that the costs will be reimbursed (sometimes a law suit remaining the only option), in any case costs reimbursed <i>only</i> to the amount that would have been paid had patients obtained that treatment in their country of affiliation
Proposed systems	3	Authorisation not required	Patients meet the costs themselves	Reimbursement at <i>least</i> * to the amount that would have been paid had patients obtained that treatment in their country of affiliation
	4	Authorisation required (a safe-guard clause possible only in the case of hospital treatment)		

*The Proposal stipulates that 'Member States *may* nevertheless provide in their national legislation for reimbursement of the costs of the treatment at the tariffs in force in the Member State of treatment if this is more beneficial for the patient' (italics added, European Commission 2008a, Preamble 21).

Source: European Commission (2008a, 2008b, 27 and 2008c)

paragraphs 76-80). Following an unauthorised treatment and in order to receive a reimbursement patients would have to argue in judicial or quasi-judicial proceedings that a system of authorisation in the case of their particular medical intervention was introduced in breach to the conditions set up the Court of Justice and the Directive. In order to avoid such situations in future, the Commission will need to screen the way member states implement the Directive and the scope of application of prior authorisation systems.

Costs emerging at the beginning of the implementation of the Directive are considered as being unlikely to put a heavy burden on domestic administrations and to undermine sustainability or planning of health systems. On the other hand, treatment and social benefits are significant (see figure 5). The Commission claims that, in the long term, initiatives suggested in the Proposal will improve the quality and efficiency of all healthcare, not only for those patients who move abroad but also those

who stay in their home state (European Commission 2008a, 9-10).

Each member state should establish central contact points to which patients-to-be can address their questions. To face challenges related to the variety of domestic systems, they should closely cooperate among each other. Although it is up to national governments to decide upon the form of those contact points and their number, the requirement of setting up contact points, imposed by this Directive, will surely constitute additional administrative and financial burden for member states. National administrations are expected to cooperate also on other issues discussed in the Proposal (and not analysed in this article) such as 'recognition of prescriptions issued in another member state', 'European reference networks', 'e-health', 'cooperation on management of new technologies' and 'data collection for statistical and monitoring purposes'.

Particularly in the Explanatory Memorandum to

Figure 5: Estimated financial impact of the Proposal based on modelling

Costs	
Treatment costs	30.4 million
Compliance costs	315 million
Administrative costs	60 million
Benefits	
Treatment benefits	585 million
Social benefit	780,000 extra patients receive treatment

Source: European Commission 2008b, 63

the Proposal the Commission reminds that it is up to member states to organize and deliver health services (see Article 152(5) of the Treaty). Against this background, the Proposal is considered to be in full compliance with these considerations. On the other hand, under other Treaty provisions (see Article 49) member states may be required to 'make adjustments to their national healthcare and social security systems' (European Commission 2008: 8-9). While it was reminded by the Commission that in the ECJ's rulings the above does not undermine member states' sovereign powers in the field, as a matter of fact it constraints them in further modifications of domestic systems and creates even pressure to reform current settings. It is because the Directive, once adopted, will give freedom to EU citizens in choosing foreign premises where they would like to receive a medical treatment. Already now it becomes obvious that national health systems will require significant adjustments to adopt

to forthcoming requirements. For instance, the current Danish system will be found in breach of EU rules. For the time being, the 'free choice' available to Danish citizens has been limited to those foreign hospitals which had concluded an agreement with competent institutions (Martinsen and Vrangbek 2008). As of July 2008, only six non-Danish premises are listed: three from Germany, two from Sweden, one from Spain (updated list available at: <http://www.sygehusvalg.dk/geoomraade.aspx>).

If the member state does not include a particular treatment as an element of its citizens' entitlement package, the Directive does not establish any extra rights for such entitlements (European Commission 2008, 14). This interestingly stands partially against further reasoning of the Commission that declares that, in coherence to the hitherto adopted anti-discrimination legislation, 'the Directive provides that patients shall enjoy equal treatment with the national of the member state

of treatment' (European Commission 2008, 25, preamble 13). If two people from different member states have free access to different packages of a medical assistance, this may constitute *de facto* discrimination. Only time will show, if under pressure of patient mobility (if any), there will be a growing convergence of scope of free treatments available to insured citizens.

The Commission mentions that 'healthcare providers are not obliged to accept patients from abroad for planned treatment if this would endanger the maintenance of treatment capacity or medical competence in the receiving member state' (European Commission 2008a, 9-10). It is not however further elaborated, either in the Communication or in the Proposal, how receiving states may prevent inflow of patients and still comply with equality provisions.

The scope of the application of new rules to third-country nationals is never explicitly discussed in the Proposal. Since the draft defines a 'patient' as any natural person who receives or wishes to receive treatment (Article 4, Proposal), the Directive should cover all third-country nationals being insured and legally residing in any EU member state. Implications of the new legislation for this group of residents and the need for measures that prevent any forms of discrimination should be mentioned and adequately strengthened in the text of the Proposal.

Chances for the adoption

According to Jean-Claude Fillon, Deputy Head of the Community and International Affairs Division within the French Ministry of Health, Youth and Sports, the French Presidency will initiate without delay an examination of the text in the Council; most probably September 2008. Nevertheless it is difficult to estimate how long deliberations on the Proposal will last, and when the final text will be adopted (if at all). As a matter of fact, the Proposal may be a source of some critical cleavages and playground for various stakeholders to gain political prominence on both domestic and European levels. The usual suspects would be those campaigning against further extension of EU competences or further enlargements, malcontents criticising free movement of citizens, and opponents of liberalisation of health services. The wide scope of this list proves that finding a compromise satisfying all parties will be a mission almost impossible¹⁷.

Official position of national governments is still to

be disclosed. As a member state representative stated, the current version improved significantly comparing to the previous version mainly thanks to the clearly stated possibility for a member state to establish a prior authorization system for hospital care. The same diplomat somewhat paradoxically argued that it should be up to national governments to decide what constitutes hospital and non-hospital care (Euractiv 2008b). The below list presents some possible difficulties arising during deliberations (a list far from being exhaustive):

- to what extent is the subsidiarity principle being respected?,
- lack of truly comparative data will make an evidence based decision-making on the part of national negotiators impossible,
- financial burden on national, regional and local authorities difficult to estimate,
- problems with common definitions, in particular of 'hospital care' due to a diversity of definitions across member states,
- unclear rules regarding safeguard clause, i.e. 'a prior authorisation system',
 - significant administrative burden comparing to the scale of benefits profiting only very few people,
 - instead of ensuring legal clarification, the new rules may lead to more cases being filed to courts unless very explicit rules are established,
 - insufficient time envisaged for the implementation (one year after the adoption as stipulated in Article 22 of the Proposal),
- governments may perceive the need for protection of health sector superior to internal market rules (see for instance the protocol to the Lisbon Treaty on services of general interest).

Carola Fischbach-Pyttell, General Secretary of the European Federation of Public Service Unions (EPSU) argued that the fact that the Proposal was published as part of the Renewed Social Agenda 'should not mislead us to think that this is a social directive'¹⁸. Concerns about liberalization trends are voiced by representatives of the Greens/European Free Alliance. In the view of UK Green MEP Jean Lambert, tailored-made labels such as 'mobility' or 'choice' veil the negative impact that the new legislation may have on domestic healthcare services. Universal healthcare, in the opinion of the Greens/European Free Alliance, must come before mobility¹⁹. Even more critical remarks are introduced by the Confederal Group of the

"The Proposal may be a source of some critical cleavages and playground for various stakeholders to gain political prominence on both domestic and European levels".

European United Left/Nordic Green Left, which perceives a new Proposal as a re-introduction of 'Bolkestein' through the backdoor and that the already existing framework of the coordination of social security schemes suffices and there is no need for new legislation²⁰.

The European Consumers Organisation (BEUC) calls for a system of a prior authorisation that would not deepen inequalities between the member states and would avoid confusion among citizens and authorities. In the opinion of the European Hospital and Healthcare Employers' Association (HOSPEEM) the draft Directive goes 'beyond the rulings of the ECJ'. This could lead to some serious consequences for the organisation, financing and delivery of healthcare in EU27. The European Patients' Forum, an EU patient lobby, stresses that the new system should ensure a smooth reimbursement procedure for citizens travelling abroad for medical treatment.

The draft will unlikely go through the codecision procedure during the current Commission mandate. Although a first reading in the Parliament may still take place next spring, the following readings will have to be started from scratch after the June 2009 elections, involving the appointment of new rapporteurs (Euractiv 2008b).

Interestingly enough, even having solved all legal and technical problems, the fate of the Proposal may be in 'God's hands'.

What's religion got to do with it?

Although 'abortion tourism' represents only a minor part of the 'patient mobility' phenomenon, it is surely one of the most controversial. Common routes – highly reported by mass media – indicate *inter alia* women going from Ireland to the United Kingdom and a number of British women travelling to Spain for late term abortions. According to the Warsaw-based Federation for Women and Family Planning, many Polish women have decided to travel to another member state, mainly Germany and Czech Republic, to have an abortion. The so-called 'abortion tourism' means often cheaper and more reliable service than the one offered by private home-based clinics back home. Women that have chosen this solution rate highly the safety of the services provided (Federation for Women and Family Planning 2008, 26). A very recent case from Poland (June 2008) heated an ongoing debate between pro-life and pro-choice camps. Although it lacked a 'cross-border' factor it is worth mentioning and putting it in the context of a new legislative Proposal. Let me first provide some facts about the so-called 'Agata' case.

Having become pregnant at the age of fourteen after being raped by an older classmate, Agata, a Polish girl from Lublin decided for an abortion²¹. During several visits to hospitals in her hometown and Warsaw she was constantly approached by a priest and pro-life activists who had been informed about a teenage girl's attempt to stop pregnancy. Meanwhile all doctors refused performing a surgery on the basis of a conscience clause (i.e., the right of doctors to refuse an abortion if it is against their religious beliefs). Only after an intervention of Ewa Kopacz, Minister of Health, Agata was referred to a hospital where the abortion could have been performed (following Kopacz's intervention, pro-life activists called for the excommunication of the Minister from the Roman Catholic Church). Agata received medical assistance only *one day* before the end of the first trimester of pregnancy (the Polish law only allows legal terminations until the 12th week). During the last week of Agata's pregnancy trimester, several Polish journalists suggested that one could go abroad without any paper work and receive medical treatment *free of charge*. With the current legal setting such an option would be impossible since Agata would need an authorisation from medical authorities in order to enjoy her right under the existing social security coordination regime. Deciding for unauthorised treatment (i.e. applying 'Kohl/Decker procedure') she could still apply for reimbursement but more likely would receive a negative reply from the Polish authorities. In that case only a very complicated judicial procedure could guarantee that she would get her money back. Would the new legislation change this situation?

Since abortion is included in a package of free medical benefits provided for by the legislation of the member state of affiliation, Agata could go abroad and apply for reimbursement after her return to Poland. According to the Polish legislation, an abortion performed in the case of the 'existence of a justified suspicion that the pregnancy arose as a result of a crime' (Article 41 par.1, The Act of 7 January 1993 on Family Planning) is not considered as subject to hospital care (Article 4a par.3). Thus the Polish government could not apply the safeguard clause included in the Directive and require the person to request for a prior authorisation. With the framework of the comitology procedure, it could still request the European Commission to have abortion classified as a hospital healthcare service since it 'may present a particular risk for a patient' (Article 8(1b), Proposal). Nevertheless, to be able to introduce a system of a prior authorisation, the Polish administration would need to prove that the outflow of women seeking abortion 'seriously undermines, or

is likely to seriously undermine the financial balance of the member state's social security system; and/or the planning and rationalisation carried out in the hospital sector' (Article 8 par. 3bii, Proposal). Ironically, because of a highly restrictive legislation, the very low number of abortions (in 2006, 340 in total, including 12 due to suspicion that the pregnancy was a result of crime, Rada Ministrów 2007, 58) could not justify such steps. Hence the Directive, once adopted, could institutionalise and guarantee free of charge 'abortion tourism' – a situation that for right-wing and religious stakeholders would be shocking and could cause a substantial turmoil both in Warsaw and Brussels (picture such a possible headline in a Polish tabloid: 'The EU lets German doctors kill Polish unborn children for our money!').

Concluding Remarks

Accompanying the legislative proposal, the European Commission published a glossy 6-page brochure and launched a 8-minute long video clip²² presenting in an illustrative manner rights and obligations of patients travelling abroad for medical treatment and the positive impact the new Directive may have in that respect. It is not often the case that the Commission devotes resources to projects that are not yet actually adopted and introduced. Through such a public relation move, the Commission wants to anticipate some criticisms or questions introduced by civil society and address well in advance concerns of EU citizens. Time will show if this initiative will give the EU a more friendly face or will help maintain the stereotype of Brussels' policies driven by free-market forces.

Besides substantial health sector-related concerns and disputes that may emerge among national governments, the new legislation touches upon some more general, yet more controversial issues such as free movement of citizens, public security, sovereign rights of national governments to decide on family law (and in particular on reproductive and anti-abortion law), and last but not least, religion. On the other hand, from the patients' perspective, the Directive may offer a genuine 'exit option' from often dysfunctional health sector (i.e. waiting lines), or mechanisms of a repressive state (i.e. lack of a legitimate choice in the case of Agata). The Directive could be a significant step towards 'a free European patient area' and could deliver to EU citizens 'medicine without frontiers', as

argued by the Liberal and Democrats²³. In that respect, the Directive may represent indeed a symbol of freedom for EU citizens (freedom of travelling, freedom to choose a health provider and more fundamentally, as it would be in the case of Agata, freedom to decide about your future).

Little known is about the exact scope of patient mobility, there are dozens of doubts and questions about consequences of the Directive and, according to senior level officials in the European Commission, the negotiation on the Proposal may last even several years (Euractiv 2008c). Nevertheless, the two fold objective of the Proposal can be clearly identified: while giving member states still a possibility to protect their domestic regimes, the Directive will codify rights as for the access to health care abroad and consequently enhance the status of an EU citizen. This, from the institutional perspective, will advance the process of 'nesting' domestic welfare states

in the EU institutional framework (see Ferrera 2005). On the other hand with the new Proposal on the negotiation table, Ferrera's account on pre-2005 developments regulating patient mobility, 'the tug of war on boundary control in the health care fields is still far from decided' remain equally if not even more relevant and accurate (Ferrera 2005, 131). Discussing the link between the Proposal and the democratic deficit in the EU, negotiations may provide

some possibilities for domestic stakeholders to intervene in the decision-making process via respective capital cities and directly in Brussels. This already represents an improvement comparing to a policy-making alike heritage of the ECJ rulings. Ironically, this very instance of a possibility for a democratic participation can be sabotaged by national governments or MEPs who may challenge the legal basis of the Proposal, criticise the Commission's reasoning behind new rules and finally reject the new Proposal.

“While giving member states still a possibility to protect their domestic regimes, the Directive will codify rights as for the access to health care abroad and consequently enhance the status of an EU citizen”.

¹ Discussing cross-border health care, Legiod-Quigley, Glinos and Baeten (2007, 188) listed five broad categories of patient mobility within the EU: temporary visitors abroad using an European Health Insurance Card, long-term residents retiring to other countries, people living in border areas, patients who are referred abroad by domestic healthcare providers, and people who seek themselves medical treatment abroad. The following overview focuses on the fourth category and the fifth one whenever patient seeks reimbursement following his

unauthorised treatment.

² Having announced the above figure, the Commission *warned* that this 'estimate was tested through the consultation exercise, and was broadly confirmed by the responses from member states and other contributors, with similar proportions both of expenditure and numbers of patients moving' (European Commission 2008b, 9).

³ C-120/95, *Nicolas Decker v. Caisse de maladie des employés privés*.

⁴ C-158/96, *Raymond Kohll v. Union des caisses de maladie*.

⁵ C-368/98, *Vanbraekel*, par 45.

⁶ C-157/99, *Geraets-Smits v. Peerbooms*.

⁷ Case C-372/04, *Yvonne Watts/Bedford Primary Care Trust a.o.*

⁸ Although the very ruling of the High Court was not favourable to Mrs Watts several specialists used this occasion to comment on the existing system with permits, waiting lines and reimbursement being no more no less but a 'legal nightmare'. Michael Sobanja, the chief executive of the National Health Service Alliance said: 'All this ruling does is leaving us in no man's land – with an open chequebook open to challenge on every occasion'. Health Secretary, Dr John Reid claimed that if thousands deserted the UK health service and go abroad, this would leave overcapacity in the NHS. In even harsher words, he underlined that 'anyone waiting less than a year would not see a penny off the NHS if they dared set foot in a foreign hospital' (BBC 2003a and 2003b).

⁹ In that respect, the policy field under investigation represents a style of communitarisation whereby hard law (i.e. the Proposal for a Directive on patient mobility) has been preceded by the far-reaching intervention of the ECJ (for elaboration of this pattern in other policies see for example Conant 2007).

¹⁰ According to the report commissioned by the Treatment Abroad (2006), over 300 of foreign clinics and hospitals promote their services in the UK.

¹¹ For instance, estimated number of visitors to the website of the Treatment Abroad increased between 2004 and 2005 from 3,000 to 30,000 per month.

¹² See for instance: www.barbarathurgood.com/testimonials_frameset.cfm.

¹³ As an interesting case in point, airlines' magazines distributed among passengers during flight include on a regular basis a number of paid advertisements of health providers in new member states (with a clear predominance of dental services).

¹⁴ The total number of claims in financial terms under the Regulation 1408/71 – over 1,22 billion Euros in 2004 – represents only a fraction of the entire bill related to patient mobility. It is because the figure does not include costs related to health care provided in the framework of pension schemes, "Kohll/Decker procedure", private insurance packages, waiver agreements between certain state and cross-border arrangements and unreported cases of abroad emergency care costs.

¹⁵ Article 8 provides for a two-fold definition of 'hospital care': 1) healthcare which requires at least one overnight accommodation or 2) healthcare (included in a specific list drafted and regularly updated by the Commission through the comitology procedure) that requires use of highly specialised and cost-intensive medical infrastructure/equipment, or that involves treatments presenting a particular risk for the patient or the population.

¹⁶ In *Smits-Peerbooms* and *Vanbraekel* cases from 2001, the

ECJ ruled that the 'Kohll & Decker procedure' can be applied to hospital care and that it affects all health systems equally (Ferrera 2005, 129).

¹⁷ A similarly difficult portfolio, the coordination of social security systems, has still not found a grand finale. Over 30 months since tabling the Proposal for a Regulation laying down the procedure for implementing Regulation 883/2004 on the coordination of social security systems, the Council is still discussing several pending issues and it is unlikely that the French Presidency will be able to wrap up negotiations on this front.

¹⁸ European Federation of Public Service Unions, Press Release, 'Commission's proposal on EU cross-border healthcare is not social', 7 July 2008, available at: <http://www.epsu.org/a/3934>.

¹⁹ Press Release, Universal healthcare must come before mobility, 2 July 2008, The Greens, available at: http://www.greens-efa.org/cms/pressreleases/dok/241/241086.crossborder_healthcare_en.htm.

²⁰ Press Release, European United Left, 'Social Package 2008': The European Commission's Great 'Social Renewal' Swindle, 2 July 2008, available at: <http://www.guengl.eu/showPage.jsp?ID=6310&AREA=27&HIGH=1>.

²¹ The Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and Conditions for Termination of Pregnancy (Journal of Laws 1993, no.17, item 78 as amended) stipulated the three cases in which the termination of pregnancy is permitted: 1) When the pregnancy constitutes a risk to the life or health of the pregnant woman, 2) Prenatal tests or other medical evidence indicate a high probability of severe and irreversible disability, to the foetus or an incurable illness threatening its life, 3) The existence of a justified suspicion that the pregnancy arose as a result of a crime (Article 41 par.1 of the Act).

²² Both available at: http://ec.europa.eu/health/ph_overview/co_operation/mobility/patient_mobility_en.htm.

²³ ALDE Press Release, Cross-border health proposal first important step, 2 July 2008, available at: http://www.alde.eu/index.php?id=42&no_cache=1&tx_ttnews%5btnews%5d=9664.

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Ireland, the Lisbon Treaty and the European Referendum

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Introduction

On 12 June 2008, 53.4% of the Irish electorate rejected the Lisbon Treaty in a national referendum with the turnout of 53.1%. As it had been the case during the ratification of the former reforming Treaty – the Nice Treaty – Irish voters were the only one deciding through the institution of referendum; and as it had happened back in June 2001, also this time the decision was negative. It is worth mentioning that between these two events the grand reform of the European Union was jeopardised as a consequence of negative outcomes in the referendums in two EU founding member states – France and the Netherlands. This suggests that the current situation is much more complex than some commentators seem to assume. Therefore, instead of focusing on direct political challenges related to the negative outcome of the plebiscite, this article is meant to shed some light on patterns of variation within European referendums.

Uniqueness of the European referendum

‘European referendum’ as an institution of direct participation of citizens in decision making processes concerning European integration issues does not imply an EU-wide simultaneous voting or ‘common procedures’ across the EU. The debate on the European referendum contributes to the wider discussion about the present condition and prospects of democracy within the European Union (e.g. Bellamy 2006). Historically, referendums are strongly connected with the national (or local) level of direct participation in the decision making process (Setälä 1999). Therefore, the application of such a tool within a supranational project such as the European

integration creates a precedent unknown before. This proves again the uniqueness of the European Union and at the same time creates a variety of challenges.

Providing a categorization of the European referendum itself proves how ambiguous our common understanding of the European integration process is. For example, according to Sara Binzer Hobolt (2007), there are three categories of European referendum concerning: 1) the accession to the EU, 2) the ratification of a new EU Treaty, 3) the decision on a specific policy issue related to the integration process (an approach shared by Min Shu 2008). Paul Taggart, on the other hand, identifies two major categories: ‘referendums are being used for membership (either EU or Euro) and for treaty ratification’ (Taggart 2006, 10). As a matter of fact, as I argue in this article, the specificity of European referendums requires a clear distinction between the ‘accession’ and ‘deepening’ kind of the referendum owing to a particular socio-psychological attitude of voters.

In comparison to the popular decision devoted to the reform of the existing legal setting (deepening type), an issue of EU membership (accession type) seems to possess a significantly different logic. Therefore it is important to recognise the difference of the content of the two types of European referendum. From the perspective of the accession referendum, the issue to be decided presents itself as exogenous (i.e. coming from outside a home-country of a voter). It implies a ‘one-time’ decision of a more symbolic meaning. The ‘deepening’ referendum comprises a much less obvious package of issues, whereby it is much more difficult for the voter to understand which kind of frame of references (exogenous/

“The specificity of European referendums requires a clear distinction between the ‘accession’ and ‘deepening’ kind of the referendum owing to a particular socio-psychological attitude of voters”.

endogenous) issues belong to. Hence, it seems that the accession referendum decision is based on much clearer implications than the deepening one. The former may be simply understood as a question about the desire of one group to join another one, whereas the latter requires a more sophisticated *insider's perspective* on the true meaning of the EU integration process.

From this point of view, the classification of the European referendum institution based on the criterion of the subject of the referendum decision shows that the most significant distinction is closely connected with one of the major dilemmas of the existing European integration process: *deepening* versus *widening* (Nugent 1992). While *widening* focuses on the accession decisions, *deepening* focuses on the increasing of integration among existing members.

Specificity of the European referendum – authors and addressees of the referendum decision

The above presented classification of existing European referendum institutions provides the possibility of putting side by side differences between them. The following comparison is based on the supposition that the crucial criterion is the relation between *authors* (i.e. those who decide) and *addressees* (i.e. those who are affected) of the referendum decision. It is important in this context to underline that the above proposed distinction relies on the assumption that only direct effects are taken into account. Additionally, it is the subjective perspective of the voter that is considered and analysed. From this perspective, the 'widening' (accession) type of referendum does not create any major controversies if we consider the legal and institutional structure of the European Union per se (note that the socio-economic consequences of a vote in accession type referendum are far more reaching and they are not discussed in this article). On the other hand, the 'deepening' sort of referendum may imply a much more complex situation.

A distinction between *rules* of the referendum and its *consequences* presents an interesting challenge for scholars. Neither 'deepening' nor 'widening' types of the referendum raise any significant questions about *rules*, because in both cases – at least from the legal point of view – it is the domestic constitutional order that provides the tools for arranging the proper procedure. However, the situation differs when it comes to the *consequences* of

decisions taken by societies during referendums and in particular in the case of the lack of congruence between those who decide and those who are affected.

Within the institution of *accession* referendum, congruence between the author and the addressee of the decision obtains. Regardless from the outcome of the decision both the author and the addressee of the decision is the political community of a particular European state seeking EU membership.

The situation is different in the case of a *deepening* type of referendum, where the distinction between positive and negative outcome of the decision seems to be crucial. From that perspective, the *positive* outcome of deepening referendum remains uncontroversial, because legal consequences of the decision binds directly its author. The opposite situation can be seen if the outcome of the deepening referendum is *negative*. In such circumstances,

the referendum decision of *one* society implies direct consequences for *all* members of the EU. In practice, a negative result of a 'deepening' referendum in one member state may jeopardise the entire process of legal modification for all remaining members, regardless of the outcome of the decision in those countries.

'Deepening' type of referendum with negative outcome

The very first 'deepening' type of referendum with negative outcome occurred in Denmark (2 June 1992) in relation to the ratification of the Treaty of Maastricht. It revealed how serious possible consequences connected with the rejection of the Treaty by any EC member state might be (Buch and Hansen 2002). This raised important questions about the final success of the Maastricht project and the then European Community as such. The event precisely indicated some unexpected consequences of the connection between domestic and European levels and the growing distance between elites, involved and interested in EU issues, and grassroots citizens usually showing a passive attitude towards the EU integration. The initial significance of that event derives from the fact that it drew attention to several issues that were not recognized before, hence it is quite frequently described as the beginning of the EU democratic deficit debate which lasts until today. As a result, the outcome of the 1992 Danish referendum put under scrutiny the concept of 'permissive consensus' of the member states' societies

"A negative result of a deepening referendum in one member state may jeopardise the entire process of legal modification for all remaining members, regardless of the outcome of the decision in those countries".

(Taggart 2006).

Consideration of another deepening type referendum with a negative output – the first ratification referendum of the Nice Treaty in Ireland (7 June 2001) – provide some further interesting insights about the very essence of the negative reply given by the society (Laffan 2001). The important aspect in this case is the possibility itself of any distinction between specific opposition to particular aspects of the European integration process or the design of EU institutions and the general pro- or anti-European integration attitude. As a matter of fact, once again it is the content of the decision that makes a crucial difference. While in the case of accession type referendums, it is more or less a binary choice ‘to be or not to be’ inside the EU, during deepening type referendums it is likely that voters may not recognise this as a decision of the utmost importance because they are already in. One may compare this to the decision of a traveller (or a group of travellers). While the accession type of vote is to get on the train or remain on the platform, the deepening type – from the subjective perspective of a voter – resembles the questions about the speed of the train that already is on its way and the traveller is already on board. In short, the Irish perturbations during the Nice Treaty ratification already suggested that it is highly likely that some social groups who support EU integration in general may wish to express their discord to some detailed aspects of that very process (Bellamy 2006; Follesdal and Hix 2006).

Therefore, it would be a huge mistake to put the blame on the Irish society for the current turmoil about the fate of the Lisbon Treaty. Much more important reasons lay in the blurred structure of European referendum and its unclear mixture of political and legal assumptions. One may argue that in the June 2008 Irish referendum it was only 0.175% of the EU population (862,415 ‘no’ Irish votes in comparison to the 495 million EU citizens) that decided about the entire Treaty reform. On the other hand – as the leader of the UK Independence Party Nigel Farage said – ‘the only people to have a say on the Treaty have kicked it into the long grass’ (Euractiv 2008).

Conclusions

The analysis of the consequences of a negative outcome in deepening type referendums underlines the possible tensions between the effectiveness of the European integration process and standards of

democratic legitimation. This suggests that the lack of coordination between authors of the decision (the domestic level) and those bearing direct consequences of the decision (the European level) in the frame of European referendum may create an unintentional source of confrontation between both levels.

Two major questions remain still unanswered: the first one is how to understand the very nature of the European integration process; the second one calls for a system whereby any general negative attitude towards the project would not sabotage the entire EU integration process. Simplifying only slightly, it is time to move forward from the Euro scepticism – Euro enthusiasm dichotomy that does not leave any place for other shades present in such a black and white split. These two challenges are of

the same significance at all important levels of European discourse and involve not only social scientists and politicians but also media and grassroots citizens (Allegri 2008). From that point of view, a positive effect of every single example of a deepening type referendum with a negative outcome so far is that these events possess an above average potential of stimulating the European-wide debate.

This does not change, however, the fact that the contemporary shape of nationally based EU deepening ratification referendums suffers from a structural inadequacy that may lead to the conclusion that ‘the only good European referendum is a positive-outcome referendum’. Thus, the final question remains still open: how to construct, present and discuss major dilemmas of the contemporary and future European Union in order to be able to foster political deliberations that seek to prevent rather than cure undesired results.

“A positive effect of every single example of a deepening type referendum with a negative outcome so far is that these events possess an above average potential of stimulating the European-wide debate”.

* Part of this article was presented at the AUSE International Conference on ‘The Road Europe Travelled Along: The Evolution of the EEC/EU Institutions and Policies’, University of Siena, Certosa di Pontignano, 23-24 May 2008.

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EVENTS

Carlo Alberto Summer School on European Governance

7 – 11 July 2008

Collegio Carlo Alberto, Turin

In July 2008 URGE organised, in collaboration with the Graduate School in Social, Economic and Political Science of Milan, and with the financial support of the Compagnia di San Paolo, the Carlo Alberto Summer School on 'Innovating Governance and Policy Making in an Enlarged Europe: EU and Member State Perspectives'. The school took place in Moncalieri, at the Collegio Carlo Alberto, and lasted for five days. It was intended for PhD students interested in European studies and witnessed the participation of eleven students from both European and American universities.

The course provided an intensive period of training for younger researchers. The programme included state-of-the-art lectures on recent developments and innovations in the architecture of EU governance and presentations by the students of their own PhD research, all related to such developments. The aim was to stimulate the debate among the students and to bring expertise of the invited scholars to bear on their particular projects and research design.

Senior scholars who took part in the school were: Maurizio Ferrera (University of Milan and Urge), Jonathan Zeitlin (EU Center of Excellence, University of Wisconsin-Madison), Stefano Sacchi (University of Milan and Urge), Luc Tholoniati (Econ Pöyry), Wade Jacoby (Brigham Young University) and Renaud Dehousse (Sciences Po, Paris). The PhD researchers were: Geoff Bakken (UW Madison), Jess Clayton (UW Madison), Gabriela Cretu (University of Milan), Marina Della Giovanna (University of Siena), Olga Fazzini (University of Milan), Kyle Hanniman (UW Madison), Heidi Herschede (UW Madison), Federico Pancaldi (University of Milan), Barbara Szelewa (University of Milan), Karolina Sztandar-Sztanderska (Sciences Po, Paris and University of Warsaw) and Timo Weishaupt (UW Madison).

A page dedicated to the summer school is available on URGE's website, at http://www.urge.it/summer_school.





The **Research Unit on European Governance (URGE)** of the Collegio Carlo Alberto is a research centre set up in December 2003 at the Collegio Carlo Alberto of Moncalieri, in the hills south of Turin. Maurizio Ferrera is its director, and Stefano Sacchi its deputy director. The work of URGE is dedicated to the study of European governance from a perspective of political science and political economy. URGE also aims to foster the education of young researchers and to promote debate on European governance.

URGE's research work is organised in three thematic areas:

- *Governance of European Public Policies*
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URGE publishes a series of working papers, fully downloadable from its website (<http://www.urge.it/papers.php>). URGE's website has been included among the 300 top Political Science websites by the International Political Science Association, IPSA (<http://ipsaportal.net>).

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