Research Repository UCD

Title	Bringing society back into our understanding of European cross-border care
Authors(s)	Stan, Sabina, Erne, Roland
Publication date	2021-10-04
Publication information	Stan, Sabina, and Roland Erne. "Bringing Society Back into Our Understanding of European Cross-Border Care." Sage, October 4, 2021. https://doi.org/10.1177/09589287211031815.
Publisher	Sage
Item record/more information	http://hdl.handle.net/10197/12705
Publisher's version (DOI)	10.1177/09589287211031815

Downloaded 2026-05-02 01:18:05

The UCD community has made this article openly available. Please share how this access benefits you. Your story matters! (@ucd_oa)

© Some rights reserved. For more information

Forum

Journal Of
European
Social Policy

Journal of European Social Policy
2021, Vol. 0(0) 1–8
© The Author(s) 2021
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/09589287211031815
journals.sagepub.com/home/esp
SAGE

Bringing society back into our understanding of European cross-border care

Sabina Stan
Dublin City University, Ireland
University College Dublin, Ireland

Roland Erne
University College Dublin, Ireland

Abstract
We are pleased to discuss our study on the European Health Insurance Card (EHIC) and the redistributive effects of EHIC-related east–west patient and payment flows across regions and social classes. Our critics confirm our key finding: EHIC patient outflows from Eastern European (EE) to Western European (WE) result in a much higher relative burden for the budgets of EE states than outflows from WE to EE do for WE countries. Starting from what they see as the true mission of social security coordination, however, they also tell us that we should never have studied the redistributive impact of EHIC patient and payment flows in the first place. In this response, we therefore explicate the differences between our empirical sociological perspective and our critics' normative legal approach. This is important, especially when social facts contradict normative legal assumptions as in our case. The EU laws that govern EHIC patient and payment flows are indeed based on the free movement provisions of the EU's internal market project, but our empirical findings show that its promise of 'economic, social and territorial cohesion, and solidarity among Member States' contained in Article 3.3 of the Treaty of the European Union is not realized in practice in the case of east–west EHIC payment flows and patient mobility.

Keywords
European integration, European Health Insurance Card, European social policy, cross-border care, migration, market citizenship, European law

We are pleased to discuss our study on the European Health Insurance Card (EHIC) and the effects of EHIC-related east–west patient and payment flows on social and economic cohesion and on solidarity among member states (Stan et al., 2020). This is an important issue, as Eurosceptic politicians have stated that Eastern European (EE) migrants use their EHICs to exploit Western European (WE) health systems, for example, during the Brexit referendum

Corresponding author:
Sabina Stan, SNHS, Dublin City University, Glasnevin, Dublin D09, Ireland.
Email: sabina.stan@dcu.ie

debate. We thank our critics for engaging in this debate, given their experience as European Commission experts in the field. Social policy consultant Frederik de Wispelaere co-authored the Commission report that provided us with the raw data on EHIC payment and patient flows between EE and WE, and healthcare lawyer Gabriella Berki acted as one of its peer reviewers as a member of the 'network of experts' tasked to produce it (Pacolet and De Wispelaere, 2017: 2).

Our critics confirm our key finding: 'EHIC patient outflows from Eastern to Western Europe result in a much higher relative financial burden for the budgets of Eastern European states than outflows from Western to Eastern Europe do for Western European countries' (Stan et al., 2020: 1). Starting from what they see as the 'true mission of social security coordination' (De Wispelaere and Berki, 2021: ?), however, our critics tell us that we should never have studied the redistributive impact of east–west EHIC patient and payment flows in the first place, which is quite odd. Do empirical social scientists not have, on the contrary, an intellectual and social obligation to question received wisdom by highlighting inconvenient sociological facts, even if they apparently contradict legal norms? Our critics' main contention seems thus to reflect a lack of awareness of the differences between fundamental, empirical social research and applied, normative legal perspectives, as exemplified by our critics' confusion of the empirical sociological concept of social integration with the normative legal concept of social harmonization.

The EHIC is not an outcome of social security harmonization but of social integration in both its literal and its sociological meaning: 'to make parts into a whole' (Threlfall, 2003: 124). We have therefore described EHIC as 'a prime example of an EU social policy designed to bring Europeans together through the development of market citizenship, that is, the enhancement of free movement rights stemming from the Single Market' (Stan et al., 2020: 3). The establishment of the internal market, however, is not a goal in itself. It also entails a very concrete social promise. According to Article 3 of the Treaty of the European Union (TEU), which outlines the EU's principal aims and objectives, the internal market 'shall promote economic, social and territorial cohesion, and solidarity among Member States' (Article 3.3 TEU). It is therefore hardly surprising that our empirical findings not only challenge those who have counterfactually argued that east–west EHIC patient and payment flows represent a burden on WE healthcare systems, but also seem to upset those who do not want to acknowledge the failed promise of social integration contained in Article 3.3 TEU and EU leaders' praise of the EHIC as 'another piece of Europe in your pocket' (European Commission, 2004).

Normative legal versus empirical sociological perspectives

The scientific perspective that informs our *Journal of European Social Policy* article does not emanate from a normative legal approach, but rather from empirical social science. We therefore start our investigations on legislation and its consequences not with normative discussions about their 'true mission', but rather by investigating their implications from the perspective of patients and citizens. This enables us to detect the larger consequences of legislation on society, and social and spatial inequalities more specifically. Legal normative analysis can indeed hardly apprehend the social impact of legislation: first, laws often entail unintended consequences. Second, the 'true meaning' of laws is not as clear as our critics think. It is often masked by figures of speech in which apparently contradictory terms appear in conjunction, as in the case of the EU's 'market citizenship' (Kochenov, 2019). We therefore adopted a sociological perspective that confronts the apparently crystal-clear categories of EU law with the reality of actual social practices. This reality is inherently messy and muddy: people behave according to the logic of their own life, with its various opportunities and constraints, rather than the logic of legal categories. To be sure, legal categories have become the basis of the administrative procedures underpinning, for example, access to and reimbursement of cross-border care. However, we do not try to mould the social reality into legal categories; rather, we study the consequences on social configurations, for example, social class and spatial inequalities.

Legislative and sociological perspectives on cross-border care therefore differ. For De Wispelaere and Berki (2021), cross-border care includes solely care which is covered by the healthcare scheme of the member state of insurance and is underpinned by one of the several legislative instruments developed by the EU in this area. These include the various Coordination Regulations and the Cross-border Care (CBC) Directive (2011/24) mentioned in both our original article and our critics' reply. From our sociological perspective however, cross-border care encompasses not only what Mainil (2012) called cross-border healthcare citizenship, but also medical tourism, for which patients pay out of their own pockets. To understand EHIC uptake and use in real life, we therefore need to see it as one of the several avenues for cross-border care available to mobile EU citizens, and EE migrants for that matter. In our article, we have therefore situated EHIC use in the larger context comprising routes to care covered by EU legislation (that is, Coordination Regulations and the CBC Directive routes) and the private routes involving cross-border care paid for from people's own pockets (that is, medical tourism and the use of private health services by returning migrants).

Paying for care and having care reimbursed: enduring territorial and social class divides

The issue of people paying for care from their own pockets is important, as it leads to class differences in access to care, as also acknowledged by our critics when referring to patients having to pay upfront for care when drawing on the CBC Directive (De Wispelaere and Berki, 2021). Nonetheless, and once again, a legal perspective on the issue, which insists on the distinctiveness of routes covered or not by EU legislation, does not allow us to capture class differences in cross-border care, which does not, at first sight, involve out-of-pocket payments by patients, such as care drawing on the EHIC.

In contemporary societies, where rights to healthcare and healthcare provision have been periodically reformed and restructured, and health services consequently becoming more concentrated in primary care centres and secondary and tertiary centres of excellence, and where rights to public healthcare came to be defined as rights to ever-changing baskets of services rather than universal access, even access to domestic, national care mobilizes different types of capitals (Bourdieu, 1986). These include economic capital in the form of resources needed to travel to the sometimes more distant places where some providers, especially in secondary and tertiary care, are located (that is, access to public or personal transport and money to pay for tickets or petrol). They also include cultural capital in the form of knowledge of the intricacies of various levels of coverage for various types of medical interventions, of various pathways to care among different levels of care (primary, secondary and tertiary), of various types of healthcare providers (public, private not-for-profit, and private for-profit providing or not care covered by national or social healthcare funds), and of various geographical and institutional settings in which the latter are located. Finally, it includes symbolic capital in the form of mastery of the varieties of language, gestures and postures valued in healthcare settings. All these capitals, which give substance of class differences, are reproduced in a healthcare context to make access to care and its quality a class-dependent phenomenon.

Cross-border care is likewise permeated by class differences. This is most apparent in medical tourism, where patients pay for care from their own pockets (or through private insurance) or for care accessed on the basis of the CBC Directive. In the latter case, patients have to pay upfront for their care, before being reimbursed by the public health scheme of their country of residence. More affluent patients have easier access than poorer ones to these advance payments; the difference is even greater for patients coming from countries where healthcare costs are lower than those in the country of treatment, as the CBC Directive covers only up to the level of costs current in the country of insurance. However, care based on the EHIC also involves subtler class differences.

Public officials from both poorer and richer countries are aware of the redistributive effects of intra-European EHIC payment flows. Given the president of the Romanian health insurance fund's

public critique of very unequal east–west EHIC payment flows (quoted in Stan et al., 2020: 12), it is hardly surprising that poorer countries, like Romania, do not automatically issue EHICs to everyone insured by their national sickness funds. The higher barriers to accessing reimbursed cross-border care in EE compared with WE states (Vasev and Vrangbæk, 2014) therefore requires EE migrants to have an in-depth knowledge of their European citizenship rights – a knowledge that is related to their cultural and symbolic capital and thus to their social class position. By contrast, social class does not determine access to the EHIC in rich countries, like Germany and Switzerland, where national sickness funds benefit from outgoing EHIC payment flows and provide their members automatically with an EHIC. Germany's leading politicians are also aware of the hurdles faced by poorer EE citizens – who are often labouring as posted or self-employed workers under precarious conditions in WE (Doellgast et al., 2018) – in getting an EHIC in their country of origin. The CDU–CSU–SPD coalition's 2013 programme for government therefore included a commitment to 'work within the EU to ensure that their countries of origin issue the EHIC to every national'; not, however, to reduce social inequalities, but to 'counteract the unjustified use of social benefits by EU citizens' [in Germany] (CDU et al., 2013: 76, *our translation*). Even so, although De Wispelaere and Berki (2021) point to differences in how the card is issued across Europe, neither they nor Pacolet and de Wispelaere's (2017) EU report captured these different political interests underpinning them.

Furthermore, even if all EE citizens knew about their entitlement to an EHIC, barriers to its obtention might still arise, ranging from online applications not being available or, if available, not being accessible to those without internet access, to, for the latter, having to print and fill in the form necessary to obtain the card, travel to the office delivering it, and then attend the office during opening hours. Like knowledge about the right to obtain an EHIC, these barriers play out differently for different social classes (with their different economic, social and symbolic capitals), especially in societies, such as those in EE, characterized by steeper class gradients. Because of these steeper class gradients, we find a significantly lower EHIC uptake in EE as compared to WE (our calculations after Pacolet and De Wispelaere, 2017).

It is thus at least disingenuous to say that one 'did not find' evidence of social class differences in EHIC use when our critics did not look for them in the first place. In our article, we triangulated data indicating that intra-EU mobility involves mostly non-work as opposed to work purposes, with data provided by the French sociologists Hugree, Penissat and Spire.[1] Compared with WE, not only is there a steeper class gradient in EE in general, but also EE citizens' participation in non-work mobility is shaped by this steeper class gradient. Thus, to be able to use the EHIC as an international tourist, a person must be able to afford to travel abroad in the first place. This condition is dependent on a person's class position, and much more so in EE than in WE.

Planned and unplanned care: unclear intentions versus the clarity of exclusionary tactics

De Wispelaere and Berki (2021) also criticise our use of the term 'EHIC mobility', as this might imply that EHIC use is intentional and thus contradicts the EHIC's legal purpose of covering only 'unplanned care'. As in the case of their mix-up of social integration and social harmonization, our critics simply misunderstand our approach. Nonetheless, their confusion reveals the difficulties that their normative perspective encounters once it is confronted with the messy social reality of cross-border care.

To start with, we used the term EHIC mobility as a shorthand for the intra-European movement of people and money that involves recourse to the EHIC. True, EU legislation designed the EHIC to cover mainly unplanned care during a temporary stay abroad, typically situations when a tourist falls ill unexpectedly during his or her holiday abroad. However, the EHIC also covers people with pre-existing conditions, namely, pregnancy and chronic illnesses (Palm and Glinos, 2010: 546), and for whom planning may, and sometimes has to, enter into the picture before the onset of the trip. More generally, in real life, people's intentions, purposes

and decisions are much more entangled than EHIC legislators may have expected. People with long-term conditions (such as diabetes) may have to plan in advance the care they may need during a temporary trip abroad. Likewise, people living temporarily in another country (such as students or EE migrants) may engage in different degrees of planning before making their trips back home. If one were to ask these people why they go back home during their holidays, probably most of them would give as reasons the need to see or take care of their families and belongings in their countries of origin. However, as several studies have shown (see Stan et al. 2020: 8), many students and EE migrants also use that occasion to conduct medical tests, or see a GP for a general check-up, or again a specialist for a recurrent ailment. Were they planning or just opportunistically using a trip back home for medical care?

The more unsettling question, though, is whether by planning for care they defrauded the system. In the run-up to the Brexit referendum, British tabloids accused EE migrants of abusing the healthcare systems in their host countries by using the EHICs delivered by the latter to cover health services provided in their home countries. This would be a drain on the NHS because of the corresponding west–east EHIC payment flows. The hidden assumption behind these accusations of abuse or even fraud was that EE migrants would not have the right to access public health coverage in their host countries and would use their WE EHICs in their EE home countries, with financially detrimental effects for their host countries. However, as our article has shown, and given that healthcare prices are considerably lower in EE as compared to WE countries, EE migrants' EHIC use in their home countries represents a saving for their WE host countries rather than a drain. In this context, judgements about intentionality and planning in EE migrants' EHIC use become part of a larger package of accusations that serve to exclude and de-legitimate their access to host countries' public services and resources – that is, to European citizenship rights fostered through Coordination Regulations, among other legislation. The danger of sticking to the clarity of legal terms even in the face of a messy reality is that it may sometimes resonate with the deceptively clear terms of scapegoating driven by xenophobic politicians.

A transnational but uneven European healthcare space

De Wispelaere and Berki (2021) also criticised our repeated references to a European healthcare 'union' or 'space'. Assuming the mission to police language and research agendas, they tell us that one should not talk in these terms, as politicians fiercely defend the national character of their countries' healthcare systems and thus resist granting competencies to the EU in the area of healthcare, as would have 'become apparent at various times during the COVID-19 pandemic' (De Wispelaere and Berki, 2021: ?). Once more however, the adoption of a social science perspective helps to approach a social reality that is messier than this account.

Many politicians in the EU do indeed defend the national character of their countries' health systems, but they do that because healthcare is one of the few grounds left for their legitimation in the context of an increasingly integrated and marketized Europe and world. In the EU, public services previously controlled by nation states have been liberalized (for example, in the energy and transport sectors), with the result that not much is left to national governments with which to embed social cohesion at national level.

More importantly, the national character of healthcare systems themselves has been challenged by global and European processes of transnationalization and marketization. The building of the Single European Market through the freedom of movement of workers and services has led to many EU countries having recourse to non-national healthcare workers, many from other EU member states. Likewise, patients move from one EU country to another in search of faster access to quality care missing in their home countries. In doing that, they may have recourse to EU legislation (the Coordination Regulations and the CBC Directive) and have care reimbursed – or not, and thus pay for care from their own pocket. The CBC Directive, in particular, opened the gate for patients to access cross-border care in private healthcare facilities and to have that

care covered by the public scheme of their home country – even if that scheme would not cover private care were it to be provided domestically. As a result, in some countries, national health systems now combine public health services and private health-care catering mostly for richer national patients and foreign medical tourists.

The Maastricht Treaty introduced the EU's competence solely over public health rather than health services. However, spill-overs from freedom of movement and competition competencies led to the pre-2000s' Coordination Regulations being challenged even during the 1990s by ECJ rulings that conceived of healthcare as a service amenable to EU law in these areas. The Lisbon Treaty effectively enlarged EU competencies in health to include cross-border care, leading, together with ECJ challenges of Regulations, to the later adoption of the CBC Directive. After the 2008 financial crisis and the introduction of new economic governance, and despite its limited competencies in healthcare, the EU effectively intervened in this area in several countries that found themselves under bailout programmes with the EU and IMF or faced the EU's binding new economic governance prescriptions when they were deemed to experience excessive deficit and debt levels or excessive macroeconomic imbalances (Stan and Erne, 2019). That some governments in these countries were only too happy to have strong EU conditionality behind their plans to further commodify healthcare does not in the least take from the fact that EU institutions were now capable of intervening directly in this fiercely guarded national sector (Stan and Erne, 2019).

During the same crisis period, national governments sought to respond to popular discontent following from austerity measures by playing the card of national versus non-national divisions. In doing that, governing parties sought to reconquer parts of the electorate receptive to extreme right parties' – and some media's – portrayal of migrants, including intra-European ones, as the ones to blame for the decreasing quality and accessibility of national health services. Media investigations on migrants' 'abuse' of the national healthcare system, and grey literature on 'fraud', including in cross-border care, reformulated the problem of national health systems as an 'us' (nationals) versus 'them' (migrants) issue. One important consequence of this framing was that several countries placed barriers, in the form of habitual residence requirements, on immediate coverage of migrant workers, including European workers. These barriers occur in a context where, in many WE host countries, EU migrants contribute disproportionately to national budgets, and per extension to healthcare budgets. The vast majority of such workers are employed in underpaid and insecure jobs, and hence pay taxes while also using proportionately fewer health services in their host countries. De Wispelaere and Berki's (2021: ?) statement that EU migrant workers' coverage in the host country is immediate shows only that a legal perspective obscures this much messier and muddier reality.

As stated at the outset, we nonetheless appreciate our critics' endorsement of the central empirical findings of our study, namely, that the financial burden of EHIC mobility is relatively higher for EE than for WE countries. They, as do we, document the difference in prices for medical care in the two regions. However, whereas de Wispelaere and Berki find this situation normal, we perceive it, as indicated in our article, as another expression of the uneven character of the European social and healthcare space. The specific EU law that underpins the EHIC may not aim to flatten social and spatial disparities, but, as seen above, the EU as a whole and its Single Market integration project rely on the assumption that market integration will bring about a convergence in terms of European citizens' social rights and living standards in the different parts of the Union. The EHIC, as an expression of rights linked to the Single Market integration project, hence of what has been called consumer or market citizenship, thus offers another example of how market integration reproduces and sometimes even enhances social and spatial inequalities.

The EU and its purposes

It may come as a surprise to scholars who assess EU policies from a normative legislative perspective that

social scientists are as careful in defining and using their concepts as legal scholars are in defining the terms of legislative acts. Our critics' contrary perception may result from the fact, noted above, that social scientists seek to account for a messy reality rather than mould it in clearly defined legal terms; but messy reality cannot be understood through messy and badly defined analytical lenses. We therefore never pretended that social integration, an empirical sociological concept, was the same as social harmonization, a normative legal term.

Behind de Wispelaere and Berki's (2021) criticism lies nonetheless an important issue: with what should policies and their legislative bases be measured, and with what implications for studies seeking to assess their effects? The aims of a particular piece of legislation are certainly limited – as they should be, given that they are legal documents that must be able to withstand legal challenges in court. And certainly, without the Coordination Regulations, the situation for mobile EU residents and EE migrants would have been worse. But the question is: could it have been better? Beyond business leaders and the upper professional classes, many of the EU's ordinary citizens continue to support the EU not so much for its market integration project as such, but because they hope that it also holds a promise of social integration and an even distribution of access to social rights. This promise is not based on one piece of legislation, but rather on the fact that the whole internal market project was 'built on a number of unquestioned assumptions' (Kochenov, 2019: 218), including the promise that it would produce 'economic, social and territorial cohesion, and solidarity among Member States' (Article 3.3 TEU). These assumptions also informed the then European Commission President Romano Prodi and Council President Bertie Ahern (European Commission, 2004, quoted Stan et al., 2020) when they used the launch of the EHIC to legitimate the EU integration project. Our empirical study on east–west EHIC patient and payment flows, however, supports those legal scholars who have argued that these assumptions would 'be ideologically informed and at times baseless, empirically' (de Búrca, 2015; Kochenov, 2019: 218). In a context of recurring economic and social crises and rising EU scepticism, notably among Europe's popular classes (Béthoux et al., 2018), the need for the Union to revisit these assumptions to ensure that it can uphold its social promise is indeed more important than ever.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This project has received funding from the European Research Council (ERC) under the European Union's Horizon 2020 research and innovation programme, grant agreement no. 725240, https://www.erc-europeanunions.eu/

ORCID iD

Sabina Stan https://orcid.org/0000-0003-1602-0519

Notes

1. Incidentally, their study has now appeared in English translation (Hugree et al., 2020).

References

Béthoux, É, Erne, R and Golden, D (2018) A primordial attachment to the nation? French and Irish workers and trade unions in past EU referendum debates. *British Journal of Industrial Relations* 56(3): 656–678.

Bourdieu, P (1986) The forms of capital. In: Richardson JG (ed) *Handbook of Theory and Research for the Sociology of Education*. New York: Greenwood, 241–258.

CDU, CSU and SPD (2013) *Deutschlands Zukunft Gestalten. Koalitionsvertrag zwischen CDU, CSU und SPD*. Rheinbach: Union Betriebs-GmbH.

De Búrca, G (2015) Conclusion. In: Kochenov D, De Búrca G and Williams A (eds) *Europe's Justice Deficit?* Oxford: Bloomsbury Publishing, 459–463.

De Wispelaere, F and Berki, G (2021) The role and limits of the European Health Insurance Card: (Too) great expectations? *Journal of European Social Policy*: 095892872110230. DOI: 10.1177/09589287211023046.

Doellgast, V, Lillie, N and Pulignano, V (eds), (2018) *Reconstructing Solidarity: Labour Unions, Precarious Work, and the Politics of Institutional Change in Europe*. Oxford: Oxford University Press.

European Commission (2004) *More Europe in Your Pocket IP/04/390*. Press release. https://ec.europa.eu/commission/presscorner/detail/en/IP_04_390.

Hugree, C, Penissat, E and Spire, A (2020) *Social Class in Europe: New Inequalities in the Old World*. London: Verso Books.

Kochenov, D (2019) The oxymoron of 'market citizenship' and the future of the union. In: Amtenbrink F, Davies G, Kochenov D, et al. (eds) *The Internal Market and the Future of European Integration*. Cambridge: Cambridge University Press, 217–230.

Mainil, T (2012) *Transnational healthcare and medical tourism*. PhD Dissertation, NHTV Breda University of Applied Sciences, The Netherlands.

Pacolet, J and de Wispelaere, F (2017) *Cross-Border Healthcare Reference Year 2016*. Brussels: European Commission.

Palm, W and Glinos, I (2010) Enabling patient mobility in the eu: between free movement and coordination. In: Mossialos E, Permanand G, Baeten R, et al. (eds) *Health Systems Governance in Europe*. Cambridge: Cambridge University Press, 509–560.

Stan, S and Erne, R (2019) *'The New Economic Governance in Health Care: A Labour Perspective', Working Paper 19-04, ERC Project 'European Unions'*. University College Dublin. https://www.erc-europeanunions.eu/working-papers/.

Stan, S, Erne, R and Gannon, S (2020) Bringing EU citizens together or pulling them apart? The European health insurance card, east–west mobility, and the failed promise of European social integration. *Journal of European Social Policy*. https://journals.sagepub.com/doi/pdf/10.1177/0958928720974188. AQ2

Threlfall, M (2003) European social integration: harmonization, convergence and single social areas. *Journal of European Social Policy* 13(2): 121–139.

Vasev, N and Vrangbæk, K (2014) Transposition and national-level resources: introducing the cross-border healthcare directive in eastern europe. *West European Politics* 37(4): 693–710.