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TRANSFERABILITY OF THE MONITORING SYSTEM
UB-CISC
Marisol Garcia and Marc Pradel

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THE SOCIO-ECONOMIC KNOWLEDGE BASE

Task 6:
Governance, Citizenship and the Dynamics of European Integration
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Immigration policies in the European Union

Marisol Garcia & Marc Pradel (UB-CISC)

EUROPUB- WP 5. Transferability
Part I: Transferability of the Monitoring System

1 Introduction

This work package has tested the applicability of the Monitoring System developed in WP4. The transferability exercise has been conducted in three policy areas other than those already covered in WP2. The policy areas chosen for the transferability exercise have been migration, trade and health. Further a national case study has been conducted in the Czech Republic. The reason to do a separate national case study has been to verify the applicability of the Monitoring System within a new democracy, and at the same time, new member state of the Union.

Transferability is a process performed by readers of research. Readers note the specifics of the research situation and compare them to the specifics of an environment or situation with which they are familiar. If there are enough similarities between the two situations, readers may be able to infer that the results of the research would be the same or similar in their own situation. In other words, they "transfer" the results of a study to another context. To do this effectively, readers need to know as much as possible about the original research situation in order to determine whether it is similar to their own. Therefore, researchers must supply a highly detailed description of their research situation and methods. The role of expert readers in transferability is to apply the methods or results of a study to their own area of expertise. In doing so, readers must take into account differences between the situation outlined by the researcher and their own.

The three policy sectors were mainly chosen on the basis on their relevance to the process of Europeanisation as well as on their increasing relevance to the emergence of a European public sphere of participation and contestation. A more detailed justification of the specific case studies is developed below. The interviews targeted experts in the three policy areas in question. These experts were not necessarily experts in democratic assessment, however they were generally ‘positive’ to the idea of a policy evaluation from a democratic assessment perspective. In relation to this it is worthwhile reflecting on the dilemmas put by the transferability exercise. A particular problem of the transferability exercise concerning policy domains and democracy is that those who are experts in democratic assessment and monitoring are most of the times no experts in the policy domains under question. Our objective has been to gather feedback from those who had expertise in the policy domain yet open in principle, to the idea of democratic assessment.
Given the above, the objective of the transferability exercise has been: Firstly, to understand better the policy domain in question as this is an important background for democratic assessment. Secondly, to obtain information that helps to refine and elaborate indicators for particular policy domains, especially regarding measurement means. Thirdly, to get some feedback about what indicators to focus on given that often it is not practical or feasible to carry out a full-fledged democratic assessment.

Overviews of the three policy areas in question—migration, trade and health—were produced in order to have a comprehensive knowledge on these policy sectors for applying the democratic audit. National reports were developed on the basis of “guidelines” elaborated by each case study leader. Consortium members adopted the guidelines in order to develop a general overview of each policy area with reference to the indicators of the Monitoring System. National reports were provided by national teams to each policy sector study leader. Consequently policy area study leaders elaborated synthesis reports included in this document.

While national reports were being elaborated the selection of indicators and experts was done. Relevant actors were identified at European and national levels in expertise in each of the policy sectors from all the seven member states of the Consortium. The Czech Republic case focused on interviews with national experts. Each policy area study leader selected a number of indicators to be part of the transferability exercise.

Following these actions a brief consultation document was elaborated by Liana Giorgi, the international coordinator, to be sent to experts with a questionnaire elaborated by the work package leader institution (CISC) and agreed by the consortium members attending a meeting in Vienna in December 2003. Finally, results of questionnaires and interviews with experts were collected and analysed separately by each case study leader and discussed at a meeting in Brussels in June 2004.

The case study leaders for this report have been Marisol García (UB-CISC) for migration policy as well as for the overall work package, Martin Peterson (UGOT) for health policy and Ingmar von Homeyer (ECOLOGIC) for trade policy. Michal Illner (IS AS CR) has directed the Czech Republic case study. Researchers from the consortium involved in WP5 have been: Anneke Klasing (ECOLOGIC) Thomas Reidel (ECOLOGIC) David Alcaud (ICCR France) Christina Parau (QMW-London), Nikki Rodousakis (ICCR-international), Tomás Kostelcky (SOC) Marc Pradel (UB-CISC), and Roger Chiva (UB-CISC). Liana Giorgi, the international coordinator, has been directly involved in the transferability exercise, especially in the planning stages. The authors of this report want to thank her as well as Aris Apollonatos (EC DG Research and Scientific Officer for EUROPUB) and Elene Saraceno (European Commission) for their constructive comments to the presentation of this report in Brussels.
2 Justification of case studies

2.1 Migration

Migration policy is a highly relevant case study for testing the Monitoring System elaborated by EUROPUB because:

(1) The European Union has become a crucial player in this policy area. An increasing role has been taken by the European Parliament, where debates have taken place. The process of European integration has gradually created a fragmentation of status in member states on the basis of internal and external immigration. Economic integration has involved free movement of workers and then citizens and parallel to this process member states have seen the need to coordinate policies of immigration from third countries. However, immigration policies at the EU level have been far from transparent. On the contrary, most important agreements have come about after discussions were conducted behind close doors in inter-governmental meetings. The Schengen and Dublin agreements were engineered in this fashion. As a result, a process of approximation has been engineered in the area of border controls. More recently, there have been attempts to develop the Open Method of Coordination for migration. Member states have been applying restrictive policies and have developed very close legislation about how to deal with entry applications.

(2) Migration is a highly contested policy area. The limited openness of decision-making process on migration issues has also become apparent in national policies. Partly as a result of the Europeanisation of immigration policy, national governments have pushed forward legislation on immigration attempting to comply with European agreements. As a result, political parties in opposition and civil society organisations have demanded more transparency. In some member states, parliamentary discussions have been very controversial.

(3) The linkage between migration and security issues has been exacerbated with the event of September 11th and March 11th. The link between security and immigration can challenge in some circumstances international agreements on human rights. Thus, international and human rights organisations have also entered the debate.

(4) In the last decades, migratory flows to Europe have increased constantly, even in those countries that have launched restrictive measures against immigration. The market logic, on the one hand, and the political instability
experienced in several parts of the world, on the other, is contributing to the constant affluence of immigrants to Europe. There is an increasing pressure from below to deal with these two types of immigration with properly designed and implemented integration policies. Thus debates at the national and sub-national level are spreading in all member states.

2.2 Trade

Trade policy is also a highly relevant case for testing the EUROPUB European democracy indicators because (1) it is a highly contested policy area and has given rise to considerable public debate and (2) the EU is a key player in this policy area. Public contestation of trade policy is most visibly carried out by the anti-globalisation movement, including organisations such as ATTAC. The disruption of the WTO negotiations in Seattle was probably the most publicly visible event. Contestation crystallised around three main (and partly overlapping) issues: The social and political implications of trade liberalisation/globalisation (for example, effects on national social security systems and democracy), the relationship between trade and the environment (including conflicts between international environmental agreements and national measures on the one side and WTO obligations on the other), and the effects of trade liberalisation on development (including agricultural subsidies). As the EU has powerful competencies in the area of trade policy, it is strongly involved in decision-making relating to all of these issues.

Trade is a policy area that is often suspected of being non-transparent, of lacking participatory elements and thus even of being illegitimate. This is due to a variety of reasons. First, the tactics of engaging in trade negotiations need - by their very nature - to be developed with a certain degree of secrecy. Furthermore, trade policy-making traditionally relies on mechanisms such as delegation, and executive authority which contribute to blurring the decision-making process. The fact that the group gaining from trade policy decisions is much broader and more diffuse than the group losing from such decisions results in a stronger articulation of the negatively affected groups than of those benefiting. This so-called collective action problem leads to an unbalanced representation of interests on trade issues, because not all social interests are necessarily incorporated.

A number of arguments speak in favour of strengthening participation and transparency in trade decision-making. As mentioned above, trade policy touches upon a range of other policies. Often these policies follow a different reasoning than trade policy. Nevertheless, or rather precisely for this reason, it is the more important to create opportunities for other policies to voice their interests within trade policy by integrating them into trade policy-making. Non-
trade but trade-related issues often include issues that concern us all and are
decisive for our future such as our environment. Therefore, these issues have to
be addressed through processes which are transparent, accountable and
democratic. When it comes to EU trade policy the call for strengthening
participation and transparency seems to become even more important. This
because the EU has the exclusive competence and the influence of Member
state governments is limited. This means that, although the delegation of trade
competencies to the EU has been agreed by the Member States, the day-to-day
decisions on EU trade policy are not necessarily indirectly legitimised through
the Member States. This fact stresses the importance of a democratic and
accountable EU decision-making.

2.3 **Health**

The field of Health Care is one of the most contested policy areas today in
terms of policy making as well as social, cultural and existential issues at large.
The relative opacity of the world of medicine at least in the relation between its
practitioners, physicians, and the general public, users, has long been well
known. The hospital domain has used to be a closed one and not very open to
debate nor obviously to any transparency. During recent decades it has become
increasingly accountable not only to policy makers but also to the general public
in terms of CSOs, user associations and other political pressure groups or
social movements. Most of all health has become contentious because of a
current political conflict between not only special interests but also schools of
economic and organisational thought. At the basis of it all is perhaps the
greatest conquest of democracy – that of health for every individual as a
fundamental right. In early post-war days every welfare state minding its dignity
offered as a basic tenet adequate medical and hospital care for its citizens
irrespective of income or place of residence. The costs were obviously subject
to democratic decision-making without questioning the object of health care as
a democratic right.

Various combinations of insurance systems are tried out at the same time as
the demand for specialist care, tentatively at a European-wide level, parallels a
more intensified gate-keeper system in the form of GPs and primary care in
order to prevent health care systems from becoming overloaded and
unmanageable. At the same time grass-root movements are becoming
increasingly active with vocal manifestations against what they consider to be
insensitive technocratic solutions, which hit the more deprived citizens the
hardest.

2.4 **The Czech Republic**
The main objective to include a transferability exercise in the Czech Republic is to test the Monitoring System in a concrete situation of a country that has recently experienced a transition to democracy. It is, therefore, a national case that puts to the test the strength of democratic functioning of specific institutional spheres. In order to develop the transferability exercise three institutional spheres were chosen: local government (regional and municipal governments), political parties and national Parliament. The justification of choosing these three institutional spheres is the following: The reintroduction of the local government structure has been considered one of the main accomplishments of post-communists transformation. Even if the time span of political and administrative transformation is short (the reform only started in 1990) the evaluation of the progress is highly relevant. Political parties are the main actors in the national political system. The national Parliament constitutes the supreme legislative body. The combination of the three spheres provides an excellent case for the transferability exercise.

3 Research Stages and Methodology

1) In order to put into practice the transferability exercise around 60 experts have been identified for each case study from the seven countries. All consortium partners contributed in the provision of relevant names. Parallel to this each case study leader selected a list of relevant indicators to be read by experts. On the basis of these indicators experts have evaluated the applicability of the Monitoring System to their policy sector. In the Czech Republic case evaluators have tested the applicability of the Monitoring System by focusing on three institutional spheres in which they work either as academics or as practitioners.

1.1) The migration case study involved a selection of a total of 42 indicators by UB-CISC. After an initial wider selection an indicators list was elaborated giving priority to those indicators that appear more relevant to migration issues. The dimensions prioritised have been that of Citizenship, Openness and Participation. Other indicators were selected from the Monitoring System from the dimensions of Rule of Law, Coherence and Effectiveness, Civil, Corporate and media responsibility). Indicators were selected on the basis of their significance for the immigration policy sector.

1.2) For the trade case study 46 indicators were selected according to their relevance for trade policy. The selection of indicators was double checked by two Ecologic experts with relevant background of trade policy. Indicators were selected from Subsidiarity, Rule of Law, Coherence and Effectiveness, Effective, Independent, Representative legislature and Openness and Participation.
1.3) For the **health case study** 45 indicators were chosen by UGOT, encompassing all relevant topics related to health care policy in the light of public democracy issues. Some related to legal indicators, most to policy and participatory issues, which might be reflected in the media, and quite a number to issues of social rights dealing with social injustice in health care whether depending on the gap between rich and poor or cultural and ethnic gaps. Selected indicators for health are mainly from three dimensions: Effectiveness, Openness and participation and Citizenship.

1.4) For the **Czech Republic case study** 79 indicators were chosen by IS AS CR encompassing the relevant topics concerning the dimensions of Effectiveness, Independent and Representative legislatures, Subsidiarity and Openness and Participation. The three dimensions were chosen because of their explicit relevance to monitor the institutional democratic spheres such as national parliament, the territorial public administrations and political parties.

2.) The transferability exercise has involved a total of 40 interviews completed. Experts’ answers to the questionnaire have been analysed in order to evaluate the Monitoring System matrix. Specific comments have also been incorporated in the analysis. In the case of the health policy area indicators were reformulated in accordance with health issues and appropriate terminology. This effort proved to be positive in terms of number and quality of results.

2.1) In the **migration case study** 11 replies were registered and used for the transferability analysis of the Monitoring System. From the total responses, three come from Sweden. Spain Austria and Czech Republic supplied two answers each, while France and Germany supplied one answer each.

The methodology used was based on two procedures. First a descriptive analysis was done. This analysis was based on observing the most frequent value assigned to each indicator, the punctuation mean of each indicator and its median, which indicates us how the values were assigned. The analysis includes also a classification of the indicators through a range constructed from the arithmetic average (2.2-2.9 = low; 2.9-3.4 = general; 3.5-4.1 = high). With this descriptive analysis a complete first view of indicators usefulness is shown. The second step was based on finding relations between indicators through a Cluster Analysis. This analysis shows patterns of response, grouping the indicators that reveal why some indicators were better valued than others. The last step was to compare experts’ responses and the pattern they have followed in their responses through a second Cluster analysis in order to find global similarities and dissimilarities.

A consistent pattern has emerged. The best rated indicators are those related to legislation regarding rights of citizens and migrants, while the less rated
indicators are those related to the existence or absence of public inquiries and participation mechanisms.

2.2) In the trade case study 9 replies were registered and used for the analysis. The following analysis of the return on the questionnaires will first show a general assessment of the importance of the strategic objectives. This assessment is based on the arithmetic average of the answers per indicator. The indicators were then grouped according to the range of the arithmetic average (2,2-2,9 = low; 2,9-3,4 = general; 3,5-4,1 = high). The objective “coherence and effectiveness of policies for example shows the following result: four indicators were assessed as highly relevant, eight were assessed as relevant and one was assessed as being of low relevance. Afterwards the indicators within the objectives are analysed more in-depth. This analysis takes into account qualitative aspects as the highest and lowest answer per indicator, the most frequent answer per indicator and the relation between the answers (if there are two answers assessing an indicator as highly relevant, two answers assessing the same indicator as relevant, two answers assessing it as irrelevant and one at a time assessing it as less relevant and more relevant this does not say much, although the arithmetic average might show that it is relevant).

2.3) In the health case study 14 answers were registered. Sweden supplied for obvious reasons most responses since it proved most effective to talk directly to experts on the phone and appeal to their sense of responsibility, which in most cases was not very difficult. Many of those respondents who filled in their evaluations found the indicators far too difficult and complicated. The UK, Spain, and Germany also supplied many responses while the Czech Republic came up with one very valuable list of indicators that was well responded to and in addition the respondent had written five pages full of comments to the list of indicators, which must be very valuable for all future work in this direction. It is clear that the Czech representatives within the profession had quite high expectations on what the EU and research within the EU might entail. No responses have come forward from France and Austria in spite of repeated reminders.

The leader of case study adapted the indicators chosen from the Monitoring Systems into a more readable form for the purpose of the specific issue of health. Most of the questions have been as direct and concrete as possible. According to the case study leader most of the respondents had never been exposed to this kind of indicator evaluation. The investigation through indicators has been encouraged within the EU. However, since it has not been in use for a very long time and there is a shortage of experience with it, there are obvious initial difficulties in finding the adequate sort of indicators to be applied to sensitive and strategic fields subject to investigation. For this reason Martin Peterson offered verbal guidance and open discussion with them regarding the exact implication of many of the indicators. There is no doubt that the form of direct face to face or at least oral communication mostly via telephone had an
unanticipated corollary effect. Since many of the indicators by necessity were ambiguous in formulation and content a very open-minded discussion ensued, which brought about an extempore explorative debate on some of the thornier and controversial issues that helped a lot to bring extra clarity.

2.4) In the Czech Republic case study 6 experts were interviewed, two per each of the three institutional spheres examined, that is national parliament, the territorial public administrations and political parties. Indicators, in this case, have been considered “practicable” in the Czech context if: (a) considered important, (b) measures what it purports to measure and (c) is empirically feasible, that is if the data needed to do the proper measurement exist, is accessible or could be generated with reasonable effort. Further to the value of each indicator given by the experts the analysis provides a contextual comment by the research team in order to provide information on the institutional frame of the Czech Republic.

4 Analysis of results

4.1 Migration

The analysis of the evaluation by experts of indicators selected for the migration policy area has shown a positive medium high level of the applicability of the Monitoring System. However, it is worth analysing the different dimensions or themes: Rule of law, Coherence and Effectiveness, Openness and participation, Civil, corporate and media responsibility and Citizenship. Each of these dimensions contained a different number of indicators, some dimensions having only one indicator and others more than ten. More specifically the selection of indicators was as follows: one for Rule of law, nine for Coherence and effectiveness of policies, twelve for Openness and participation, two for Civil, corporate and media responsibility and eighteen for Citizenship.

The number of indicators for each dimension in the transferability exercise has been uneven and therefore we can only conclude tentatively as a result the outcome of comparing dimensions. Citizenship is the dimension in which indicators have received higher evaluation with nine out of eighteen indicators being evaluated as highly relevant and six as relevant. The dimension Coherence and effectiveness has one indicator being valued very relevant and five as relevant within a total of nine indicators. Openness and participation has six indicators out of twelve being evaluated as relevant. The Rule of law dimension has been very highly valued with only one indicator,
whereas the Civil, corporate and media responsibility have one out of two indicators being evaluated as relevant and the other one as less relevant.

The overall analysis of the responses concerning the applicability of the Monitoring System to migration has been positive with relevant contributions as to which type of indicator is considered more valuable and which needs reformulation. With the help of cluster analysis it becomes apparent that indicators, which have a very precise formulation and content –those referring to specific legislation- are highly rated. For example:

Specification of civil rights in Constitution and relevant legislation (C13)

Whereas indicators having a generic formulation are rated low and generate a large diversity of opinions. For example:

Characterization of Welfare state and recent reforms (C18)

The difficulty with the previous indicator is the high level of generality, which puts into question its usefulness, according to the experts consulted. There is well know that all countries likely to be monitored have a welfare state and most probably will have gone through reforms. What is needed –according to one expert- is a set of specific indicators measuring specific policies relevant to migrants’ social integration and welfare.

Similar comments emerged in relation to the indicator:


The critical appraisal from experts focused on the ombudsman offices’ lack of effective power to enforce the respect of human rights. Human rights courts need to be checked in their effective ruling in terms of independence and time. Thus effective accessibility will also have to be measure. Therefore, the following indicator has been suggested to complement (J6)

Average length and result of the procedure before an independent court reviewing administrative decisions concerning human rights of an individual.

Experts’ critical appraisal of indicators that seem to portray a high level of generality can be interpreted also as a consequence of policy actors’ own specialisation when working in specific policy domains. This working experience may sacrifice the processing of background or contextual information. Nonetheless, it may be useful to consider such broad indicators as adequate in the future Monitoring System as providing background or contextual information.
Considering a highly overall rated dimension such as Citizenship the indicators that are most highly evaluated are those referring to legislations, executive institutions (Government) and mechanisms of participation. On the other hand, the indicators less rated are those of a more general formulation dealing with broad institutions such as the welfare state.

Citizenship was the dimension containing the most indicators to evaluate. The choice to include a higher number of indicators in this dimension was informed by the migration overview done at the time of the selection. Members States have been redefining their migration policies not only in terms of entrance of numbers of newcomers, but also in relation to their citizenship laws. One of the most challenging aspects of migration into the EU is the redefinition of who is a citizen and what are the rights and duties attached to citizenship. As explained in the migration overview the market logic that attracts migration often enters into conflict with the national welfare logic of Member States. Furthermore, the international agreements defending human rights have increasingly entered into conflict with security concerns. In this context mechanisms of participation and contestation of restrictive migration laws have inspired civil society groups. It is no surprise that Citizenship is the dimension with the highest scores, with average evaluations between 2.9 and 4.2. Observing the mode and the average score of the indicators we could see that, in general, the majority of experts went for grades 3, 4 or 5. It should also be pointed out that the degree of agreement amongst the different experts was high due to the low level of dispersion of the different evaluations (as can be seen from the frequency tables).

There is also the case that within Citizenship indicators dealing with civic and political rights are evaluated better than those referring to social rights, which are considered less specific and directed to the overall population. More relevance is given to those indicators because large numbers of immigrants do not have political rights and many experience civic rights problems in Europe. This evaluation tells us something about the desirability of adjusting the Monitoring System to the specific policy sectors before conducting a democratic audit.

The analysis of responses to the value of indicators within the dimension Coherence and effectiveness of policies has shown that the same indicator when it is applied to formulation and evaluation gets a different evaluation that when applied to evaluation. For example the two following indicators have been rated as highly and less relevant respectively:

Role of different levels of government and legislative in policy formulation and implementation (P28)

Role of different levels of government and legislative in policy evaluation (P31)
This example shows experts sceptical view concerning the extent to which some of the indicators can be operational in evaluating policy. As we made clear in WP2 policy evaluation has been more difficult to exercise than policy formulation (or even policy implementation) in some policy sectors such as Employment. However, it may also be the case that downgrading of evaluation-related indicators is not a phase of policy making most policy actors think about.

Indicators measuring the role of societal actors, social partners and civil society (P7, P29 and P32) were rated as highly relevant. In the case of the indicator measuring the role of civil society organisation in terms of numbers of such organisations one expert pointed out that representation may prove to be difficult to measure. Not only the number of associations concerned with specific issues are relevant, but also the percentage of citizens and/or residents who are members of the organisations. Experts focused on the making indicators as accurate as possible within the Monitoring System.

In the dimension **Openness and participation** there also is a variation in terms of content between those indicators evaluated as relevant focusing on how to measure the mechanisms of participation and those referring to the political culture of citizens and to the information citizens have available, which are considered less relevant. One example is:

Legislation on the availability and access to information regarding societal actors (08)

This and other indicators (016 and 025) relate to legislative frameworks for citizens and civil society participation in the formulation and implementation of policies as well as to the use made by administrations of the existing mechanism. Experts on migration suggested that indicators should be formulated making specific reference to the policy area. For example the wording for indicators suggested to be added was as follows:

- **Third country nationals’ legal ability to participate in local elections**

- **Effective participation of third country nationals in local elections**

- **Openness of political parties to immigrants. Numbers of councillors, MPs with immigrant background.**

At the other end indicators with the lowest scores were therefore those related to citizens’ political knowledge (via the press or in general) and with the effective use of public audiences.

The issue of corruption was felt missing by a respondent as efficient democracy should be inversely related to corruption. In the Czech context, foreigners are
seriously confronted with corruption in the decision-making structures concerning their status. Therefore the following indicator was suggested:

Percentage of citizens/NGOs experiencing corruption in the decision making process.

This evaluation is reinforced by the recommendation of respondents that indicators should avoid a high degree of generality and instead should focus on specific institutions as well as on mechanisms or policies.

Finally some indicators were found excessively broad, for example (P23, P25 and C18). The extreme broadness of C4 makes it impossible for one of the readers to make an assessment. On the other hand some indicators were seen as difficult to separate from each other, for example O11 and O12.

As in the analysis of previous dimensions those indicators focusing on legislation and ways to measure its applicability for citizenship practices were highly rated.

4.2 Trade

The original set of indicators is grouped according to seven key dimensions or so-called strategic objectives. These build the framework for a series of intermediate objectives and indicators of the EUROPE Monitoring System. They include: Subsidiarity; Coherence and effectiveness; Effective, independent, representative legislature; Openness and participation; Civil, corporate and media responsibility; Rule of law and access to justice; and Citizenship.

Two of these strategic objectives, namely “Civil, corporate and media responsibility” and “Citizenship”, were not applicable for trade policy. Consequently, none of these indicators were included in the questionnaire.

Of the remaining strategic objectives, none, according to the arithmetic average, was assessed as being highly relevant, but all were assessed as being of relevance (= all or a majority of the indicators of the respective area were evaluated as being relevant). Nevertheless, the precise assessment of the indicators varies.

The objective with the largest number of indicators assessed as highly relevant is Coherence and effectiveness of policies, with four out of thirteen indicators being evaluated as highly relevant. This objective is closely followed by the objective Subsidiarity, which includes three out of fourteen indicators under the heading “highly relevant”. This order is also confirmed by the assessment of the
indicators of general relevance. Coherence and effectiveness of policies includes nine indicators assessed as relevant, none being assessed as less relevant, and “subsidiarity” contains eight of relevance and three of less relevance. The objectives Effective, independent, representative legislature as well as Openness and participation show more indicators of general relevance then of less or high relevance. Three indicators out of six under “effective, independent, representative legislature” were assessed as being relevant and two as being less relevant. Openness and participation contains eleven indicators. Seven of them were assessed as relevant and three as less relevant. A particular case is the Rule of law and access to justice because this objective only contains two indicators, of which one was assessed as being important while the other was assessed as being of medium relevance.

Within Subsidiarity, out of the fourteen indicators tested for this strategic objective, three indicators were assessed as highly relevant. Eight indicators were assessed as being relevant, while three were assessed as being less relevant.

These results show that, first of all, the involvement of the European Parliament (EP), the Committee of the Regions (CoR), the Social Committee and citizens in decision-making is deemed an important indicator in assessing how democratic trade policy is. Consultation of the mentioned institutions, however, focuses on the policy proposal stage, while consultation of citizens relates both to the stages of policy proposal and formulation. Furthermore, the role of the institutions clearly refers to the European level, while citizen involvement concerns the national level. Apart from the existence of consultation mechanisms, the results show that the adherence to rules on institutional reform is assessed as being more important than their existence.

The indicators assessed as being relevant closely relate to the indicators assessed as being highly relevant. Among the indicators perceived here as relevant, the existence rather than the application of rules on institutional reform is highlighted, and the mechanisms of consultation with EP, CoR and the Social Committee here relate to the stage of policy formulation compared to the policy proposal stage in the first group. Although the establishment of rules cannot be thought without assuming that they will be applied, sometimes rules are not adhered to in practice. The remaining indicator concerns the scope of co-voting in the European Parliament. This gives new support to the statement that its involvement in general is important for democratic trade policy-making. The scope of co-voting in the European Parliament of course touches upon one of the main issues with regard to European trade policy making from a democratic perspective and is one of the most frequently mentioned allegations against European trade policy.

Of the two indicators of the category Rule of law and access to justice, both show no clear preference of the experts (J9 and J10). The existence of
specialised commercial courts shows a weak tendency to being relevant, while the consistency of legislation with WTO standards gives no clear indication. The former indicator was highlighted as being unclear to one expert. The second was deemed as not being a problem of democracy at the national or European level, but rather a problem with the standards set by trade officials, because the WTO illegitimately limits the opportunity to create new legislation (e.g. on the environment).

Within the objective **Coherence and effectiveness of policies**, fourteen indicators were tested. According to the arithmetic average, four indicators were assessed as being highly relevant, nine were assessed as being relevant and none was assessed as being less relevant.

Of the four important indicators, only one gives a clear indication, and the other three are more ambiguous. The indicator of high relevance is the “role of societal actors: social partners and civil society organisations”. This assessment clearly confirms the aforementioned discussions concerning the lack of civil society participation in the EU trade policy making process. Experts in the area of trade regard the role of societal actors, social partners and civil society organisations as highly important for an equitable and democratic trade policy making process.

Indicators were assessed as being relevant when they were measuring how democratic trade policy is in relation to consultation practices. These practices were considered important, whether consultation takes place as a direct consequence of pressure from civil society or not, as is the case in indicators (P49 and P41).

The indicator (P11) which asks for the existence of international regulations or agreements setting standards or targets and adherence to these by EU or Member States was also considered relevant. International regulations or agreements can also include participatory standards or targets. If this is the case, it is important that Member States or the EU also apply these standards. This indicator was highlighted as difficult to understand by one expert. The fact that indicators measuring number and scope of legislation and measures dealing with regulation of trade were rated as relevant to saying how democratic trade policy is, is closely related to this specific policy field. International trade liberalisation frequently requires deregulation in national markets. The final outcome of this process is highly influenced by the design and the implementation of the deregulation process itself. One expert, however, remarked that market openness and economic regulation / de-regulation does in his view not directly relate to democracy / openness and citizen participation.

Within the objective **Effective, independent and representative legislature**, one out of the five indicators tested, according to the arithmetic average, was assessed as being highly relevant; two were assessed as being relevant and
two as being less relevant. The only indicator assessed as highly relevant within the objective “effective, independent, representative legislature” is the scorecard of citizen access: (a) do citizens have access to records of meetings; (b) are citizens able to find out who or what group is responsible for particular areas or decisions; (c) are citizens able to obtain voting records of MPs; (d) are citizens granted access to meetings of parliament; (e) are citizens granted access to committee meetings; (f) are plenary and committee meetings open to press?

Out of the eleven indicators chosen for the objective **Openness and participation**, one was assessed as highly relevant, seven as relevant and three as less relevant. As in the policy area of migration experts have rated indicators measuring existing legislation as highly relevant or relevant.

The general pertinence of the full set of indicators is assessed as being relevant, as well as the scope of the indicators, at least from a formal point of view. Concerning the scope, one expert stated that it was very difficult to assess if the indicators listed are sufficient for assessing the trade policy from a democratic perspective, as there might be hundreds of additional indicators. Two additional indicators were suggested, which mainly refer to European trade policy:

- **The number of international treaties and WTO conferences where parliament debated before the negotiations about what should be achieved in the negotiations and decided on the mandate, and**

- **The number of trade agreements rejected by a legislature against the wishes of the trade minister.**

One expert suggested considering the self-perception of policymakers and Parliamentarians in the indicators.

### 4.3 Health

In the health data analysis we can show that there are some tendencies towards national profiles under each indicator. At the same time it may be possible to detect more of a trust in transnationalism and transnational operations. There are some vague indications of a support for a European health care approach based on European culture. But these do not tend to be strong enough. It is clear from the responses that grass root movements are forming. Most respondents are very satisfied with the enormous attention given internationally to the difficult issues of giving priority to certain treatments. However, most are still sceptical to the idea of a European health care culture built on specialised hospitals and with local GPs handling local cases. One
issue favoured by respondents was the issue of bottom up action from grass root movements and the impact of such protest actions.

The leader of this policy case considered the one-to-five evaluation of each indicator a limited instrument when based only on a response to a questionnaire. He chose to rely on in depth interviews as well. According to him, if we judge the results we may see that comparisons of responses to one indicator do not tell us qualitatively more than if we look at the overall response profile of one respondent. The results are of course different but equally informative in their own special ways. For instance we may learn that one respondent is consistently negative in judging the democratic content of both legislation and participatory processes in policy making. Many respondents from one and the same nation such as for instance Sweden tend to consider mass media of overwhelming importance in bringing health care issues into the public sphere. Other questions relating to policy process or participatory processes may either be positively assessed depending on nation or correspondingly negatively assessed. There is for instance a slight tendency in Spain among experts and CSO representatives to inflate the importance of Spanish medicine. Many foreign experts corroborate this judgement by pointing to the remarkable advances Spanish medicine has made over the past quarter century. At the same time there is an evident ambiguity on the part of some of the Swedish responses since most respondents are apt to endorse the own system in comparison to others.

The scores were Rule of law, one indicator was valued as highly relevant and one general. Coherence and Effectiveness of policies, four indicators were rated as highly relevant and six general. Openness and participation, three indicators were highly relevant, ten general and three low. Civil, corporate and media responsibility, was valued as one indicator highly relevant and two general. Citizenship (Civil, Political and Social Rights) indicators were rated two highly relevant, six general and one low. Citizenship (User Rights and Inclusiveness) indicators were rated as five highly relevant.

Analyzing the indicator results, we can see that the low scores all occur regarding Openness and participation, which have sore points. We also see that the dimension Citizenship (Civil, Political & Social Rights) has few high scores. On the other hand, Citizenship with regard to user rights and inclusiveness in combination with Rule of Law and Effectiveness as well as role of Media constitute a high level to build on. These rated values can very well indicate the experts’ awareness of the existing limitations in national contexts of mechanisms of participation in decision making concerning the health systems in general and the local health institutions in particular. The fact that health care has been a crucial element of welfare rights will explain the high value given to indicators that measure the rights of citizens.
From a national context perspective (and based on the interviews) it seems fair to suggest that the Czech Republic is ascertaining its health care to a much stronger degree than do other western nations. Only with regard to law and media is there any trace of scepticism. There may be a psychological factor at play here. A boost of strategic and sensitive sectors in society is to be regarded as part of national consciousness-raising. The importance of media issues are emphatic in the Swedish context, legal issues are clearly the strength of the UK, social rights still tend to be weak points everywhere even though Swedes consider them to be dated, a thing of the past. There are uneven appreciations and assessments with regard to CSOs and patient/customer rights. In the Swedish case they are viewed rather optimistically since an immense growth in patient/customer say on health care policy matters has occurred.

On matters such as political culture the indicators tend to be somewhat inconclusive. The authoritarian and hierarchical attitude to Government ministers lingers on in most places, which means that even deliberate long-term attempts at decentralising health care such as in Sweden only imply a two-headed dominance. The priority issue is one of the more sensitive current difficulties, which may eventually end up in common European approaches with highly specialised.

Experts comments indicated satisfaction with legislation on health care rights but considerable doubts about its application with the exception of the UK where there appears to be a confidence in the workings of the legal system. The Czech evaluation of rule of law is by contrast the lowest Czech rating.

Concerning the role of relations between different forms of Health care institutions in promoting a health care culture as well as a policy programme there was a clear-cut nationally determined high rating in Germany. The indicator relating to the role of media in promoting public debate on health care issues was very highly rated by all Swedes. The media role is definitely certified in the Swedish case and much more clearly so than in even the Czech Republic where media are still regarded with caution.

The sixteen indicators comprise Openness and Participation included indicators on Information access and participation standards, as well as civilian competence and political culture. German rating of the use of mechanisms promoting participatory processes was relatively high. Also worth noting is that overall British evaluations are high when it comes to the access of citizens to formal bodies of decision-making indicating a wider and more advanced climate of democracy in the UK in this respect. Otherwise there is the same uneven pattern as regards national evaluations but certain interest patterns may be discerned.

Civil, corporate and media responsibility related to plural information sources with regard to health care shows once again Swedish ratings as higher
than others'. The other evaluations show the same uneven pattern as before with only the Czech rating being consistently very high. The remaining fourteen indicators are related to Citizenship with social rights being the most obvious indicator on actual citizen status. Only in Sweden once again is there a clear pattern that class divisions do not matter any longer as regards health care.

4.4 The Czech Republic case

A significant part of the indicators was evaluated as relevant or very relevant. This suggests that, by and large, the Monitoring System was well-designed and can be developed to become a workable democratic audit. It was particularly its well-thought-out structure that was much appreciated by experts. The dimension of Subsidiarity was evaluated on the basis on sixteen indicators. Moreover the Czech team also asked the empirical feasibility of the indicators. Of the total number of indicators selected for this dimension eighty one per cent was rated as relevant, the rest as not relevant or problematic and also seventy five per cent of them were considered empirically feasible. Seventeen indicators were evaluated from the dimension Openness and participation, of which eighty six per cent were rated as relevant and fifty per cent as empirically feasible. Finally the largest number of selected indicators belonged to the dimension More effective, independent representation legislation-political parties, in this case experts were more critical rating forty three per cent as relevant and only thirty five per cent as empirically feasible.

As pointed out by the Czech research team conclusion of the case study one of the drawbacks of the exercise was that only two experts have evaluated each indicator. This limitation constitutes a problem especially when there was sharp disagreement within the pairs of experts on how to evaluate some of the indicators, which happened in many cases. Such cases are mentioned in the analytical part of the case study report. We learn from this that it will be desirable to consider a good number of experts when using the democratic audit.

The critical appraisal of experts in this case focuses on the way in which the indicators actually monitor democracy in the Czech Republic. Experts were either political scientists or politicians and rated the Monitory System according to the Czech national context. This was precisely what was expected of them, however, many negative evaluation refer to the applicability of the indicator to the specific national example, which means that we can expect a different evaluation in a different national context. Here is an example:
Research of political parties to identify and represent constituencies’ concerns (L50)

This indicator was rated as not a relevant indicator without empirical feasibility in a national context in which Czech political parties have show no interest in conducting such research. What we can learn from this particular exercise is that the Monitoring System could be best used by national evaluators taking into account the specificity of national practices corresponding to national political cultures.

Experts distinguish between the indicators according to their perceived relevance, to point to some conceptual and methodological problems which they recommended to tackle and to test the indicators by applying them to the situation in their own country.

Some of the indicators were viewed as not too relevant or problematic in terms of their ability to measure the phenomena they were intended to measure within the Monitoring System. As the main reasons the experts mentioned their following faults:

1. unclear or ambiguous definition of some indicators (as, for example, L26, L28)
2. excessive complexity of some indicators calling for their further disaggregation into measurable variables (as, for example, L67, L68)
3. descriptive character of some indicators whose conceptual relation to aspects of democracy the experts were unable to recognize (as, for example, L36, L47, L48, L51, L69)
4. indicators where the experts questioned their purported ability to measure some aspect of democracy (as, for example, S54, L47, L51, L69); here, the skepticism which the experts developed during the Communist regime has been probably reflected in the evaluation: number of public meetings, production of planning documents, updating of membership lists etc. were purely formal acts which had no meaning in terms of democracy
5. some indicators were considered less relevant because, in the experts’ opinion, the events they measure do seldom occur or in the Czech Republic - which does not, of course, mean that they could not occur elsewhere (as, for example, L32, L33, L37, L39)
6. the group of fifteen indicators measuring representation of marginalized groups by and in political parties (L49 to L63) was considered disproportionately extensive and, about one half of the indicators were evaluated as less relevant
7. in some cases, relevance of the indicators was considered low because of their inferential character and the assumed impossibility to do the measurement in real circumstances (as for, example, “number of major government decisions in which input from participation mechanisms was used” or “number or percentage of occasions (among those for which it is required to do so) for which government agencies provide adequate notice of public hearings”).

Another criticism concerned unrealistic demands which, in the experts’ opinion, some indicators make on data. The measurement of a considerable proportion of the indicators would require availability of non-standard data – realization of ad hoc surveys and case studies, often laborious and expensive, digging for inaccessible administrative records etc. and, in one or two cases, even starting full-scale ad hoc research projects. Such demands may seriously impair practicability and usefulness of the Monitoring System. The experts recommended to re-consider the respective indicators in the process of further refinement of the Monitoring System.

4.5 Concluding remarks

The transferability exercise has been comprehensive in terms of number of indicators submitted to experts. Over two hundred indicators – half of the total comprising the Monitoring System – were read and evaluated by experts. Of the total number an average of seventy per cent were rated as highly relevant or relevant. However, the interesting result of the exercise was the constructive comments as the way in which the Monitoring System could be made more useful in the future.

In general, the indicators selected for the migration, trade and health policy areas were assessed as useful for assessing how democratic policy is. However, some aspects hamper their application, In the case of trade experts found difficult to assess the indicators without any reference to trade; an adaptation to the policy field in question should be considered when applying the set of indicators. Both in the cases of migration and trade policies indicators considered by the experts as very abstract were rated low. In this sense giving some more concrete examples for the addressees of the questionnaires could be helpful.

From a comparative perspective of the migration and trade policy area, it is interesting to note that the migration experts emphasized detail and the local level of implementation whereas the trade experts emphasized the transparency of political and policy frameworks. This could have two complementary interpretations. One that more emphasis should have been put on the part of the research teams in selecting indicators that will measure the
particular policy domain and two the different character of the policy domain. In the concrete case of migration policy it will be desirable to take into account indicators in the dimension of Subsidiarity. This will be in accordance with national and sub-national developments. The migration policy overview informs of the increasing role of municipal institutions and local civil societies in the management of social integration policies in Europe. The more these institutions and organizations play an important role in policy design and implementation of immigration the more need there is for assessing their democratic input in relation to other levels of governance.

Experts evaluating the Monitoring System in the three policy areas coincided in giving a high value to indicators that related to the rule of law and legislation in general for setting the framework of policy or participation.

Some experts found some of the indicators contain unclear terms. In some cases a definition of terms would be helpful. This will be especially the case when the Monitoring System is used by professionals of policy sectors rather than specialists in democratic assessment. Also the Czech team pointed out that experts have voiced their concern on the unrealistic demands which some indicators make on data. Experts in this case also criticized what they perceived as methodological unevenness of the Monitoring System where some indicators are true analytical variables while other indicators are complex phenomena that have yet to be structured and operationalized.
The aim of the Case Study is to test transferability (applicability) of the Europub Monitoring System’s indicators in the concrete situation of a country participating in the project and within its concrete institutional spheres.

Three institutional spheres were chosen in the Czech Republic where the transferability was assessed:

1. the local government
2. the political parties.
3. the national Parliament, citizens and NGOs

The local government sphere involves two levels— the regional and the municipal one. Its present form has been shaped by a reform which started as early as 1990 and lasted until the end of 2002. The main aim of the reform was to dismantle the communist-type territorial government and establish a democratic decentralized system applying the principle of self-administration on the municipal and regional levels. The self-administering branch of the territorial government has been anchored in the 1992 Constitution of the Czech Republic (effective since 1993). This new structure is considered to be one of the main accomplishments of the post-communist transformation and is, therefore, an appropriate target of the evaluation.

As in other democratic states, political parties are among the main actors in the political system of the Czech Republic. The present parties have been gradually
crystallizing since 1989 when the monopoly of the Communist Party was broken. Presently, the number of registered political parties exceeds one hundred, but only few play any significant role on the national level. The party system is the second institutional sphere where the Monitoring System was evaluated.

Also the national Parliament is a new institution. It was created in its present form as late as 1993, along with the birth of the Czech Republic, following the split of the former Czechoslovakia. It too, has been anchored by the 1992 Constitution. The Parliament is a bicameral structure, composed of the Chamber of Deputies and the Senate. As the supreme legislative body, the Parliament is another important institutional field where evaluation of the Monitoring System was performed. Together with the Parliament, also the civil society, as represented by the citizens and the NGOs, became a relevant social and political actor after the fall of the communist regime.

Applicability was assessed of indicators belonging to three segments (objectives) of the Europub Monitoring System:

A. Subsidiarity – Responsiveness to local level

B. More effective, independent and representative legislatures – Political parties

C. Openness and participation – Consultation and participation standards.

These three segments of the Monitoring System were chosen because of their relevance for above-mentioned institutional spheres. Thus,

- the Subsidiarity – Responsiveness to local level segment of the Monitoring System relates to the local government sphere,

- the More effective, independent and representative legislatures – Political parties segment is directly relevant for the Political Parties institutional sphere,

- the Openness and participation – Consultation and participation standards segment relates particularly to the Parliament sphere.

The following numbers of indicators were evaluated:

- 16 indicators belonging to segment B (Subsidiarity – Responsiveness to local level),

- 46 indicators belonging to segment A (More effective, independent and representative legislatures – Political parties)
- 17 indicators belonging to segment C (Openness and participation – Consultation and participation standards).

Each indicator was assessed from two angles:

- as regards its relevance, i.e. its ability to measure the objective and the intermediary result which it purports to measure within the Monitoring System,

- as regards its empirical feasibility within the Czech context, i.e. the availability or accessibility in the context of this country of the data or other kind of information needed to do the measurement.

In addition, the indicators were also used to assess the contemporary situation in the Czech Republic (CR), in the three institutional spheres, i.e. to find how far does the country meet the criteria implied by the indicators. The aim of this exercise was to evaluate applicability of the monitoring system by applying it to the case of a concrete country.

Six Czech experts (two per each institutional sphere) were asked to do the assessment. The experts were given the respective lists of indicators and were asked, for each individual indicator, to express their opinion on how the indicator meets the above two methodological criteria and also how does the Czech Republic meet the substantive expectations implied by that indicator. A five-point scale was used to gauge the indicator’s relevance (where 5 points represent the highest relevance and 1 point the lowest one) and a three-point scale to gauge the indicator’s empirical feasibility within the Czech context (3 points expressed the situation when the data or other information exist and are available, 2 points meant that special efforts are needed to obtain the data, and 1 point signalized that no data exist). Experts were also encouraged to add qualitative comments on individual indicators.

The following experts took part in the assessment:

Ing. Jan Kerner (Mr.), a university educated technician, presently a city mayor of Louny in north-west Bohemia (population 20 thousand).

JUDr. Jiri Grospic, PhD. (Mr.), legal scientist, public administration specialist, senior researcher at the Institute of State and Law, Academy of Sciences of the Czech Republic, lecturer at the Czech Economic University in Prague.

PhDr. Emil Voracek, PhD.(Mr.), political scientist, senior researcher at the Institute of History, Academy of Sciences of the Czech Republic.

PhDr. Jan Outly (Mr.), independent political scientist.
5.2 The Analysis

In this analytical part of the Case Study, evaluation of the individual indicators according to the above-mentioned criteria is presented and also situation in the Czech Republic is briefly characterized, as viewed through the indicators. Two scales were used:

The scale of indicator relevance where:

5 points indicate the highest relevance - 1 point indicates the lowest one.

The scale of indicator’s empirical feasibility (in the Czech context) where:

3 points indicate that the data or other information exist and are available
2 points indicate that extra efforts are needed to obtain the data or other information
1 point indicates that no data / information exist or can be reached.

5.2.1 Evaluation of the 'Subsidiarity - responsiveness to local level' indicators

Indicators pertinent to this objective were evaluated by

Mr. Jan Kerner

Mr. Jiri Grospic

5.2.1.1 Constitutional devolution of powers

S42 Devolution of powers within Member States
a. Relevance: 4, 4 A relevant indicator, but insufficiently concrete.

b. Empirical feasibility in the CR: 1, 3 Low. It would be rather demanding to obtain the necessary data and to comparatively gauge the level of devolution in different countries. An *ad hoc* study would have to be launched.

c. Situation in the CR The new system of regional government which introduced in the CR in 2001 makes it possible to apply the principle of subsidiarity in public administration and to increase civic participation in government. However, the process of devolution of powers to the regions is not completed and the central authorities hesitate to devolve their still considerable powers.

**S43 Number and character of laws which seek to devolve power being implemented by central government and level of implementation**

a) Relevance: 3, 4

A relevant indicator. However, it aims to measure two potentially divergent things: one, the number and character of laws, second, the degree of their implementation. Laws do exist which devolve powers, yet their implementation is insufficient or lacking.

b) Empirical feasibility in the CR: 3, 3

c) Situation in the CR:

The devolution of powers and responsibilities is not matched by a corresponding devolution in the sphere of budgeting and financing. The self-administering regions are heavily dependent on the central state budget, their independent revenues are minimal. Moreover, ministries distribute the subsidies directly to the different institutions within the regions, circumventing the regional authorities.

**S44 Number or percentage of local laws passed without hindrance or in coordination with central government within an acceptable time frame**
a) Relevance: 4, 4
A relevant indicator of devolution.

b) Empirical feasibility in the CR: 3, 3

c) Situation in the CR:
Municipal authorities in the CR have adequate powers to issue locally binding ordinances. Larger municipalities do make use of them. Sometimes, administrators from the Ministry of Interior try to intervene and to influence this activity. Unlike the municipalities, regional authorities are rather restricted in this respect.

5.2.1.2 Local governments’ capacity to act

A45 Degree to which regional and local governments may levy taxes and fees

a) Relevance: 3, 3 A relevant indicator.

b) Empirical feasibility in the CR: 3, 3 The budget allocation of taxes is determined by law.

c) Situation in the CR: Own revenues of municipalities (local fees and the municipalities’ share of centrally collected taxes) are satisfactory, although municipalities have only a limited power to determine the tax rate. The situation is far from satisfactory on the regional level – own revenues of regions are not guaranteed by the present legislation.

A46 Percent of locally generated revenue retained locally

One of the two experts (the city Mayor) did not answer as he did not understand the meaning of the indicator

a) Relevance: 3 A relevant indicator.

b) Empirical feasibility in the CR: 3 The national data are available.

c) Situation in the CR: All taxes are collected by the state. With the exception of the real estate tax (and the locally collected local fees) which proceed fully to the local coffers, returns on all other taxes are redistributed among the state, the municipalities and the regions according to predetermined criteria. Summarily, about 21% of the
tax return go to municipalities, about 3 % to regions and 76 % to the state budget.

A47 Number of times or months government transfers to local governments fall into arrears

One of the two experts (the public administration expert) did not answer as he was not sufficiently informed about the regime of the transfers.

a) Relevance: 4  A relevant indicator.

b) Empirical feasibility in the CR: 3

c) Situation in the CR: The situation is satisfactory – financial transfers are timely, the money arrives every month. The Mayor commented that the problem is not so much the timeliness, but rather the amounts of money received.

A48 Ratio of capital to recurrent expenditures

a) Relevance: 4, 4 A very relevant indicator.

b) Empirical feasibility in the CR: 3, 3 The data are easily obtainable both for the individual municipalities as well as aggregated on the national level.

c) Situation in the CR: Municipalities differ as regards the proportion of capital expenditures within their budgets. Particularly the very small municipalities (of which there is the majority) find it difficult to accumulate sufficient means needed to finance larger projects.

Ad 49 Authority of local governments to hire civil servants

a) Relevance: 5, 5 A highly relevant indicator.

b) Empirical feasibility in the CR: 3, 3 Data are easily obtainable.

c) Situation in the CR: All civil servants working in the municipal and regional authorities are hired by the respective governments. There are no state employees in the municipal and regional governments. An Act on civil servants in local and regional self-governing units exits whose impact is considered to be very positive.
S50 Percentage of local government staff replaced after elections

a) Relevance: 4, 4 A relevant indicator of the degree of politicization and clientelism in local and regional government.

b) Empirical feasibility in the CR: 1, 3 Low. The Mayor is very sceptical as regards the availability of any data on this indicator. No summary records or statistics are kept on the turnover of the staff. An ad hoc study would have to be made. No data are as yet available on the regional level where only single elections have so far taken place in 2000.

c) There is no evidence, according to the two experts, of any increased staff mobility following the municipal elections. Some changes do occur, but mostly in the top positions of the administration. This is an unresearched terrain in the CR.

S51 Level of professional education and work experience of local government civil servants

a) Relevance: 2, 4 The two experts differ in their opinion. The Mayor means that this is not a good indicator because formal education and work experience do not automatically translate into work performance. The public administration expert has a more positive opinion as regards the relevance of education and experience.

b) Empirical feasibility in the CR: 1, 3 Opinions of the experts diverge. The Mayor means that performance of civil servants is difficult to measure quantitatively. The public administration expert mentioned that the data on the qualification and work experience of the municipal and regional civil servants are available with the respective authorities. He is not sure if there exists any national statistics covering this issue.

c) Situation in the CR: The level of professional education of the civil servants differs depending on the size and administrative status of the local authority. University educated people are more frequently represented in the larger urban Municipal Offices and in the Municipal Offices of cities with extended powers. University educated civil servants prevail in the Regional Offices.
S52 Number of regional / local governments which belong to a regional / local association

a. Relevance: 3, 5 A relevant indicator. Opinions, however, differ. The Mayor’s opinion is determined by the Czech situation: he means that there are too many associations whose activities dysfunctionally overlap, so that their influence suffers. The public administration expert meant that the main associations are influential and are accepted as partners by the central government.

b. Empirical feasibility in the CR: 3, 3 Membership data are easily obtainable from the individual associations.

c. Situation in the CR: There exist a number of associations of municipalities, the largest, most universal and most influential one being the Union of Cities and Municipalities of the Czech Republic. All regions are members of the Association of Regions which is an active and influential partner of the central government.

5.2.1.3 Mechanisms of participation

S53 Existence of regular regional / local elections

a. Relevance: 5, 5 A very relevant indicator. It indicates the existence of a fundamental institutional prerequisite to civic participation. A question can be, however, asked if this indicator makes sense within the EU Member States all of which are democracies where regular local and regional elections have been guaranteed and do regularly take place.

b. Empirical feasibility in the CR: 3, 3 Data on the elections – on their existence, legislation, rules, organization and results are generally accessible.

c. Situation in the CR: Regular democratic municipal elections have been taking place in the CR in four year intervals since 1990. Regional elections took place in 2000, new regional governments started their work in 2001, next regional elections will follow in fall 2004. The turn-out has been steadily falling in the municipal elections and it was very low in the regional elections.
S54 Number of town meetings and / or citizen council meetings on special issues

a) Relevance: 3, 3 Not very relevant indicator. The Mayor does not consider this to be a useful indicator. According to him, participation or non-participation in the meetings does not necessarily express citizens’ interest in public issues. People can be involved in other ways than going to meetings.

b) Empirical feasibility in the CR: 2, 1 Problematic. No comparable official records exist on the numbers of meetings and of numbers of people attending. Individual municipal governments may keep their own records, but this is not guaranteed and such records tend to be unreliable.

c) Situation in the CR: Public meetings organized by municipal governments are rare. Most frequently, they are convened in connection with the local elections. Beyond the election campaign, meetings are convened to discuss town planning issues or some exceptional issues like the privatization of municipal houses and apartments. Some meetings are occasionally organized by the NGO’s, mostly to discuss environmental problems. Political parties organize public meetings as part of the election campaign.

S55 Average number of people attending town meeting or percentage of local governments holding a prescribed X number of town meetings per year with more than Y people attending

a. Relevance: 3, 2 Same comment as S54 above.

b. Empirical feasibility in the CR: 2, 1 Problematic – same comments as S54 above.

c. Situation in the CR: As above.

S56 Annual reports and budgets of local councils available to councillors, the public, the media, NGOs

a. Relevance: 5, 4 A very relevant indicator.
b. Empirical feasibility in the CR: 3, 3 These documents are routinely accessible.

c. Situation in the CR: Local budgets, financial reports, agendas and minutes of council meetings and annual or other summary reports of local councils are routinely accessible to councillors, citizens and the media. Their public accessibility is guaranteed by the Local government Act and the Act on the free access to information.

S57 Audits of budgets of local governments

Relevance: 4, 4 A relevant indicator of the municipal governments’ financial discipline and of its accountability. Not so relevant indicator of of the civic participation.

a) Empirical feasibility in the CR: 3, 2

b) Data on the individual audits – their existence and results – are available. The experts were not sure if there exists a regular summary report or a statistical material on the audits at the national level.

c) Situation in the CR: Audits of municipal budgets are obligatory ex lege. Information on results of the individual audits is publicly accessible.

5.2.2 Evaluation of the „More effective, independent and representative legislatures – political parties’ indicators

Indicators pertinent to this objective were evaluated by

Mr. Emil Voracek

Mr. Jan Outly

5.2.2.1 Electoral / political system

L25 Degree to which electoral laws conform to international standards
a) Relevance: 5, 3 A very relevant indicator.

b) Empirical feasibility in the CR: 3, 3

c) Situation in the CR: Electoral laws in the CR comply with the international standards (see Freedom House and Bertelsmann). As excessive are considered by the experts powers of the electoral representatives who are authorized to exclude any name from the lists of candidates because of formal shortcomings.

L26 Degree to which multiple parties are recognized and sanctioned by electoral laws

a) Relevance: 4, 4 The meaning of the term ‘multiple’ is not clear as it is used here. Could be a relevant indicator if multiplicity is understood as plurality of political parties (such was the experts’ interpretation of this term). Could be, however, as well understood as internal multiplicity of political parties – the acceptance of their coalitions.

b) Empirical feasibility in the CR: 3, 3 Electoral laws and by-laws are easily accessible.

c) Situation in the CR: Electoral laws admit the coalitions of political parties.

L27 Degree to which political parties field candidates at all applicable levels of government

a) Relevance: 2, 2 Is not considered to be a relevant indicator. Is acceptable as a descriptive variable without evaluative reading. The fact that some parties do not field candidates at some levels of government is not a shortcoming.

b) Empirical feasibility in the CR: 3, 3 Is reasonably good, the relevant information is published.

c) Situation in the CR: There is a sharp difference between the national and regional levels and the municipal level on the other hand as regards fielding the candidates. National parties are much less present on the local level where ad hoc local parties and movements as well as independent candidates abound. Only the Communist Party of Bohemia and Moravia with its large membership and a dense network of local organizations and, partly, also the centre-right Civic Democratic Party field their candidates at all territorial levels.

L28 Degree of independence of electoral authority
a) Relevance: 5, 2 The two experts disagreed with each other on relevance of this indicator. One of them meant that it is ambiguous as several authorities may have a role in organizing the elections.

b) Empirical feasibility in the CR: 2, 3

c) Situation in the CR: In the CR, three kinds of authorities play a role in the elections: the state authorities are responsible for their preparation, the electoral committees for the elections proper and the Czech Statistical Office for processing of their results. Their independence has been never questioned.

L29 Level of confidence of political actors and citizens in electoral process and authority

a) Relevance: 5, 4 A very relevant indicator.

b) Empirical feasibility in the CR: 1, 1 No data are readily available, an ad hoc survey would have to be carried out.

c) Situation in the CR: The electoral process and authority are considered trustworthy.

L30 Adequacy and timeliness of resources made available to electoral authority

a) Relevance: 5, 2 The two experts disagreed with each other on this indicator. No explanation is available why this was the case.

b) Empirical feasibility in the CR: 2, 2 No summary data available. An ad hoc analysis of administrative records and/or an opinion survey of members of the electoral authorities would have to be carried out.

c) Situation in the CR: There is no evidence of problems in this respect.

L31 Number of years since update of voter registry completed and procedures for this update

a) Relevance: 1, 2 Considered to be irrelevant indicator.

b) Empirical feasibility in the CR: 1, 3 Low ranking because a system of continuous updating is used in the CR.
c) Situation in the CR: Voter registries are updated continually.

L32 Percentage of eligible voters registered to vote

a) Relevance: 1, 5 The experts disagreed as regards relevance of this indicator. Perhaps, they used different perspectives in their evaluation: the low mark was chosen because the indicator was viewed within the Czech context where gaps in lists of voters seldom occur (see below), while the other expert might have evaluated it from a more general perspective.

b) Empirical feasibility in the CR: 1, 3 Low, there is no systematic source where the necessary data could be found.

c) Situation in the CR: Citizens aged 18 and more are registered automatically as voters by the authorities, unless deprived by law of the right to vote (people mentally incapacitated). Failure to register eligible persons seldom occurs. If so, it may be the result of administrative gaps. Lists of voters must be made public ahead of the elections and citizens can check their completeness and accuracy and ask, if necessary, their completion.

L33 Percentage of voters with proof of registration whose name does not appear on voting lists

a) Relevance: 1, 5 Experts disagreed as regards relevance of this indicator. No explanation is available why this was so.

b) Empirical feasibility in the CR: 1, 2 No data are available on the occurrence of such a situations which are not likely to occur in the CR.

c) Situation in the CR: Experts disagreed on whether and when a missing voter’s name can be added to the list.

L34 Key benchmarks in electoral calendar accomplished

a) Relevance: 4, 4 A relevant indicator.

b) Empirical feasibility in the CR: 2, 3 No generalized data are available as regards potential failures to observe the benchmarks in local elections.

c) Situation in the CR: The electoral calendar is mostly observed. Problems are rare – if any, they occur mostly in local elections.
L35 Degree to which vote tabulation and reporting is carried out accurately and transparently

a) Relevance: 5, 5 A very relevant indicator.

b) Empirical feasibility in the CR: 3, 3

c) Situation in the CR: All such information is accurately and continuously published on the Internet.

L36 Number of days required to tabulate and announce official results

a) Relevance: 2, 2 Not a relevant indicator. Rather than measuring the level of democracy, it reflects the technical and administrative efficiency of the administrative structures. Moreover, the speed of tabulating and announcing the election results depends also on the size and the territorial administrative structure of the country and on the kind of elections (local – regional – national).

b) Empirical feasibility in the CR: 3, 3

c) Situation in the CR: Election results are available timely.

L37 Number and nature of complaints by political parties regarding equitable access to print and visual media during campaigns

a) Relevance: 1, 3 A problematic indicator. It is too generalized in assuming the right of the political parties to equal access to media without distinguishing between the public and private media as well as the electronic and printed ones.

b) Empirical feasibility in the CR: 1, 2

c) Situation in the CR: There is the right to equal access to the public electronic media. No political campaigning is permitted in the private electronic media. But no restrictions exist as regards political campaigning in the printed media (all of them are in private hands). The rule of equal access does not apply there - financial resources of the political parties play the main role as regards their access to such media time and space.

L38 Breadth of dissemination and quality of voter education material by election authority
a) Relevance: 5, 4 A very relevant indicator. But it confuses two different issues which may not go hand in hand: quantity and quality of the materials.

b) Empirical feasibility in the CR: 4, 2 An ad hoc analysis would have to be carried out, no stand-by data are available. It is not clear how will be measured the quality of the materials?

c) Situation in the CR: Monitoring of voters' education materials is not carried out, no systematic information is available on dissemination and quality of such materials. Analytic information, together with the instructions how to vote, is usually disseminated by the public media, instructions how to vote are distributed to all voters by the authorities.

L39 Degree to which spoiled ballots are due to inadequate understanding of voting process

a) Relevance: 2, 4 A problematic indicator. Ballots can be spoiled either by inadequate understanding of the voting process or they can be spoiled by the voters intentionally. To distinguish between the two situations, a voters’ survey would have to be carried out. Monitoring of the spoiled ballots would not be by itself sufficient.

b) Empirical feasibility in the CR:3, 1 Data on the number of spoiled ballots are easily available. No data are available on the reasons why they were spoiled. To find about this, an ad hoc survey would be necessary.

c) Situation in the CR: The proportion of spoiled ballots is minimal in the CR.

L40 % of eligible and registered voters unable to vote due to irregularities at polling stations

a) Relevance: 4, 4 A very relevant indicator.

b) Empirical feasibility in the CR: 1, 1

c) Situation in the CR: Such situations are practically unknown in the CR.

5.2.2.2 Internal management and democracy

L41 Political parties have written by-laws that promote internal democratic party government and are adhered to by party leaders
a) Relevance: 5, 4 A very relevant indicator. However, it is over-specified. Too many criteria are enumerated with which the party by-laws and the parties’ actual behaviour should comply.

b) Empirical feasibility in the CR: 1, 1 Empirically a most difficult indicator. A laborious analysis of party-by-laws and, in particular, of their actual behaviour, would have to be carried out.

c) Situation in the CR: To be registered by the Ministry of Interior, parties must submit their by-laws for examination as regards the democratic principles. There is, however, little control as regards the actual decision-making within the parties and there are reasons to believe that the democratic rules have not been always adhered to, particularly by some more extreme smaller parties.

L42 Degree to which political parties allow for broad membership participation in drafting party platforms

a) Relevance: 2, 4 Experts disagree on relevance of this indicator. More important than the proportion of party members contributing to the policy debate is the share of those identifying themselves with such policies.

b) Empirical feasibility in the CR: 1, 1 Low. A demanding analysis of the parties’ internal decision-making procedures would be needed.

c) Situation in the CR: Parties differ as regards this criterion.

L43 Degree to which political parties have internal communication structures that promote two-way communication between party branches and headquarters

a) Relevance: 5, 4 An relevant indicator, particularly in larger countries where parties have many members and more complicated organizational structure. There are fewer problems with internal communication within parties with smaller membership.

b) Empirical feasibility in the CR: 2, 1 Low, an ad hoc analysis would have to be carried out.

c) Situation in the CR: Intra-party communication exists, but usually it is too personalized.
L44 Degree to which political parties have well-trained staff and/or volunteer staff support

a) Relevance: 2, 2 Not a relevant indicator. Two criteria have been mixed here: availability of the professional and of the volunteer staff. Parties may rate differently on each of the two criteria.

b) Empirical feasibility in the CR: 1,1 Low. Little is known, parties are secretive in this respect. An ad hoc analysis would be needed.

c) Situation in the CR: As above

L45 Degree to which political parties have established leadership development programmes

a) Relevance: 2, 2 Not a relevant indicator. There is no reason to consider it more democratic if parties promote their leaders gradually by internal education instead of choosing competent personalities in a straightforward way, without any previous schooling.

b) Empirical feasibility in the CR: 1, 1 Low. Little is known, an ad hoc analysis would have to be carried out.

c) Situation in the CR: The situation is different in individual parties. A leadership development programme is applied by the Civic Democratic Party.

L46 Political parties have established internal staff/volunteer training programmes

a) Relevance: 5, 2 Experts differ as regards relevance of this indicator. The opinion was expressed that the existence of training programmes does not say much about the democratic character of the political parties.

b) Empirical feasibility in the CR: 2, 3 An ad hoc study would have to be carried out.

c) Situation in the CR: Some of the larger parties organize their internal staff/volunteer training. If so, not on a larger scale and only occasionally.

L47 Political parties have planning documents

a) Relevance: 3, 2 A problematic indicator. Two different things are covered by this indicator which should be better treated separately: general planning and financial planning.
b) Empirical feasibility in the CR: 1, 1Low, an ad hoc analysis would have to be carried out.

c) Situation in the CR: Parties have financial plans, other kinds of plans are mostly absent.

L48 Political parties maintain internal public policy research institutions

a) Relevance: 1, 2 The indicator says little about the parties’ internal democracy.

b) Empirical feasibility in the CR: 2, 3 Information is available.

c) Situation in the CR: The Civic Democratic Party (centre-right) has an associated research body. Experts doubt if any other party has a similar institution. Parties can and do use services of independent external research agencies.

5.2.2.3 Representation of marginalised groups

L49 Extent to which parties conduct demographic research to identify voting patterns and representation of special groups

a) Relevance: 1, 3 Experts disagree as regards relevance of this indicator. An objection was raised that while such research is important for the effectiveness of party politics, it has not much to do with democracy. Parties have sometimes to pursue unpopular policies which run against public opinion. They care about representation of special groups only if they consider this to be politically expedient for them – if, for example, that party’s target group is concerned.

b) Empirical feasibility on the CR: 2, 1 Low – an ad hoc analysis would have to be made.

Situation in the CR: Large parties contract research from commercial consultancies and polling agencies.

L 50 Research of political parties to identify and represent constituencies’ concerns

a) Relevance: 2, 2 Not a relevant indicator. Here, the experts were probably influenced by the Czech situation.

b) Empirical feasibility in the CR: 2, 1 An ad hoc analysis would be necessary.
c) Situation in the CR: The present Czech catch-all parties are not interested in such research.

L 51 Regular update of membership lists

a) Relevance: 1, 3 Not a relevant indicator. Regular updates of membership lists have little meaning in terms of party democracy. Parties are motivated to update the lists in order to have a firm basis for collecting membership fees.

b) Empirical feasibility in the CR: 1, one expert was unable to answer Experts were not sure – an ad hoc analysis would be necessary.

Situation in the CR: Not known,

L 52 Extent to which political parties conduct periodic recruitment for members

a) Relevance: 3, 4 A relevant indicator in terms of the parties’ growth mechanism. Not too relevant in terms of their internal democracy.

b) Empirical feasibility in the CR: 2, 2 Low, an ad hoc analysis would have to be conducted.

c) Situation in the CR: Periodic large-scale recruitment campaigns do not occur.

L53 Extent of anti-discrimination regulations

a) Relevance: 5, 5 A very relevant indicator of the parties’ internal democracy. However, the formal regulations do not per se guarantee absence of any discrimination which may have a more hidden informal guise.

b) Empirical feasibility in the CR: 1,1 Low, an ad hoc analysis would have to be conducted.

c) Situation in the CR: Experts did not have reliable knowledge on this issue.

L54 Extent to which parties have auxiliaries for youth, women, minorities, etc.

a) Relevance: 5, 4 A relevant indicator.

b) Empirical feasibility in the CR: 2, 3 Only partial information is available. To get a full picture, an ad hoc survey would be necessary.
c) Situation in the CR: All large parties have their youth organizations. The Social Democratic Party has as well an (inactive) women organization.

L55 Degree to which party programmes are free of language that constrains specific groups (according to gender, age, minority status) to become politically active

a) Relevance: 5, 3 A relevant indicator of the parties’ democratic character.

b) Empirical feasibility in the CR: 3,3 The experts’ opinion is positive. However, to get a systematic picture, an ad hoc analysis of party programmes would have to be conducted.

c) Situation in the CR: No problems in this respect. The programmes are written in “children's language.”

L56 Degree to which political participation in party mirrors that in general population

a) Relevance: 5, 1 Problematic. Experts totally disagreed as regards this indicator. One of them objected that: the membership structure of parties cannot and should not mirror the social structure of the population. Most parties aim to represent different social groups and their specific interests.

b) Empirical feasibility in the CR: 1, 2 Low, data not readily available, an ad hoc analysis would have to be carried out.

c) Situation in the CR: Social structures of the individual parties' membership do not correspond with the structure of the general population.

L57 Degree to which statutes and institutional practices facilitate running of disadvantaged groups for party posts

a) Relevance: 1, 4 Experts disagree between themselves regarding this indicator. This is a good indicator in terms of intra-party democracy and the representation of the disadvantaged. Yet the experts meant that parties are not obliged to care about representing the disadvantaged, unless this is part of their political programme.

b) Empirical feasibility in the CR: 1, 1 Low, an ad hoc analysis would have to be conducted.
c) Situation in the CR: Experts are not sufficiently informed. They feel that most party documents do not have provisions in favour of the handicapped.

L58 Number and nature of complaints filed regarding discrimination

a) Relevance: 3, 3 Number of complaints is a relatively weak indicator of discrimination.

b) Empirical feasibility in the CR: 1, 1 Low – data on complaints, if any, are scattered. An ad hoc analysis would have to be conducted.

c) Situation in the CR: Experts lack knowledge on this issue.

L59 Number of material specifically geared towards inclusion of women, youth, old, minorities and other disadvantaged groups

a) Relevance: 1, 2 Is not a relevant indicator. Number of materials is a poor measure: materials can be so diverse that it makes no sense counting them without a qualitative categorisation. Moreover, a larger number of materials does not by itself indicate larger intra-intra-party democracy.

b) Empirical feasibility in the CR: 1, 3 Poor, no stand-by information available, an ad hoc analysis would be needed.

c) Situation in the CR: Experts lack knowledge on this issue.

L60 Percentage of candidates who are women or members of disadvantaged groups

a) Relevance: 4, 3 A relevant indicator.

b) Empirical feasibility in the CR: 2, 2 Statistics is available on the representation of women among candidates. Scattered or no data at all exist on the representation of other categories of the disadvantaged.

c) Situation in the CR: No obligatory quotas are applied by the parties. The Social Democratic Party has a rule that at least 30 % women should be among its candidates. Yet, in practice, women are usually placed in ineligible positions on the candidates lists. The proportion of women depends, inter alia, on their interest and willingness to stand as candidates. Which falls so far behind that of men.
L61 Level of financial support provided to women and members of disadvantaged groups

a) Relevance: 2, 2 Not a relevant indicator. Parties do not support financially individual candidates in the system of proportional representation, neither – in most cases, within the system of majority representation.

b) Empirical feasibility in the CR: 1, 1 Low, no stand-by data are available beyond the success rate of women in elections. It is questionable if any other data exist.

c) Situation in the CR: A system of financial support of individual candidates is not used.

L62 Women / disadvantaged candidates success rates as compared to others

a) Relevance: 1, 2 Not a relevant indicator, the information it would provide cannot be interpreted in terms of intra-party democracy. Success rate depends on many other factors beyond being or not being member of a disadvantaged group.

b) Empirical feasibility in the CR: 2, 1 Low - no stand-by data are available beyond the success rate of women and it is questionable if any other data exist.

c) Situation in the CR: Unknown.

L63 Number of members of disadvantaged groups or women in party leadership positions

a) Relevance: 5, 2 Could be a relevant indicator, however, the experts disagreed between themselves about its standing.

b) Empirical feasibility in the CR 3, 3 Data on the representation of women in party leadership can be easily found. But data are not available on members of other disadvantaged groups – an ad hoc analysis would be necessary.

c) Situation in the CR: Few women can be found in party leadership positions.
5.2.2.4 Political programmes

L64 Degree to which competing political parties articulate distinct programmatic agendas that provide clear choices of electorate

a) Relevance: 3, 5 A relevant indicator. Within the system of proportional representation parties must differ as regards their programmes, otherwise they would not attract voters’ attention.

b) Empirical feasibility in the CR: 3, undecided Information can be found in analytical publications.

c) Situation in the CR: Parties’ programmes differ between themselves.

L65 Degree to which citizens discern differences between competing political parties

a) Relevance: 3, 5 An relevant indicator, but difficult to operationalise.

b) Empirical feasibility in the CR: 1, 3 Analytical data are not available – an ad hoc opinion survey would have to be carried out. Some information can be derived from the polls.

c) Situation in the CR: Citizens discern differences between parties. However, more than differences between party programmes, the differences between party politicians, frequently superficial ones, play an important role.

L66 Degree to which programmatic party differences are perceived and communicated by media

a) Relevance: 2, 4 Experts disagreed between themselves as regards relevance of this indicator.

Note: The number of indicators within the theme “Representation of marginalised groups” was considered excessively large, compared with other parts of the system.
b) Empirical feasibility in the CR: 1, 2 Low – an ad hoc content analysis of media would be needed.

c) Situation in the CR: Media seldom pay analytical attention to the contents of party programmes. Public relations agencies hired by political parties promote intensively their paymasters in private media.

5.2.2.5 Political elites

L67 Career paths of party officials

a) Relevance: 5, 3 An relevant but imperfect descriptive indicator. It would have to be disaggregated into more concrete measures.

b) Empirical feasibility in the CR: 1, 2 Low – parties tend to hide this information. Something can be found in scientific publications, yet to get a systematic up-to-date picture, an ad hoc survey would have to be carried-out.

c) Situation in the CR: As above.

L68 Mechanisms of reproduction of party leadership

a) Relevance: 1, 3 An imperfect descriptive indicator – in this form, it is too complex to be useful. Would have to be disaggregated into more concrete measures.

b) Empirical feasibility in the CR: 1, 1 Very low. Something can be found in scientific publications, however, a full research programme would have to be launched to get a systematic information.

c) Situation in the CR: There is no short way to give the answer. Moreover, available data are not sufficient.

L69 Profile of party membership in media

a) Relevance: 1,1 The indicator is incomprehensible. Experts did not understand what is the meaning and function of this information.

b) Empirical feasibility in the CR: 1, 2 It is not clear what kind of information would be needed.

c) Situation in the CR: Cannot be answered because of the above problems.
L70 Perception of party leaders by citizens

a) Relevance: 1, 3 Can have some relevance, but the value of this indicator is decreased by frequent fluctuations of politicians’ popularity.

b) Empirical feasibility in the CR: 1,1 Ranking of politicians according to their popularity is continuously monitored by the polling agencies. However, popular perception of party leaders is a more complex phenomenon and to learn about it and ad hoc survey would have to be carried out.

c) Situation in the CR: Perception of politicians is often based on superficial criteria that have little to do with their programmes and political behaviour. With some exceptions, it tends to fluctuate quite frequently.

5.2.3 Evaluation of the ‘Openness and participation’ indicators

Indicators pertinent to this objective were evaluated by

Mr. Edvard Outrata

Mr. Lukas Linek

5.2.3.1 Consultation and participation standards

**Handbooks on consultation and participation**

a) Relevance: 5, 2 Potentially a relevant indicator. Experts disagreed between themselves as regards its relevance.

b) Empirical feasibility in the CR: 3, 2 Low. An ad hoc investigation would have to be carried out.

c) Situation in the CR: Handbooks and similar materials do exist. They were mostly distributed in the 90s, less so nowadays. The existence of handbooks is relevant if officially sponsored by the authorities. Sometimes, such publications were formal result of activities of foreign-sponsored foundations which did not manage to use and distribute them properly.
Existence and description of mechanisms of consultation and participation

a) Relevance: 5, 2 Potentially relevant, but the experts disagreed on this item. This is a rather complicated and complex indicator which needs to be disaggregated into more concrete measurable components. It should be distinguished between not binding procedures and such which have the character of co-decision and oblige the decision-makers.

b) Empirical feasibility in the CR: 2, 1 Low. Data on some consultation mechanisms are easily accessible, but ad hoc research would be required to learn about other ones.

c) Situation in the CR: Some consultation mechanisms like, for example, local referenda or submission of draft physical plans to public discussion, are anchored by law. Others – like the tripartite - are anchored by extra-legal agreements. But most mechanism are not regulated at all.

Use of mechanisms of consultation and participation

a) Relevance: 5, 3 A relevant indicator. The experts appreciated that separate attention is paid to the “use of mechanisms" as separate from their mere “existence”.

b) Empirical feasibility in the CR: 1, 2 Low. Data are more easily accessible as regards the use of the obligatory mechanisms, but difficult to find as regards the rest.

c) Situation in the CR: As above. Local referenda have been used, physical plans are submitted for public discussion, the tripartite does functions, though imperfectly. Little information is available as regards other mechanisms.

Number or percentage of occasions (among those for which it is required to do so) for which government agencies provide adequate notice of public hearings

a) Relevance: 5, 1 Experts disagreed as regards relevance of this indicator. The skeptical opinion of one of them was caused by his conviction that this indicator is empirically unfeasible.

b) Empirical feasibility in the CR: 2,1 Poor, no data are available, an ad hoc survey would have to be carried out.
c) Situation in the CR: The practice of obligatory public hearings is not
developed in this country. Authorities may occasionally use this instrument on
their own will.

Perception of citizens with regard to having adequate
information on key policy issues

a) Relevance: 4, 3
A relevant indicator. However, people may give a positive or negative answer
on this issue to express their positive or negative attitude towards the
government rather than their actual feeling of being or not being informed.

b) Empirical feasibility in the CR: 2, 3 Some data are irregularly generated by
opinion polls and by social science research. To get an up-to-date systematic
information, an ad hoc opinion survey would have to be carried out.

c) Situation in the CR: People mostly tend to declare that they lack sufficient
information on policy issues.

Perception of journalists with regard to having adequate
information on key policy issues

a) Relevance: 4, 2 relatively relevant indicator. However, journalists tend to
play their own politics when answering questions concerning this issue.
Disaggregation of the data by socio-economic characteristics does make sense
in this case. Journalists are a selective group and also size of the sample would
not be sufficiently large to allow for disaggregation by social characteristics.

b) Empirical feasibility in the CR:2, 1 Poor, no source is known that could
provide the necessary data.. An ad hoc survey would have to be conducted.

c) Situation in the CR: Unknown.

Number or percentage of well publicized government
meetings open to citizens and citizen groups

a) Relevance: 5, 1 Experts sharply disagreed as regards this indicator. One of
them made the critical comment that the indicator is not well defined and also
too complicated: He did not understand what is meant by the expected number
of well publicized government meetings.
b) Empirical feasibility in the CR: 2, 1 Poor. No data exist on this issue and it would be near impossible to get any. Not the least because of the insufficient definition of the indicator.

c) Situation in the CR: Meetings of all Municipal and Regional Councils are public ex lege and their agendas and dates must be announced in advance. Central governments’ meetings are not accessible for the public. Ex post reports are usually published by media.

Number of major government decisions in which input from participation mechanisms was used

a) Relevance: 5, 3 Theoretically a relevant indicator, posing however near insurmountable measurement problems. It is usually extremely difficult to prove if a piece of information was or was not used within a decision-making process.

b) Empirical feasibility in the CR: 2, 2 Low - see above. No generalized data exist. Case studies could be used, but their findings cannot be generalized. More information is available on the decision making in the Parliament, little or nothing as regards the central government.

c) Situation in the CR; Not known.

Examples of decisions taken at governmental level as a consequence of pressure from civil society

a) Relevance: 5, 2 Experts disagreed on this indicator. Same critical remarks apply here as mentioned above. The indicator can as well measure politicization of public administration which bows to public pressure in order to succeed in the next elections.

b) Empirical feasibility in the CR: 1, 2 As above.

c) Situation in the CR: Such situations do occur.

Number or percentage of regional / local governments implementing investment decisions with citizen input

a) Relevance: 5, 4 A very relevant indicator posing, however, measurement problems. How can be the “citizen input” operationalized? What is a public consultation?
b) Empirical feasibility in the CR: 2, 1 Poor – no data exist. To get some, only case studies come in consideration.

c) Situation in the CR: There does not exist any general rule that citizen input should be obtained in investment decisions. However, public discussions are sometimes organized.

**Number of joint commission meetings between government and civil society organizations**

a) Relevance: 4, 5 A relevant indicator.

b) Empirical feasibility in the CR: 2, 3 Problematic – an ad hoc analysis would be needed.

c) Situation in the CR: Joint commissions and consultative groups exist.

**Number of NGOs saying they experienced a valid engagement with the executive branch of government in the process of policy formulation and implementation**

a) Relevance: 3, 3 A relatively relevant indicator. It will be important to define properly the NGOs which will be considered here.

b) Empirical feasibility in the CR: 2, 2 Low – an ad hoc survey would have to be carried out.

c) Situation in the CR: NGOs compete for influence and contacts with the executive branch of government.

**Number of public hearings in Parliament open to citizens, citizen groups and the press (print and audiovisuals)**

a) Relevance: 5, 3 A relevant indicator. However, the mere existence of open public hearings does not say much about public participation itself.

b) Empirical feasibility in the CR: 3, 3 Data can be obtained from the Parliaments’ Press Department.

c) Situation in the CR: Public hearings are used only by the Senat (the Parliament’s upper chamber). About three such hearings are organized annually. Due to the Senat’s weak powers, the impact of the hearings is small. Media pay minimum attention.
Average number of meetings per year held by legislators in which citizens / constituents are invited or % of MPs who meet with NGOs and constituents on a regular basis (more than X times a year)

a) Relevance: 4, 4. A relevant indicator. It is necessary to define what a meeting is and to distinguish between trivial formal meetings and the substantive ones.

b) Empirical feasibility in the CR: 1, 2

No systematic data exist. However, data from an existing survey can be used.

c) Situation in the CR: Most meetings are of the formal kind.

Number of legislature committee meetings where citizens are invited to actively participate or provide input

a) Relevance: 5, 3 A relevant indicator. It is necessary to define what is meant by “invitation”.

b) Empirical feasibility in the CR: 2, 3 Data exist and can be obtained from the Parliament’s Office.

c) Situation in the CR:

All the Parliament’s committee meetings are public, yet few people and institutions use this opportunity. The Committees usually invite subjects whom they wish to be present in the meetings. However, the mere presence does not indicate their ability to influence the agenda. Often, subjects come to the committee meetings who failed to promote their interests through other more effective channels.

Scorecard of citizen access to legislative procedures

a) Do citizens have access to records of meetings?

a) Relevance: 5, 4

b) Empirical feasibility in the CR: 3, 3

c) Situation in the CR: the records are public
b) Are citizens able to find out who or what group is responsible for particular areas or decisions?

a) Relevance: 5, 3

b) Empirical feasibility in the CR: 2, 3

c) Situation in the CR: yes, in the minutes of sessions and other documentation, available mostly on the Internet

c) Are citizens able to obtain voting records of MPs?

Relevance: 5, 3

Empirical feasibility in the CR: 3, 3

Situation in the CR: yes, voting records accessible

d) Are citizens granted access to meetings of parliaments?

Relevance: 5, 3

Empirical feasibility in the CR: 3, 3

Situation in the CR: the meetings are public

e) Are citizens granted access to committee meetings?

Relevance: 5, 3

Empirical feasibility in the CR: 3, 3

Situation in the CR: committee meetings are public

f) Are plenary and committee meetings open to the press?

Relevance: 5, 3

Empirical feasibility in the CR: 3, 3

Situation in the CR: plenary and committee meetings are open to media.

Open are as well the meetings of regional and Municipal Councils.
One of the two experts considers the above indicators trivial in the European democratic states.

**Content of public participation in Committees at Parliament level factored into legislation and budget**

a) Relevance: 5, 5  
A highly relevant indicator.

b) Empirical feasibility in the CR: 2, 3  
Low, data are not available. An ad hoc analysis would have to be conducted.

c) Situation in the CR: Public influence does not usually materialize during Committee sessions, but during the preparatory phases of the sessions. Usually, the interested subjects contact the Committee’s rapporteur responsible for the respective item of the agenda prior to the meeting. If they manage to explain their point, the rapporteur prepares the respective amendment and presents it during the Committee meeting. The interested party may or may not be present there. Thus, participation in Committee meetings is a poor measure of the actual influence of the interested public.

5.3 **Conclusions**

Due to the small number of experts, the results of this evaluation have but an indicative value and they do not permit any far-reaching generalizations. The opinion of the experts was influenced by their individual professional and political experience and by the specifics of the Czech scene, by their position and age as well as by the subjective scales they applied in the evaluation. Such idiosyncrasies which would mutually cancel in a larger team of judges played a substantive role in the small teams of two. There was often a sharp disagreement within the pairs of experts on how to evaluate some of the indicators. Such cases were duly mentioned in the analytical part of this report.

In spite of these caveats, the experts, some of them politicians and some academicians, were able to agree on the evaluation of quite a number of indicators. They managed to distinguish between the indicators according to their perceived relevance, to point to some conceptual and methodological problems which they recommended to tackle and to test the indicators by applying them to the situation in their own country.

A significant part of the indicators was evaluated as relevant or very relevant. This suggests that, by and large, the monitoring system was well-designed and can be developed to become a workable instrument, capable of measuring the
European democracy. It was particularly its well-thought-out structure that was much appreciated.

However, some of the indicators were viewed as not too relevant or problematic in terms of their ability to measure the phenomena they were intended to measure within the Monitoring System. As the main reasons the experts mentioned their following faults:

1. unclear or ambiguous definition of some indicators (as, for example, L26, L28)

2. excessive complexity of some indicators calling for their further disaggregation into measurable variables (as, for example, L67, L68)

3. descriptive character of some indicators whose conceptual relation to aspects of democracy the experts were unable to recognize (as, for example, L36, L47, L48, L51, L69)

4. indicators where the experts questioned their purported ability to measure some aspect of democracy (as, for example, S54, L47, L51, L69); here, the skepticism which the experts developed during the Communist regime has been probably reflected in the evaluation: number of public meetings, production of planning documents, updating of membership lists etc. were purely formal acts which had no meaning in terms of democracy

5. some indicators were considered less relevant because, in the experts' opinion, the events they measure do seldom occur or in the Czech Republic - which does not, of course, mean that they could not occur elsewhere (as, for example, L32, L33, L37, L39)

6. the group of fifteen indicators measuring representation of marginalized groups by and in political parties (L49 to L63) was considered disproportionately extensive and, about one half of the indicators were evaluated as less relevant

7. in some cases, relevance of the indicators was considered low because of their inferential character and the assumed impossibility to do the measurement in real circumstances (as for, example, "number of major government decisions in which input from participation mechanisms was used" or, "number or percentage of occasions (among those for which it is required to do so) for which government agencies provide adequate notice of public hearings".

The experts also criticized methodological unevenness of the monitoring system where some indicators are true analytical variables while other indicators are complex phenomena that have yet to be structured and operationalized.

Another criticism, relevant form the feasibility perspective, concerned unrealistic demands which, in the experts' opinion, some indicators make on data. The
measurement of a considerable proportion of the indicators would require availability of non-standard data – realization of ad hoc surveys and case studies, often laborious and expensive, digging for inaccessible administrative records etc. and, in one or two cases, even starting full-scale ad hoc research projects. Such demands may seriously impair practicability and usefulness of the Monitoring System. The experts recommended to re-consider the respective indicators in the process of further refinement of the Monitoring System.

It can be said that the experts tended to recommend indicators whose conceptual relation to the different aspects of democracy is clearly discernible and uncontested (being, for example, supported by normative rules and other formal structures), which are sufficiently analytical and operational, can be covered by existing or easily obtainable data, such as the periodically produced statistics, administrative data or opinion surveys, and do not require more demanding ad hoc research.

Of the three segments (objectives) of the Monitoring System which we have tested here, indicators of the segment A – Evaluation of the ‘Subsidiarity – responsiveness to local level’ indicators got the highest approval, closely followed by segment C. Less positive was evaluation of the segment B indicators where, however, the discrepancy of the two experts’ opinions complicates the picture.

The quantitative results of the evaluation can be summarized as follows:

5.3.1 Subsidiarity – Responsiveness to local level (16 indicators)

Indicators according to their relevance

| Relevant | 81 % |
| Not so relevant or problematic | 19 % |

Indicators according to their empirical feasibility in the Czech Republic

| Data exist and are (fully or partly) accessible | 75 % |
| Data do not exist or are not accessible, ad hoc research has to be carried out | 25 % |
5.3.2 More effective, independent and representative legislatures – political parties

Indicators according to their relevance

<table>
<thead>
<tr>
<th>Relevant</th>
<th>43 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not so relevant or problematic</td>
<td>57 %</td>
</tr>
</tbody>
</table>

Indicators according to their empirical feasibility in the Czech Republic

| Data exist and are (fully or partly) accessible | 35 % |
| Data do not exist or are not accessible, ad hoc research has to be carried out | 65 % |

5.3.3 Openness and participation – Consultation and participation standards

Indicators according to their relevance

<table>
<thead>
<tr>
<th>Relevant</th>
<th>86 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not so relevant or problematic</td>
<td>14 %</td>
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</tbody>
</table>

Indicators according to their empirical feasibility in the Czech Republic

| Data exist and are (fully or partly) accessible | 50 % |
| Data do not exist or are not accessible, ad hoc research has to be carried out | 50 % |
Annex 1: indicators of the case studies

6.1 Selected indicators for migration

6.1.1 RULE OF LAW

6.1.1.1 Human Rights Mechanisms for implementing human rights

1. (J6) Existence of independent human rights commission, human rights court or ombudsman

6.1.2 COHERENCE AND EFFECTIVENESS

6.1.2.1 Governance mode

2. (P7) Number of civil society organisations concerned with specific policy issues

3. (P23) Existence of autonomous agencies and function

4. (P25) Practice of evaluation at policy level

6.1.2.2 Policy process (policy formulation and implementation)

5. (P28) Role of different levels of government and legislative in policy formulation and implementation

6. (P29) Role of societal actors: social partners and civil society organisations in policy formulation and implementation

7. (P30) Role of citizens in policy formulation and implementation
6.1.2.3 Policy process (policy evaluation)

8. (P31) Role of different levels of government and legislative in policy evaluation

9. (P32) Role of societal actors: social partners and civil society organisations in policy evaluation

10. (P33) Role of citizens in policy evaluation

6.1.3 OPENNESS AND PARTICIPATION:

6.1.3.1 Laws on participation

11. (O1) Legislation on citizen consultation and participation for instance with regard to public inquiries

6.1.3.2 Laws on information access

12. (O8) Legislation on the availability and access to information regarding societal actors (like NGOs, trade-unions, etc.)

6.1.3.3 Consultation and participation standards

13. (O11) Existence and description of mechanisms of consultation and participation

14. (O12) Use of mechanisms of consultation and participation

15. (O13) Number or percentage of occasions (among those for which it is required to do so) for which government agencies provide adequate notice of public hearings

16. (O16) Number of major government decisions in which input from participation mechanisms was used

17. (O20) Number of joint commission meetings between government and civil society organisations
18. **(O21)** Number of NGOs saying they experienced a valid engagement with the executive branch of government in the process of policy formulation and implementation

19. **(O25)** Scorecard of citizen access to legislative procedures: (a) do citizens have access to records of meetings; (b) are citizens able to find out who or what group is responsible for particular areas or decisions; (c) are citizens able to obtain voting records of MPs; (d) are citizens granted access to meetings of parliaments; (e) are citizens granted access to committee meetings; (f) are plenary and committee meetings open to the press?

### 6.1.3.4 Civilian competence and political culture

20. **(O28)** Level of political knowledge and understanding of political system

21. **(O31)** Newspaper reading, radio and/or television listening (political programmes)

22. **(O37)** Percentage of eligible women / voters of disadvantaged groups and percentage who vote

### 6.1.4 CIVIL, CORPORATE AND MEDIA RESPONSIBILITY

#### 6.1.4.1 Plural information sources

23. **(R40)** Number of hours of minority language programming on TV

24. **(R41)** Number of minority language print periodicals

### 6.1.5 CITIZENSHIP

#### 6.1.5.1 Inclusive citizenship (constitutional and political arrangements)

25. **(C1)** Definition of citizenship rights in Constitution

26. **(C2)** Adequate consideration of citizenship rights in legislation
6.1.5.2 *Inclusive citizenship (multiculturalism)*

27. **(C4)** Legislation regarding acquisition of citizenship in host country -- length, procedures, barriers

28. **(C5)** Support for multicultural integration or absence of discrimination in fields like: education, health, housing, labour market

29. **(C6)** Degree of organisation and representation of migrant, ethnic, religious or generally minority communities

6.1.5.3 *Civil and political rights*

30. **(C13)** Specification of civil rights in Constitution and relevant legislation

31. **(C14)** Existence of mechanisms (like Ombudsman) or NGOs with mandate of investigating violations of civil rights

32. **(C15)** Existence of institutions or organisations that show existence of civil rights

33. **(C16)** Specification of political rights in Constitution and relevant legislation

34. **(C17)** Existence of mechanisms or NGOs with mandate of investigating violations of political rights

6.1.5.4 *Social Rights (Universal Social rights)*

35. **(C18)** Characterisation of welfare state and recent reforms

36. **(C19)** Listing and characterisation of universal social rights with regard to income, work, education, health, family, housing, etc.

37. **(C20)** Governmental expenditures on welfare by sub-area

38. **(C21)** Social statistics

6.1.5.5 *Social rights (protecting against risk of poverty & social exclusion)*

39. **(C22)** Governmental action against poverty and social exclusion
40. (C23) Number of NGOs and voluntary organisations working to combat poverty and social exclusion and scope of work

41. (C24) Poverty rate in time series

42. (C25) Characterisation of poor populations and pathways to social exclusion

6.2 **Selected indicators for Trade**

6.2.1 **SUBSIDIARITY**

6.2.1.1 *Division of powers at European level*

1. (S7) Rules / Procedures on consultation between European institutions

2. (S8) Existence of rules on institutional reform at European level at the aggregate level

3. (S9) Adherence to rules on institutional reform at aggregate level

4. (S14) Number and character of mechanisms used for intra- and inter-ministerial (directorate) consultation

5. (S15) Number or % of political functionaries who say they have sufficient information for making decisions

6.2.1.2 *Shared competencies European / national / regional*

6. (S19) Scope of co-voting vs. Consultation with European Parliament

7. (S24) Efficiency and transparency of mechanisms used for consultation among national governments for policies governed by unanimity

8. (S29) Extent to which mechanisms above are adhered to and scope of inter-governmental bargaining

9. (S27) Mechanisms for consultation with EP, CoR and Social Committee at policy proposal stage
10. **(S28)** Mechanisms for consultation with EP, CoR and Social Committee at policy formulation stage

11. **(S30)** Efficiency and transparency of mechanism of consultation between national governments and national parliaments at policy proposal and formulation stages

12. **(S31)** Consistency of above mechanisms across Member States

13. **(S32)** Role adhered to citizen consultation and public inquiries at stages of policy proposal and formulation at European level

14. **(S33)** Role adhered to citizen consultation and public inquiries at stages of policy proposal and formulation at national levels

6.2.2 **RULE OF LAW AND ACCESS TO JUSTICE**

6.2.2.1 *Market-based economies*

15. **(J9)** Specialised commercial courts

16. **(J10)** Consistency of legislation with WTO standards

6.2.3 **COHERENCE AND EFFECTIVENESS OF POLICIES**

6.2.3.1 *Governance mode*

17. **(P11)** Existence of international regulations or agreements setting standards or targets and adherence to these by EU or Member States

18. **(P13)** Number and scope of legislation concerned with the removal of barriers to competition as a percentage of total

19. **(P14)** Number and scope of legislation concerned with regulating deregulation

20. **(P15)** Number and scope of economic measures targeting the sector
6.2.3.2 **Policy process**

21. **(P28)** Role of different levels of government and legislative in policy formulation and implementation

22. **(P29)** Role of societal actors: social partners and civil society organisations

23. **(P30)** Role of citizens

24. **(P38)** Number and scope of inter-governmental consultations (between Member States and national / subnational levels)

25. **(P39)** Number and scope of intra-governmental consultations (among Ministries)

26. **(P41)** Number or percentage of policy decisions in which input from consultation was taken into account

27. **(P45)** Perception of journalists concerning they have adequate information on key policy issues

28. **(P49)** Examples of decisions taken at government level as a consequence of pressure from civil society

29. **(P52)** Number of NGOs saying experienced a valid engagement with the executive branch in the process of policy formulation and implementation

6.2.4 **EFFECTIVE, INDEPENDENT AND REPRESENTATIVE LEGISLATURE**

6.2.4.1 **Legislative capacity**

30. **(L16)** Index of committee capacity

31. **(L17)** Committee oversight

32. **(L20)** Number of public hearings open to citizens, citizen groups and the press
6.2.4.2 Citizen access

33. (L21) Average number of meetings per year held by legislators in which citizens/constituents are invited or % of MPs who meet with NGOs and constituents more than x times a year.

34. (L22) Number of committee meetings where citizens are invited to actively participate or provide input.

35. (L23) Scorecard of citizen access: (a) do citizens have access to records of meetings; (b) are citizens able to find out who or what group is responsible for particular areas or decisions; (c) are citizens able to obtain voting records of MPs; (d) are citizens granted access to meetings of parliament; (e) are citizens granted access to committee meetings; (f) are plenary and committee meetings open to press?

6.2.5 OPENNESS AND PARTICIPATION

6.2.5.1 Laws on participation

36. (O2) Legislation on stakeholder consultation

6.2.5.2 Laws on information access

37. (O4) Legislation on the availability and access to information regarding the executive branch of government

38. (O5) Legislation on the availability and access to information regarding the legislative branch of government

39. (O6) Legislation on the availability and access to information regarding the judiciary branch of government

40. (O8) Legislation on the availability and access to information regarding societal actors (like NGOs, trade-unions, etc.)

6.2.5.3 Consultation and participation standards

41. (O11) Existence and description of mechanisms of consultation and participation
42. (O12) Use of mechanisms of consultation and participation

43. (O14) Perception of citizens with regard to having adequate information on key policy issues

44. (O15) Perception of journalists with regard to having adequate information on key policy issues

45. (O18) Examples of decisions taken at governmental level as a consequence of pressure from civil society

46. (O21) Number of NGOs saying they experienced a valid engagement with the executive branch of government in the process of policy formulation and implementation

6.2.6 GENERAL PERTINENCE

47. General Pertinence of the full set of indicators

48. Do you think the indicators listed are sufficient for assessing trade policy from a democratic perspective? Are there any that you think are missing and should be added?

6.3 Health case study

6.3.1 RULE OF LAW

1. (Connection to C18, J15) Health Care defined by law as activity to prevent, trace, investigate and treat illness and injuries

2. Application and implementation of law to secure correct diagnosis and adequate treatment

6.3.2 EFFECTIVENESS
6.3.2.1 Governance Mode

3. *(Connection to P4, P22)* Division of modes of health care organisations where priorities of primary care, emergency care, and planned clinical care vary with state, regional and municipal organisation

4. *(Connection to P4)* Method of insurance system - public or private or mixed – and its relation to modes of health care organisations

5. *(Connection to P7)* Role of pharmaceuticals and CSO reaction on medication as substitute to clinical health care

6.3.2.2 Policy Process – Policy Formulation and Implementation

6. *(Connection to P17, P20)* Role of relation between different forms of Health care institutions in elaboration and implementation of Health Care Systems

7. Application of adequate treatment irrespective of costs and location

8. *(Connection to P17, O24)* Role and opportunity on the part of patients to have a democratic say in formulation of health care policies

9. *(Connection to P7, P22, P23, O19, O20)* Role and opportunity on the part of citizens to have a democratic say in formulation of health care policies

6.3.2.3 Policy process – policy evaluation

10. *(Connection to P25)* Role of different levels of Governmental and legislative bodies in policy evaluation

11. *(Connection to O2, R16, R17 and R21)* Role of societal actors: social partners, medical associations, hospital workers’ unions and CSOs in policy evaluation

12. *(Connection to P8)* Role of media in evaluation of health care policy

6.3.3 OPENNESS AND PARTICIPATION
6.3.3.1 Information access

13. (Connection to O1, O20) Role of state committee investigations and reports

14. (Connection to O22) Role of public debates in preferably legislative bodies

6.3.3.2 Participation standards

15. (Connection to O11) Existence and description of modes of participation in opinion formation and decision-making processes

16. (Connection to O12) Use of mechanisms of participatory processes

17. (Connection to O13, O22) Frequency of public hearings initiated by government agencies

18. (Connection to O26) Number of successful inputs from participation mechanisms into political decision-making

19. (Connection to O20, O21, O13) Frequency of joint consultation between government agencies and CSOs on health policies

20. (Connection to O21) Frequency of executive branch of government in joint engagement with NGOs for policy formulation and implementation

21. (Connection to O14, O22, O24) Citizen access to formal bodies of decision-making

6.3.3.3 civilian competence and political culture

22. (Connection to O28, O30) Level of sector knowledge and its relevance to political system

23. (Connection to O15, O31) The impact of media consumption on trust or distrust in medical system

24. (Connection to L32) Percentage of eligible voters of disadvantaged groups and percentage of these who vote

25. (Connection to O23, R5, R7) Adjustment to hierarchical structures where CSOs are easily co-opted by existing ruling regimes
26. *(Connection to R13)* Egalitarian structures questioning any formation of uncalled for hierarchies and CSOs remain strictly independent

27. *(Connection to O28)* Spatial access to and cost of utilities such as educational facilities and health care

28. *(Connection to O10)* Degree of linguistic rigours and old fashioned formalities ruling social dialogue and social relations in health care

6.3.4 CIVIL, CORPORATE AND MEDIA RESPONSIBILITY

6.3.4.1 *Plural information sources*

29. *(Connection to R10)* Space given to health care issues, relevant CSOs and debates on TV & radio, in newspapers & periodicals

30. *(Connection to R26)* Civic action against policy decisions on health care

31. *(Connection to R24)* Number of medical and health periodicals

6.3.5 CITIZENSHIP

6.3.5.1 *civil and political rights*

32. *(Connection to R1 and R7)* Constitution specifies fundamental rights to good health care

33. *(Connection to C19, O12)* Built in institutional toleration of multicultural integration in every phase of treatment and process

34. *(Connection to C19, C22)* Zero-tolerance of discriminatory behaviour or treatment in health care process

6.3.5.2 *social rights*

35. *(Connection to C18, C20, C21)* Existence of prevailing class divisions in terms of health patterns

36. *(Connection to C19, C20, C21)* Existence of prevailing ethnic divisions in terms of health patterns
37. *(Connection to C21)* Policy/specialisation priorities and effects on/of class division

38. *(Connection to C22)* Existence of independent civil rights agency or ombudsman in relation to legislation on rights to adequate health care

39. *(Connection to C24)* Reduced access to health care due to lack of means to reach adequate treatment

40. *(Connection to C19)* Conditions of deprived sections of population as one sure pathway to be excluded from meaningful health care and hence societal participation or quality of life

6.3.6 **User rights as inclusive citizenship**

41. *(Connection to J23)* Definition of user rights with Regard to Health Care Law

42. *(Connection to O7, O8)* Adequate consideration of user rights in legislation

6.3.7 **inclusive user state as adequate citizenship**

43. *(Connection to O9)* Legislation regarding acquisition of user rights in terms of accessibility to adequate health care functions

6.3.8 **inclusive user state as adequate citizenship**

44. *(Connection to O1, R1)* Readiness to uphold and support user rights

6.3.9 **inclusive user state as adequate citizenship**

45. *(Connection to R20, R21, L42)* Degree of user organisation and kind of user representation
## Annex 2: tables results immigration, trade and health

### 7.1 Migration

<table>
<thead>
<tr>
<th>Ref.</th>
<th>indicator</th>
<th>Num. of answers</th>
<th>Min.</th>
<th>Max.</th>
<th>Arith. Av.</th>
<th>Most freq. value</th>
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<tr>
<td>J6</td>
<td>Human rights mechanisms for implementing human rights</td>
<td>11</td>
<td>1</td>
<td>5</td>
<td>3.7</td>
<td>4</td>
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<tr>
<td></td>
<td>Existence of independent human rights commission, human rights court or ombudsman</td>
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### COHERENCE AND EFFECTIVENESS OF POLICIES

<table>
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<th>Governance mode</th>
<th>Num. of answers</th>
<th>Min.</th>
<th>Max.</th>
<th>Arith. Av.</th>
<th>Most freq. value</th>
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<tr>
<td>P7</td>
<td>Number of civil society organisations concerned with specific policy issues</td>
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<td>2</td>
<td>5</td>
<td>3.6</td>
</tr>
<tr>
<td>P23</td>
<td>Existence of autonomous agencies and function</td>
<td>11</td>
<td>1</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>P25</td>
<td>Practice of evaluation at policy level</td>
<td>11</td>
<td>1</td>
<td>5</td>
<td>3.3</td>
</tr>
</tbody>
</table>

### Policy process (policy formulation and implementation)

| Role of different levels of government and legislative in policy formulation and implementation | 10 | 3 | 5 | 3.8 | 3 |
| Role of societal actors: social partners and civil society organisations in policy formulation and implementation | 11 | 2 | 5 | 3.7 | 4 |
| Role of citizens in policy formulation and implementation | 11 | 2 | 4 | 2.7 | 4 |

### Policy process (policy evaluation)

| Role of different levels of government and legislative in policy evaluation | 11 | 1 | 5 | 3.1 | 3 |
| Role of societal actors: social partners and civil society organisations in policy evaluation | 11 | 1 | 5 | 3.6 | 4 |
| Role of citizens in policy evaluation | 11 | 1 | 4 | 2.7 | 4 |

### OPENNESS AND PARTICIPATION

<table>
<thead>
<tr>
<th>Laws on participation</th>
<th>Num. of answers</th>
<th>Min.</th>
<th>Max.</th>
<th>Arith. Av.</th>
<th>Most freq. value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislation on citizen consultation and participation for instance with regard to public inquiries</td>
<td>11</td>
<td>1</td>
<td>5</td>
<td>2.9</td>
<td>2</td>
</tr>
<tr>
<td>Legislation on information access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Legislation on the availability and access to information regarding societal actors (like NGOs, trade-unions, etc.)</td>
<td>11</td>
<td>2</td>
<td>5</td>
<td>3.6</td>
<td>3</td>
</tr>
</tbody>
</table>

### Consultation and participation standards

| Existence and description of mechanisms of consultation and participation | 11 | 2 | 5 | 3.5 | 2 |
| Use of mechanisms of consultation and participation | | | | | |
| Number or percentage of occasions (among those for which it is required to do so) for which government agencies provide adequate notice of public hearings | 9 | 1 | 4 | 2.6 | 2 |
| Number of major government decisions in which input from participation mechanisms was used | 10 | 2 | 5 | 3.6 | 4 |
| Number of joint commission meetings between government and civil society organisations | 10 | 1 | 5 | 3.1 | 3 |
| Number of NGOs saying they experienced a valid engagement with the executive branch of government in the process of policy formulation and implementation | 10 | 1 | 5 | 3.0 | 2 |
### Scorecard of citizen access to legislative procedures:

- (a) do citizens have access to records of meetings?
- (b) are citizens able to find out who or what group is responsible for particular areas or decisions?
- (c) are citizens able to obtain voting records of MPs?
- (d) are citizens granted access to meetings of parliaments?
- (e) are citizens granted access to committee meetings?
- (f) are plenary and committee meetings open to the press?

| O25 | 10 | 1 | 5 | 3.5 | 4 |

### Civilian competence and political culture

- Level of political knowledge and understanding of political system
- Newspaper reading, radio and/or television listening (political programmes)
- Percentage of eligible women / voters of disadvantaged groups and percentage who vote

| O28 | 11 | 1 | 5 | 2.8 | 3 |
| O31 | 11 | 1 | 5 | 2.9 | 3 |
| O37 | 11 | 1 | 5 | 3.2 | 1 |

### CIVIL, CORPORATE AND MEDIA RESPONSIBILITY

- Plural information sources
  - Number of hours of minority language programming on TV
  - Number of minority language print periodicals

| R40 | 11 | 2 | 5 | 3.0 | 2 |
| R41 | 10 | 1 | 5 | 3.3 | 4 |

### CITIZENSHIP

- Inclusive Citizenship (constitutional and political arrangements)
  - Definition of citizenship rights in Constitution
  - Adequate consideration of citizenship rights in legislation

| C1  | 11 | 1 | 5 | 3.6 | 5 |
| C2  | 11 | 1 | 5 | 3.9 | 4 |

- Inclusive Citizenship (multiculturalism)
  - Legislation regarding acquisition of citizenship in host country -- length, procedures, barriers
  - Support for multicultural integration or absence of discrimination in fields like: education, health, housing, labour market
  - Degree of organisation and representation of migrant, ethnic, religious or generally minority communities

| C4  | 10 | 1 | 5 | 4.2 | 5 |
| C5  | 11 | 1 | 5 | 3.8 | 4 |
| C6  | 11 | 1 | 5 | 3.4 | 5 |

- Civil and political rights
  - Specification of civil rights in Constitution and relevant legislation
  - Existence of mechanisms (like Ombudsman) or NGOs with mandate of investigating violations of civil rights
  - Existence of institutions or organisations that show existence of civil rights
  - Specification of political rights in Constitution and relevant legislation
  - Existence of mechanisms or NGOs with mandate of investigating violations of political rights

| C13 | 11 | 1 | 5 | 4.2 | 5 |
| C14 | 11 | 2 | 5 | 4.2 | 4 |
| C15 | 11 | 2 | 5 | 3.9 | 4 |
| C16 | 11 | 1 | 5 | 4.2 | 5 |
| C17 | 11 | 1 | 5 | 3.7 | 4 |

- Social Rights (Universal Social Rights)
  - Characterisation of welfare state and recent reforms
  - Listing and characterisation of universal social rights with regard to income, work, education, health, family, housing, etc.
  - Governmental expenditures on welfare by sub-area
  - Social statistics

| C18 | 11 | 1 | 5 | 2.9 | 3 |
| C19 | 11 | 1 | 5 | 3.2 | 3 |
| C20 | 11 | 2 | 4 | 3.0 | 3 |
| C21 | 11 | 2 | 5 | 3.6 | 3 |

- Social Rights (protecting against risk of poverty & social exclusion)
  - Governmental action against poverty and social exclusion
  - Number of NGOs and voluntary organisations working to combat poverty and social exclusion and scope of work
  - Poverty rate in time series
  - Characterisation of poor populations and pathways to social exclusion

| C22 | 11 | 1 | 5 | 4.0 | 4 |
| C23 | 11 | 1 | 5 | 3.1 | 4 |
| C24 | 11 | 1 | 5 | 3.2 | 3 |
| C25 | 11 | 1 | 5 | 3.7 | 4 |

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### Trade

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**EFFECTIVE, INDEPENDENT AND REPRESENTATIVE LEGISLATURE**

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**Citizen access**

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<td>L21</td>
<td>Average number of meetings per year held by legislators in which citizens / constituents are invited or % of MPs who meet with NGOs and constituents more than x times a year.</td>
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<td>Number of committee meetings where citizens are invited to actively participate or provide input.</td>
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<td>Scorecard of citizen access: (a) do citizens have access to records of meetings; (b) are citizens able to find out who or what group is responsible for particular areas or decisions; (c) are citizens able to obtain voting records of MPs; (d) are citizens granted access to meetings of parliament; (e) are citizens granted to access to committee meetings open to press?</td>
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**OPENNESS AND PARTICIPATION**

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**Consultation and participation standards**

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# 7.3 Health

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**Civilian Competence and political culture**

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<td>L32</td>
<td>Percentage of eligible voters of disadvantaged groups and percentage of those who vote</td>
<td>14</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>O23</td>
<td>R5</td>
<td>Adjustment to hierarchical structures where CSOs are easily co-opted by existing ruling regimes</td>
<td>14</td>
<td>3.4</td>
</tr>
<tr>
<td>R13</td>
<td>Egalitarian structures questioning any formation of uncalled for hierarchies and CSOs remain strictly independent</td>
<td>14</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>O28</td>
<td>Spatial access to and cost of utilities such as educational facilities and health care</td>
<td>14</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>O10</td>
<td>Degree of linguistic rigours and old fashioned formalities ruling social dialogue and social relations in health care</td>
<td>14</td>
<td>3.2</td>
<td></td>
</tr>
</tbody>
</table>

**CIVIL, CORPORATE AND MEDIA RESPONSIBILITY**

<table>
<thead>
<tr>
<th>R10</th>
<th>Plural information sources</th>
<th>14</th>
<th>3.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>R26</td>
<td>Civic action against policy decisions on health care</td>
<td>14</td>
<td>3.6</td>
</tr>
<tr>
<td>R24</td>
<td>Number of medical and health periodicals</td>
<td>14</td>
<td>3.3</td>
</tr>
</tbody>
</table>

**CITIZENSHIP**

<table>
<thead>
<tr>
<th>R17</th>
<th>Civil and political rights</th>
<th>14</th>
<th>3.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>C19</td>
<td>Constitution specifies fundamental rights to good health care</td>
<td>14</td>
<td>3.6</td>
</tr>
<tr>
<td>O12</td>
<td>Built in institutional toleration of multicultural integration in every phase of treatment and process</td>
<td>14</td>
<td>3.2</td>
</tr>
<tr>
<td>C19</td>
<td>Zero-tolerance of discriminatory behaviour or treatment in health care process</td>
<td>14</td>
<td>3.1</td>
</tr>
<tr>
<td>C21</td>
<td>Social rights</td>
<td>14</td>
<td>3.1</td>
</tr>
<tr>
<td>C18</td>
<td>Existence of prevailing class divisions in terms of health patterns</td>
<td>14</td>
<td>3.1</td>
</tr>
<tr>
<td>C19</td>
<td>Existence of prevailing ethnic divisions in terms of health patterns</td>
<td>14</td>
<td>3.1</td>
</tr>
<tr>
<td>C21</td>
<td>Policy/specialisation priorities and effects on/of class division</td>
<td>14</td>
<td>3.2</td>
</tr>
<tr>
<td>C22</td>
<td>Existence of independent civil rights agency or ombudsman in relation to legislation on rights to adequate health care</td>
<td>14</td>
<td>3.2</td>
</tr>
<tr>
<td>C24</td>
<td>Reduced access to health care due to lack of means to reach adequate</td>
<td>14</td>
<td>3.7</td>
</tr>
<tr>
<td>Treatment</td>
<td>Metric</td>
<td>Score</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>C19 Conditions of deprived sections of population as one sure pathway to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>be excluded from meaningful health care and hence societal participation</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>or quality of life</td>
<td></td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td>User rights as inclusive citizenship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J23 Definition of user rights with regard to Health Care Law</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>O7 O8 Adequate consideration of user rights in legislation</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>O9 Legislation regarding acquisition of user rights in terms of accessibility to adequate health care functions</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>O1 R1 Readiness to uphold and support user rights</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>R20 R21 L42 Degree of user organisation and kind of user representation</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.7</td>
<td></td>
</tr>
</tbody>
</table>
Questions regarding migration indicators:

1. From a democratic perspective, please assess the degree of relevance of each indicator for the area of migration you are working on or are familiar with. Please mark each indicator separately on a scale from 1 – 5.

2. Please indicate the level of general pertinence of the full set of indicators for migration policy. Please mark on a scale from 1 – 5.

3. Do you think the indicators listed are sufficient for assessing migration policy from a democratic perspective? Are there any that you think are missing and should be added?

Please add any comments you deem useful.
Part II: Overviews of the three policy areas

This section includes the overviews of the policy areas: migration, trade and health. Each of the three overviews constitutes a comparative analysis of the national overviews for all EUROPUB countries. The purpose of these synthesis documents is to provide background information that serves to better understand the applicability of the Monitoring System. Also the overviews parallel those presented in WP2. Each overview examines the level of Europeanisation of the policy area as well as the policy structure and policy process within Member States.
1 Migration

Immigration policies in the European Union

Marisol Garcia & Marc Pradel (UB-CISC)

EUROPUB- WP 5. Transferability
1.1 Introduction

This report analyses immigration policies at the European and national level. The first section stresses the interplay between the European integration process and member states migration policies. This mutual influence has, in practice, translated in a move towards a creation of common guidelines for immigration. The current common agreements have their origin in the free movement of goods and people as part of the process of European integration. In the European Union the multi-state collaboration creates a complex picture in which political actors as well as policy-makers operating at different levels of governance actively intervene in migration policies.

The challenge faced by member states political leaders and policy-makers to design a common migration policy, is partly due to their varied colonial and cultural histories as well as to their nationally grounded definitions of citizenship. EU actors, such as the European Commission, the European Parliament and the European Court of Justice have moved forward debates concerning the rights of internal mobility as well as conditions for entry and residence for Third Country Nationals and minimum standards of reception of refugees. Advances have been made with the Amsterdam Treaty, where member states have agreed on creating a balance between national control and supranational governance. At the national level tensions between different policy views and practices help to explain the expanding and contracting policies. The multi-state peculiarity is not the only variable to take into account within the EU. The logic of European integration interacts with the free-market logic, which gives citizens of member states the right to work and reside in other member state, but which denies this right to Third Country Nationals. The strong resistance to provide free movement to long-standing residents in Europe is to be explained by the logic of welfare. Welfare and social assistance rights are nationally bounded and enter into conflict with free movement of labour.

In fact EU immigration policies have until recently addressed solely the issue of internal labour market migration according to the Single European Act and the Single Market project. With the economic and political changes taking place since the mid 1980s it became apparent that a more complex migration picture was emerging in Europe. This picture prompted a concern among member-states governments about the need for tightening external borders leading to, what seemed at the time, a ‘Fortress Europe’. Moreover, in the 1990s EU national governments had to come to terms with the fact that the new economic order, based on more flexible labour markets, had limits among indigenous populations. As national workers unions defended their job security foreign workers became more attractive to business companies across Europe. With this free-market logic calling for cheap labour immigration policy member-states governments had to adapt to an environment in

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which borders were seen as potential barriers to economic efficiency\(^2\). On the other hand, trans-national conventions for asserting rights of migrants pose a direct challenge to the national polities. In order to resist such a challenge the member states of Europe have developed various techniques to facilitate border controls.

It has been argued that a double process developed in EU countries. On the one hand, the liberalization accompanying the creation of a Single Market leads to internal labour migration. Some member-states response has been re-regulation at the national level on citizenship and asylum. On the other hand, member states launched initiatives concerning external labour migration often as a result of national public debates\(^3\).

From the variety of mechanisms of national controls emerges the picture of civic stratification. In her analysis Morris identifies eight different statuses operating in the member states: (1) full membership status or citizens; (2) legal residents also known as third country nationals who have rights to work; (3) other third country national who do not have a legal right to work; (4) legal immigrant workers under a specific Association of Co-operation agreement with third countries; (5) recognized refugees with unlimited residence; (6) asylum seekers with humanitarian leave for a specific period; (7) asylum seekers whose cases are pending, and (8) migrants in an unlawful status. This stratification of rights precludes claims to equal treatment thus challenging in some cases human rights principles\(^4\)

However, for the purpose of this report immigration policies in EU are better understood by using the concept of migration regimes, as established by Koslowski\(^5\). Four different situations can be observed in EU referring to migration. These situations represent in some way a scale of rights from a high degree of citizen rights to the illegal residence in the country. Koslowski clusters these four groups in two regimes (see table 1). These are: the intra EU-migration regime and the migration-to-EU regime. The first regime includes -EU citizens, and Third Country Nationals'. The second regime includes -immigrants and asylum seekers.

These four groups are:

- The first one is the situation of European citizens, who have a member-state citizenship. All EU citizens have free movement and residing rights in the whole EU.

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• The second situation is made up of all the legal residents in EU that have no member-state nationality. This is the case of many minority groups living in EU (for example the Turkish community in Germany). Here are included also all people that have a co-ethnic\(^6\) origin with a member state although not having this member state citizenship. There is a current discussion in the EU concerning the provision of similar rights of movement and settlement as EU citizens to these Third Country Nationals residing in the EU countries (TCN).

• The third group are the immigrants that are living in EU with temporal visas or illegally, waiting to achieve EU citizenship or long-term residence permit. The main difference between this group and the previous one is that the first ones are long-term legal residents although they have not a member-state citizenship\(^7\).

• The asylum seekers form the fourth and last group. They are refugees that are prosecuted for political or other reasons in their countries of origin. Hence, they are refugees and member states have a special legislation for them.

Table 1: groups and migration regimes

<table>
<thead>
<tr>
<th>Group</th>
<th>Definition</th>
<th>Migration Regime</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU Citizens</td>
<td>All citizens of EU member states.</td>
<td>Intra EU Regime</td>
</tr>
<tr>
<td>Third Country National residents</td>
<td>All legal long-term residents in EU, who have not the nationality of any member states. (TCN)</td>
<td>Migration-to-EU Regime</td>
</tr>
<tr>
<td>Immigrants</td>
<td>All legal temporal residents and the illegal ones in the EU, who are looking for regularizing it’s situation</td>
<td>Migration-to-EU Regime</td>
</tr>
<tr>
<td>Asylum seekers</td>
<td>All who are living in the EU because they are prosecuted in their country of origin, and all who seek protection in the European Union.</td>
<td>Migration-to-EU Regime</td>
</tr>
</tbody>
</table>

European Union legislation varies considerably for the four mentioned groups. Whereas intra-EU migration legislation for EU citizens is clear, there has not been a similar process with regard to TCNs. Thus a double process has taken place by which EU has adopted some common policies for citizens and at the same time has left TCN policies in the charge of member states. Since 1970 internal migration flows and the

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\(^6\) As co-ethnics we understand, following Koslowski, foreigners whose familiars were host country nationals. An example is the population of the Eastern Europe with familiar relations within Germany.

\(^7\) As will be shown in this report, the European legislation has stipulated the conditions to be considered a third country national with similar rights to the European Citizens. These rights are in relation with the adoption of a long-term residence permit, which provides a third national resident status.
growing interdependence of member states economies prompted them to increasingly coordinate policies. However, not until the European Council in Paris in 1974 immigration issues entered the EC domain. Between 1974 and 1985 the TREVI group dealt with problems related to the free movement of persons. This working group operated on an intergovernmental basis from which the European Commission and the European Parliament were excluded. Thus Europeanisation of migration policies started from the mid 1980s, as it will be explained below in this report⁸.

In order to spell out the processes involved we consider: Firstly, the two migration regimes in a historical perspective, showing the policy structure of migration policies in the European Union. Secondly, we examine the process of consolidation of a common position on migration policies.

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1.2 Policy Structure

1.2.1 Historical background

The evolution of European legislation on immigration is a reflection of how the migratory flows have developed in Europe. As Ireland shows, the nature of migration flows after the Second World War in Europe explains why the immigration question has not been fully integrated in the EU structure. Looking at these flows we can observe the emergence of different national conceptions on migration through the years as well as governments' responses to the challenges involved.

In contrast with countries like the United States, Canada and Australia, modern European countries were not immigration countries before the Second World War, but emigration ones. In fact, they had not a tradition of permanent migrants' communities in their territories. The former group of countries developed a Western democratic state with the help of the immigrants who came from Europe. This factor became part of their national identity, an element which is lacking in European countries. The only migration flows were from one European country to another and there were no permanent communities in the different host countries.

However, after the Second World War Europe's reconstruction and the independence of the former colonies generated new migration flows. Europe became an immigration continent. These new migration flows had a strong ethnic character and affected the Northern European countries, where immigrants came from Southern Europe (mainly Spain and Italy), Northern Africa and Central and Eastern Europe. Also people of the former colonies\(^9\) immigrated to Europe. This Immigration was considered necessary for the reconstruction of some European countries, as a source of cheap labour, and of temporary nature.

These migration flows to Europe started at the same time as the European integration process, by the end of the 1950s. The Rome Treaty of 1958 opened Europe towards the free movement of workers, granting the right to all member-state citizens to work in another member state. This step was taken in the framework of the European Economic Integration in a common market. Nevertheless, European economic integration process did not mean a common policy on migration. The history and politics of each member state as well as the special characteristics of their migration flows complicate the harmonisation of national legislations on this issue.

However, common elements of migration policies across Europe did eventually lead to a European migration policy. During the second half of XXth century there has been a permanent settlement process of migration flows. We can observe three main periods:

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\(^9\) The migratory flows from the former British, Dutch and French colonies are particularly important. These countries received during the second half of 20th century important immigration flows from former colonies such as India or Algeria.
After the second World War until the 70’s, when migration flows came from former colonies and neighbour countries (mainly from Southern Europe to Northern countries)

During the 70’s, when there was a family reunification process among the previous emigrant population. There was also an important return flow of Southern Europe migrants to their country of origin (Spain, Greece, Portugal and Italy).

At the end of 80’s, when most of the migrants were refugees and came from Eastern and South Eastern European countries. The fall of Communist systems and the conflicts in the Balkans gave rise to these new emigrant movements across Europe.

The Extra-EU migration was not perceived as a problem by the European host countries until the 1970s, when the first tensions on immigration affair came up. The main economic cause was the 1973 crisis, which caused a sharp decline of the host countries’ industrial economies and gave rise to high unemployment rates. Governments controlled new extra-EU migration through restrictive laws (for example on family reunification). Nevertheless, many resident migrants decided to remain in the host countries and brought their family members with them. In consequence, the new strict laws on migration and political asylum brought about increased illegal immigration. Despite these increasing restrictions, migration flows did not decrease. In fact, migrants moved from one country to another avoiding the more restrictive legislations. Particularly striking is the case of asylum seekers whose asylum requests were rejected in one country, because they then sent a request to another one. This meant that one country’s refusal increased asylum requests for the neighbour country. In this context national governments came to terms with the need to build some co-ordination to face the immigration problems. However, a formal agreement was only reached at the Dublin Convention (1990) in which it was stipulated that asylum applications are to be dealt with by one country on behalf of the EU as a whole.

In this context two different and parallel legislative processes took off. Firstly, the process on the intra-EU migration, which has led to the introduction of European citizenship for all EU member-state nationals. The second process is a consequence of the need for a major coordination of member states on migration in relation to external border controls.

The European citizenship

EU has legislated on intra-migration from its foundations. One of the main objectives of the Treaty of Rome was to promote a common economic market of goods, services and capital. The Treaty referred to labour mobility among the states, including certain provisions for the progressive acceptance of free movement of workers. During the 1960s workers mobility was guaranteed for all European Community workers, who gained protections, such as equal treatment in housing and social assistance or the

10 The Dublin Convention agreement was incorporated in the Amsterdam Treaty becoming operative from 1997.
11 Koslowksi gives two migration regimes in Europe, the intra-EU migration regime and the extra-EU migration regime.
same trade-union rights in all the EC member states. However, member states maintained their sovereignty on migration issues according to articles 48 and 51 of the Treaty on the basis on safety. The Single European Act\textsuperscript{13} (1986) expanded the scope of free movement principle, which has led with the Maastricht revision of the Treaty as de facto EU citizens’ free movement\textsuperscript{14} The Maastricht Treaty consolidated the four freedoms: capital, goods, services and persons. However, politically the most prominent advance was the inclusion of the principle of the Citizen of the Union.

European citizenship as a principle was formally introduced in the Maastricht Treaty in 1992. The establishment of an internal market based on the elimination of economic barriers between European Member States required not only free movement of goods, but also free movement of people. All citizens moving from one Member State to another were losing political rights and thus the need arose to introduce corrective measures to protect these rights in the country of residence. An added reason was first advanced in 1975, when the concept of ‘Europe of citizens’ made its appearance. It was argued then that the birth of a European ‘consciousness’ needed concrete measures and reassuring signals\textsuperscript{15}

Thus European citizenship was introduced in the Maastricht Treaty in 1992 in order to bring the ordinary citizen closer to the European project by enhancing a sense of belonging as well as by providing the means of political participation. The Treaty was finally ratified in October 1993 after ratification in the twelve national parliaments as well as referenda in Denmark (having to vote twice!), France and Ireland. In the June 1994 campaign for European elections all political parties campaigned with the slogan ‘Europe of the citizens’.

It has been argued that with the introduction of European citizenship in the Treaty of the Union a transition was made from the ‘the market citizen’ to the ‘political citizen’ even if at an embryonic stage. As the concrete rights introduced in Article 8 of the Maastricht Treaty added relatively little to the existing rights of the majority of citizens of the Union the debate that originated had as much impact on public opinion as the introduction of the rights themselves as we shall see further down. Article 8 (1) stated: ‘Every person holding the nationality of a member state shall be a citizen of the Union’. Specific rights were granted such as:

- The right to move and reside freely within the territory of the member States.
- The right to vote or to stand for election in municipal elections for those citizens residing in Member States of which they are not nationals.
- The right to vote or to stand for election in European Parliament elections for those citizens residing in Member States of which they are not nationals.
- The right to petition to the European Parliament

\textsuperscript{13} in the article 8a of this act “an area without frontiers in which the movement of goods, persons, services and capital is ensured”.

\textsuperscript{14} Koslowski, R.; \textit{op. cit.} pp. 153-188.

\textsuperscript{15} The Belgian Prime Minister, Leo Tindemans presented in December 1975 a report known as the Tindemans report on the construction of the European Union. Chapter IV of the report was denominated “The Europe of Citizens”. The two lines of action recommended by the report in order to develop the concept were: the protection of the rights of citizens and the establishment of measures to enhance European consciousness.
• The right to appeal to the Union Ombudsman
• The right to diplomatic or consular protection by any Member States when an EU citizens find themselves in the territory of a third country.

In the aftermath of the Maastricht Treaty the limited scope of the principle was widely discussed in academic and political forums. One crucial limitation—it was argued—concerned the fact that the national dimension was not superseded. That is, only EU nationals could become European citizens. This means that around fifteen million residents in the territories of the Member States are denizens no matter how long they have resided within the boundaries of the Union or whether they have even been born within its territorial frontiers. This obviously contradicts the democratic culture of which Europeans feel so proud. Maastricht was the first of several steps in the process of formalizing European citizenship.

The Treaty of Maastricht and it’s revision in Amsterdam (1997) assured in its article 14 that “…the internal market shall comprise an area without internal frontiers in which the free movement of goods, persons, services and capital is ensured in accordance with the provisions of this Treaty”\(^\text{16}\). The inflexion point was that the Treaty of the European Union established the right to reside while detaching it from employment. Despite this fundamental change, nationals from one Member State residing in another only benefit from a limited set of rights\(^\text{17}\). Furthermore, the European Court of Justice has had an important role in fostering free movement and residence of all EU citizens. European jurisprudence warrants these rights to EU citizens and has defined the limits of member states to rule over migration and to restrict migrants’ rights. We will discuss to the impact of the Amsterdam Treaty below in this report.

Although the Amsterdam Treaty has created the scope for reflecting about access to EU rights for TCNs, legislation has not advanced in a parallel way to the development of European citizenship. Thus intra-EU migration policy does not concern this large group of stable residents in the Union. Moreover, national sovereignty has been supreme in recruiting labour from third countries and offering political asylum.

1.2.2 Legislation on Third Country Nationals and non-member states migration

The contradiction between the requirements of labour market expansion and the emphasis on controlling national frontiers to potential undesired immigrants has prompted member states to search for possible common approaches to a common concern. Thus, national governments have been looking for mechanisms to coordinate their policies while maintaining their autonomy. The first steps were based on non-public summits of the Justice and Security ministers\(^\text{18}\). These meetings developed coordinated security policies based on restriction and security systems to check the

\(^\text{16}\) Treaty Establishing the European Community, (consolidated version) article 14, part 2
\(^\text{17}\) There is a large literature on European citizenship. For example, XXXXXXXX
\(^\text{18}\) These meetings were in the framework of the Trevi intergovernmental Group, which was created in 1975 by Member States. Its objective was the coordination of the European security and police.
increasing migration flows. These policies are the forerunners of the current EU legislation on security and control of external borders. As for TCNs a process of rights acquisition has developed relatively recent at European level\textsuperscript{19}

The only directive on third-country national rights, of 1996, gives to member states the ability to define who is a long term third-country national resident, and the rights that these persons have\textsuperscript{20}. In addition to this, the Amsterdam Treaty strengthens the legislation through common criteria of giving this status. This Treaty stipulates also the creation of a common policy on citizenship adoption in the framework of a common foreign policy. This policy foresees the creation of common criteria on citizenship acquisition, as well as common criteria on legal immigration and rights of migrants.

One crucial factor impeding further integration on immigration policies has been the fact that each EU country has its migration and asylum policies, traditions, and migratory historical background, as well as its long-term TCN communities. These differences make it difficult even to coordinate policies with common criteria. The agreements must take into account the peculiarities of each country. One of such peculiarities is the way national citizenship is understood.

1.2.3 Citizenship acquisition systems and definition of legal migration

One of the main elements to distinguish between countries’ migration policies lies in the method of the citizenship acquisition. There are two main routes to obtain citizenship in Member States: the \textit{jus soli} system and the \textit{jus sanguinis} system\textsuperscript{21}. These two ways influence immigrants’ integration process\textsuperscript{22}. Whereas countries like United Kingdom have a jus soli tradition, other countries, such as Germany have been strongly identified as belonging to the \textit{jus sanguinis} tradition\textsuperscript{23}. A set of countries falls halfway between these two models. In addition, a change of government can tilt legislation towards one or another system. As Hentzinger shows, there is an ideological background to these two systems:

\begin{itemize}
\item \textsuperscript{19} After the Amsterdam Treaty of 1997 UE started legislation on this direction under the framework of recommendations and best practices.
\item \textsuperscript{20} DN: PRESS/03/42, 27/02/2003
\item \textsuperscript{22} The \textit{jus soli} system gives the same rights to all residents in a territory, regardless of the length of their residence or their familiar bond with the territory. This system includes a transition period for the recent immigrants who receive rights gradually until they have all the citizenship rights. The \textit{jus sanguinis} system entails citizenship on the bases of bloodlines.
\item \textsuperscript{23} The German case is important because of its restrictive criteria in citizenship rights. This creates a high number of co-ethnic immigrants with the legal status of third country nationals.
\end{itemize}
When the Right is in power it tends to listen to the nationalists and to favour jus sanguinis, whilst the Left tends to give more weight to the interests of the second generation of immigrants.

National legislations on immigration are more or less flexible depending on the country. This complicates the adoption of common positions by all member states. The two legislation systems (Jus soli and jus sanguinis) define two big channels to citizenship access that have their own migrants’ integration models. These two ways are not easily compatible in terms of legislation.

The enlargement processes has meant a more problematic situation in coordination policies. More countries in the Union translates in more complex bargaining in order to achieve agreements on migration policies. This complexity has taken place at the same time of frontiers being closed to new extra-EU immigrants, which in turn has led to an increase in illegal immigration. For example, with the incorporation of the South European countries migration shifted to the east European countries and the countries outside the continent. North African countries, whose migrants have traditionally come to Europe, have a frontier with the Community and easier access. Member states have made important efforts to control co-ordinately these frontiers as an important part of the freedom, security and justice area in the EU policy. These efforts have translated into the Schengen agreements, which developed parallel to the progressive abolition of internal control borders.

1.2.4 Current and future situation of immigration in the European Union

After the EU expansion with 10 new countries in the Union three main migration flows can be distinguished: the intra-EU migration flows, the new-member states migration flows and the extra-EU migration flows.

The intra-EU migration flows are virtually inexistent nowadays. Some migrants of Southern Europe are now returning to their homelands, in the trend started in the 70’s, when the economic crisis narrowed possibilities for these migrants in Northern Europe. EU institutions want to promote intra EU mobility to ensure a common labour market but by now there is little internal mobility.

The “immigration” from the 10 new member states has been a recent matter of concern. As in previous enlargements the anxieties surpass likely trends. In order to prevent a massive “immigration” from these countries the European Commission has promoted a gradual mechanism of rights acquisition. During the first five years after accession the citizens of the new Member States will have not free movement rights. European Union had adopted this mechanism before, when southern countries like Spain and Portugal became part of the Community. Nevertheless, some studies

24 Entzinger, H. op. cit. pp. 102

25 On 14 June 1985 the Federal Republic of Germany, France, Belgium, Luxembourg and the Netherlands signed the Schengen Agreement (Schengen being a place in Luxembourg) on the gradual abolition of checks at their common borders. After that other countries of the EU have been included in the agreement.
reveal that the future migration flows will be moderate. Even so, these countries can be a gate for extra-EU migration coming from poor countries like Romania.\(^{26}\)

Therefore the main immigration flow coming to Europe is the extra-EU migration. The general trend is a growing immigration in southern Europe (Spain, Portugal, Italy, and Greece) as well as the maintenance of migrant communities in the EU countries where they already exist. In Table 2 we can see the different migration rates per country. It is important to point out that the phenomena are changing very fast and that data do not reflect the most recent situation (Spain for example by the end of 2003 had over 6% of immigration, an increase of 35% from 2002).

**Table 2: Migration in the European Union (2001)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Own country Nationals</th>
<th>Other EU citizens</th>
<th>New EU countries citizens</th>
<th>Third country nationals</th>
<th>Total immigration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greece</td>
<td>98,42</td>
<td>0,42</td>
<td>0,19</td>
<td>0,96</td>
<td>1,57</td>
</tr>
<tr>
<td>Finland</td>
<td>98,24</td>
<td>0,33</td>
<td>0,25</td>
<td>1,18</td>
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1.3 **Actors participating in the process**

The main actors in the emerging European immigration policy are: the Commission, the European Parliament and the member states. The European Court of Justice, as well as the civil-society organizations also have an important role. The European Parliament and the European Commission have had an active role in the integration and rights policies, whereas Member States have worked mainly in terms of security and control of external borders. Nevertheless they are involved in an institutional framework that forces them to legislate in other fields as well. This framework promotes coordination of their migration policies.

1.3.1 **European Parliament and European Commission**

From the strictly legislative point of view the European Commission launches proposals and specific programmes, while the European Parliament has the last word on refusing or accepting the directives approved. The role of the European Parliament and the European Commission has been to widen the scope of the debate on a common area of Justice, Security and Freedom. These two institutions have introduced questions related to the immigrants’ rights, integration and citizenship rights. The European Commission has launched different proposals while the European Parliament has pronounced opinions. The European Council cannot ignore totally the debate created so that a European policy discourse on immigration issues has emerged. This discourse calls into question the conceptualisation of immigration policy as a security problem\(^{27}\). The European Parliament has pronounced itself in favour of a common legislation on migration in terms of integration and rights of immigrants. Opinions from the Parliament have encouraged the fight against discrimination and the coverage of migrants’ rights, opening the debate. The European Commission has played a similar role launching some proposals on immigrants’ rights. These proposals, described later, are directed to ensure a fair treatment of immigrants and a similar rights framework for the TCN.

**Member States**

The role of member states in the approval of the common migration policies has proven to be more self-restrained than the role of the Commission and the European Parliament. In spite of that, Member States feel pressed to develop these policies because of the institutional framework\(^{28}\). Member states participate in policy making through the Council of Ministers of Justice and Foreign affairs, and through the decisions taken at summit meetings of the European Council. In this respect, the role of member states has been important in coordinating external EU borders policy and


\(^{28}\) Dedja, (2003) pp. 59
in combating illegal immigration flows. Member states have shown no interest in promoting legislation neither on integration of immigrants’ policies, nor on the immigrants’ rights. The main reason for this is that Member States consider the question of immigration as a security issue. As shown before, member states started to legislate co-ordinately on migration during the 1970s with limited objectives, preserving their national objectives. However, the institutional dynamics changed the scope of European immigration policies and the consolidation of the European Union led to a common position on migration, and to a more open policy of citizenship rights. In this sense, the European Commission and the European Parliament have had an important role, pressing the Council to include immigrants’ rights and integration in the common policy.

Member states implement their own migration policies in the framework of the European policy coordination. In that way each country has its own migration policy as well as their specific border controls. The degree of openness or closure varies in each case.

1.3.2 Role of Civil Society Organizations

Civil society has not participated in any convincing way in the policy process towards a common migration policy. Nevertheless, the European Parliament has heard some civil society organisations on the subject of the demand for the rights of immigrants. In response to these hearings, the EP put forward a Resolution for the creation of a Forum where these organisations could have a voice in the EU framework. The Commission created the European Union Migrants’ Forum, which is a non-governmental organisation that represents 65 non-EU nationalities. It is composed of 190 organisations and national associations. The European Parliament through its committees consults this Forum concerning questions regarding immigration. This organisation and many others have been important in helping the European Parliament and the European Commission to launch a debate on migrants’ rights in the EU. Civil society organisations also defend migrants’ rights at European level through the European Court of Justice. Their transnational dimension is useful when defending immigrants’ rights. No doubt pro-migrant NGOs support more Europeanisation of migration policies.

It is also important to point out that many civil society organisations put the accent on values, education and the fight against racism and xenophobia. These organisations have put pressure on national governments to promote EU legislation on immigration and in this respect have had a modest role in setting the European political agenda.

1.3.3 European Court of Justice

The European Court of Justice (ECJ) has played a key role in the consolidation of the rights of EU citizens. It has been particularly important in terms of protection and observance of these rights. In fact, the ECJ has nowadays a fundamental role to play in defending the rights of TCN. The ECJ is also concerned with member states’ observance of the legislation in force. The national laws on visas and legal residence
permits in many member states, and the national interpretation of these laws are frequently appealed in the ECJ by migrants’ organisations, individuals or other civil-society actors.
1.4 Policy process

1.4.1 Europeanisation of migration policies: towards a common migration policy

Europeanisation of migration policies can be traced to the mid 1980s, starting with the 1985 communication of the European Commission to the Council entitled ‘Guidelines for a Community Policy on Migration’. This was a consultative document whose importance was reinforced by the European Court of Justice decision that the Commission could, in virtue of Article 137 TEC, adopt a binding decision in order to organise a consultative procedure. The following year the European Council created the ad hoc Working Group on Immigration in 1986. The Council granted the Commission the right to participate as an observer to the ad hoc Working Group. “This was the first time that a supranational agent was invited to participate in the regulation of EU migration policies.”

The EU made cautious moves towards a common migration policy through the 1990 Dublin and Schengen agreements. These agreements, originally effective on a bilateral basis, became integrated in the Maastricht and Amsterdam treaties. It has been argued that these agreements can be considered partly as responses to bottom-up impetus originating mainly in Germany and France, where immigration issues have entered the national political agenda through the electoral successes of far-right parties. In these countries issues of citizenship and asylum laws became salient. Thus, “The EU’s growing initiative in immigration policy in the early 1990s coincides with national reforms of citizenship laws (France) and asylum regulations (German), intense public debate and media coverage, and the rise of populist xenophobe parties throughout Western Europe (France, Belgium, Denmark, Norway, Germany, Austria) in response to de facto increase in migration to Western Europe.” The electoral successes of far-right wing parties in the Netherlands and Italy are also seen to shape immigration policy. The Schengen Treaty was effectively implemented in 1995 and the Dublin Convention entered into force in 1997.

Migration policy was further institutionalised in the Treaty of the European Union in 1992. Provisions of the Title VI (Cooperation, Justice and Home Affairs) of the TEU cover most aspects of migration, but do not include visa policies. Decision-making concerning migration issues continue to be shaped by inter-governmental agreements. Thus relatively little advance was made in developing instruments to pursue common policy objectives. Thus, the other big question left unresolved was an effective collective response to the need for a major coordination in immigration policies.

Moreover, the existence of a common legislation for all EU-citizens raises several dilemmas for member states. One of them concerns the political status of long-term TCNs. EU institutions - the European Parliament and the Commission and the European

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29 Bill Jordan et.al., op.cit., p:208.
30 George Menz, op.cit, p: 724.
Council\textsuperscript{31}) are confronted with the question to put on similar level the rights of these foreigners and the EU citizens’ rights.

The Amsterdam Treaty constitutes an agreement of member states to give to EU full responsibility in immigration policies. For this reason we may consider that a common policy on migration is starting to be shaped.

1.4.2 The impact of the Amsterdam Treaty of 1997

The Amsterdam Treaty agreed in 1997 and in force since 1999 broadens and modifies the Constitutive Treaty of the European Community. The introduction of a Title IV in the section III (Community policies) is an important modification. This Title IV refers to Visas, Asylum, Immigration, as well as all the relevant questions concerning free movement of persons through member states. It provides the main guidelines to the Council to warrant the free movement of EU citizens, whereas the coordination of the control of the EU external borders as well as migration and asylum fall to national governments. Article 62 provides the framework for the creation, in five years after the approval of the Treaty, of:

“1) Measures with a view to ensuring, in compliance with Article 14, the absence of any controls on persons, be they citizens of the Union or TCN, when crossing internal borders.

2) Measures on crossing of the external borders of Member States, which shall establish:

- Standards and procedures to be followed by Member States in carrying out checks on persons at such borders
- Rules on visas for intended stays of no more than three months, including:
  - The list of third countries whose nationals must be in possession of visas when crossing the external borders and those whose nationals are exempt from that requirement;
  - The procedures and conditions for issuing visas by Member States
  - A uniform format for visas
  - Rules on a uniform visa

3) Measures setting out the conditions under which nationals of third countries shall have the freedom to travel within the territory of Member States during a period of no more than three months.\textsuperscript{32}"

It is important to remember that some European countries are not under the Title IV. Denmark decided to opt out of the Title IV. Also article 14 does not affect the United Kingdom and Ireland, although the governments of these countries can adopt it in concrete cases. Article 67 of this title fixes the rules on the decision-making with regard to subjects that are under the title IV. These decisions must be taken with unanimity in the Council until five years after the entry in force of the Treaty. At that moment member

\textsuperscript{31} The European Council concluded in Tampere (1999) that it was necessary give to third country nationals similar rights as those enjoyed by EU-citizens

\textsuperscript{32} Treaty Establishing the European Community, art. 62, (Consolidated text) (Official Journal C325 of 24 December 2002)
states should decide if a majority voting system is adopted through the application of the article 251\textsuperscript{33}.

The Amsterdam Treaty also introduces a limit to the jurisdiction of the European Court of Justice on migration policies. This has been seen as a guarantee of a balance between national control and supranational governance\textsuperscript{34}.

1.4.3 Legislation after the Amsterdam Treaty: the road to policy harmonization?

The Amsterdam Treaty creates the framework for a common immigration policy. From the moment of its approval, the main EU institutions have made efforts to reach the objective of a common policy on these issues. The roles of the different institutions are clearly delineated from 1997. European Commission launches proposals, the European Council adopts them in draft form and the European Parliament reviews and approves the measures. The European Council can also launch proposals until 2004, when a Common Policy on migration must be implemented\textsuperscript{35}. Since 1999 the European Council has had three meetings specially focused on promoting common measures on immigration. The first one took place in Vienna in 1998.

In the Vienna meeting the European Council launched an Action Plan to implement the common area of freedom security and justice. The Plan, which the European Commission had proposed to the Council, was known as Vienna Action Plan\textsuperscript{36}, and was based on the Amsterdam Treaty framework. The Vienna Action Plan establishes priorities and measures to create the common policies provided in Title IV of the third part of the Treaty. The Council’s main objective was to develop a common strategy on migration. For that reason, the Council agreed that the measures of the plan would be put into force within a maximum of four years. To reinforce their initiative, the Council also decided to have a special summit at the end of the year devoted to justice and home affairs. In October 1999 during the Tampere meeting Member States agreed on the main guidelines to elaborate a common policy. The four pillars on which the agreement was reached were the following:

1. **Comprehensive approach to the management of migratory flows** to find a balance between humanitarian and economic admission.

2. **Fair treatment for third-country nationals** aiming as far as possible to give them comparable rights and obligations to those of nationals of the Member State in which they live.

3. **Development of partnerships with the countries of origin**, as policies of co-development.

4. **Development of a common policy for asylum** consolidating a common position according to the international treaties.

\textsuperscript{33} Article 251 permits the Council to approve decisions with majority voting.

\textsuperscript{34} Bill Jordan, et.al, op.cit., p: 209.

\textsuperscript{35} This deadline does not apply to the measures concerning the conditions of entry and residence and the rights of third-country nationals living in the EU.

\textsuperscript{36} COM (1998) 459
These guidelines consolidated the Amsterdam Treaty provisions fixing the way to follow for all Member States. One of the main objectives to achieve was the coordination with countries of origin to ensure the management of legal migration. This coordination had two dimensions: to help countries of origin to develop a framework of human rights and democracy, and create mechanisms to facilitate legal migration in order to ensure the job demands by European entrepreneurs. In the same way, the Plan promoted a coordinated fight against illegal immigration and the creation of common criteria on asylum.

In the Laeken summit in 2001 member states understood that the provisions of the Amsterdam treaty were too ambitious, and that serious difficulties existed to implement what they had approved earlier. Instead they discussed the possible adoption of an Open Method of Coordination. As Sokol Dedja\(^{37}\) shows, the EU has had difficulties to advance a common immigration policy especially because those policies would imply changes in national legislations. As a result the Laeken summit had as main objective to promote a faster implementation of migration issues in European foreign policies. The Council recommended various actions: the creation of common mechanisms for exchanging information; better coordination in external borders control; the establishment of common standards in procedures for asylum, family reunification and reception; the establishment of programmes to combat racism and discrimination. The 2002 European Council meeting in Seville showed once more the need to speed up implementation of agreements previously adopted. There is still no clear sign that the Open Method of Coordination will be applied to immigration.

In Table 3 we include a summary of the common agenda put forward by the European Commission. The table constitutes a summary of all policy fields where the European Union institutions have taken concrete decisions. As can be seen the European Commission has launched several measures that put into effect the Tampere guidelines on the “fair treatment of third-country nationals”. The Commission has made proposals for a common legislation on family reunification\(^{38}\), long term residents\(^{39}\), students\(^{40}\) and workers\(^{41}\). Many of these directives are being discussed at the European Council level and some are already approved.

The European Council has taken the lead in the area of “Management of migration flows”. The main tool is the Action Plan adopted in 2002, which provides common measures against illegal immigration and human trafficking. In the same way a return programme has been created to return the illegal immigrants to their countries of origin. The Action Plan has six main areas:

1. Visa policy: Meant to ensure the exchange of information on visas between member states. A European Visa information System will be created

\(^{37}\) Dedja op. Cit.

\(^{38}\) The directive on family reunification was approved in September 22nd 2003 by the Council of Ministers for the interior market. Although this directive increases the family reunification possibilities, the Council of ministers did not include all the measures that the Commission and the EP had proposed. The two main lines of the proposal were the extension of the period to obtain the residence permit and the enlargement of the concept of family.

\(^{39}\) COM(2001)127 final 13/03/2001

\(^{40}\) COM (2002) 548, 7/10/2002

\(^{41}\) COM (2001) 386 final 11/07/2001
2. Information exchange, cooperation and coordination.

3. Border Management

4. Police co-operation

5. Aliens and criminal law

6. Return and readmission policy.

The Commission has also participated in the management of flows. In July 2003 the EC created a programme of technical assistance to third countries in matters of migration and asylum, following the guidelines established in Tampere and Laeken. This programme wants to provide specific and complementary financial and technical aid to third countries in order to support their efforts in better managing migratory flows in all their dimensions. At the same time it contributes to reinforcing the coordination between member states and has created common databases to facilitate a European perspective on migration.

The progress of the whole elaboration and implementation processes of the common policy on immigration appears in the Scoreboard42 edited by the European Parliament and actualised every six months. This document shows the steps taken in every concrete policy and their current stage.

In conclusion, we can see that the legislation on control of migratory flows has been included in the security, justice and freedom area of the EU. Inside this area the measures adopted to control the migration and to establish common fields have been extensively developed. On the other hand, because of the pressures from the Commission and the EP, legislation on immigrants’ rights has been introduced. In this sense it is important to recall that some indirect legislation had appeared in other fields, although related to migrants’ rights, such as the 1999 directive against discrimination in the framework of the employment policy43. Also, the European Charter of Fundamental Rights approved in 2000 is clearly relevant because it forbids discrimination of any kind44.


43 The European Union Race Directive James A. Goldston, Executive Director, Open Society Justice Initiative in www.justiceinitiative.org

44 Charter of Fundamental Rights of the European Union, Art. 21 (1)
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<td>Proposal determining common definitions, criteria and procedures regarding conditions of entry and residence of third-country nationals for the purpose of paid employment and self-employed economic activities.</td>
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<td>Study</td>
<td>Draft directive on council table</td>
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<td>Family reunification</td>
<td>Directive approved by the Council</td>
<td>Directive that regulates the right to family reunification. Legal third country national residents can bring their spouse, under-age children, and the children of their spouse. Member States can restrict the entrance in some cases and can authorise the entry of unmarried partners, ascendants and adult dependent children.</td>
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<td>Long-term residents status</td>
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<td>Directive that will enable third country nationals to enjoy similar rights to EU citizens: free movement from one Member State to another maintaining the rights acquired in the first host country</td>
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<td>Integration</td>
<td>Recommendation to member states from the European Commission</td>
<td>Calling on the EU Member States to step up their efforts to integrate immigrants. The Commission remarks that not only labour integration is desirable but also social cultural and civic integration. In this area two directives have been approved: The directive on racial discrimination and the directive on discrimination in employment</td>
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<td>Collaboration with Countries of Origin</td>
<td>European Commission Programme (2003)</td>
<td>Programme for financial and technical assistance to third countries in the area of migration and asylum. In 2003 the programme will be focused on Afghanistan with a funding of 7€ million.</td>
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<td>Return Policy</td>
<td>Return Action Programme Adopted by the European Council (2002)</td>
<td>Programme inside the Comprehensive plan to fight illegal immigration (see above). This plan ensures the return of illegal immigrants and the rule of law. It provides mechanisms for voluntary and forced return.</td>
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1.5 Migration policy coordination in national contexts

EU immigration policy continues to be strongly defined by national immigration policies. Salient cultural traditions linked to historical national specificities concerning immigration and citizenship remain highly dominant for policy decisions in Europe. These traditions are reinforced by the welfare logic defended by citizens. Against this, market logic is exercising pressure on national governments to make their countries economically efficient and competitive in a global economy. A third logic, guided by international human rights conventions, is adding further pressure on member states. This section examines the different cultural traditions of EUROPEAN countries as well as the more recent changes in immigration policies. It takes into consideration the policy structure and policy process of each country in a comparative perspective. Particular significance is placed on immigration regulatory changes as a result of political shifts. The underlying assumption we have worked with is that national policies are best understood in their particular political and policy process dynamic, but also in relation with the process of European integration. Moreover, the road to Europeanisation of migration policy cannot be separated from the strong influence that national peculiarities bring to bear on it.

1.5.1 Cultural traditions on immigration policies

There are several cultural traditions concerning immigration and citizenship within the EUROPEAN countries. Austria resembles Germany in their common geopolitical location in Western Europe. They shared a history of affluence of immigrants from Eastern Europe and of an influx of asylum seekers. Both have developed legislations that favoured guest workers’ integration after the Second World War. Despite differences, both countries have gone through heated debates in recent years concerning border controls, leading to re-regulation on immigration and citizenship laws. Their model of citizenship acquisition is *jus sanguinis*. France and the United Kingdom shared a colonial past that has strongly contributed to their policy choices in immigration. As large numbers of members from the ex-colonies arrived in these countries integration policies have occupied a prominent place on their national citizenship agenda. Both have favoured the *jus soli* model of citizenship acquisition. However, the increasing numbers of immigrants arriving in these countries in the last half of the XXth Century have fuelled political confrontation and put considerable pressure on re-assessing citizenship laws. Finally, Sweden, Spain, and the Czech Republic are countries in which immigration in modern times is relatively recent. Sweden was a country of emigration until the beginning of the XXth Century. Sweden’s free movement of people has existed among Nordic Countries and the country received limited numbers of refugees after the European wars. Spain has passed from being a country of emigration to be a country of immigration more recently and the Czech Republic is a country that has changed borders as a result of dramatic political changes and is arriving only recently at a clear picture about immigration in relation to national citizenship.

1.5.1.1 Austria and Germany: guest workers and asylum seekers

There are historical reasons to focus on the similarities of these two countries. Austrian laws on immigration, residence and employment were replaced by German regulation
with the annexation in 1938\textsuperscript{45}. The German Decree on Foreign Workers that came into effect in 1941 served as a legal basis for the regulation of the Austrian labour market until 1975. Until the mid-1970s, Austrian policy on the employment of foreign workers was dominated by the demands of the employers. Bilateral agreements were signed with Turkey and Yugoslavia, not without the opposition of the Trade Unions Federation. Immigrant workers were requested by the Chamber of Commerce representing the business interests. However, foreign workers were increasingly bringing in their families to Austria, which affected the country’s employment structure and the housing situation\textsuperscript{46}. With the oil crisis in 1973 and the following recession political debates around immigration led to the end of recruitment of guest workers in 1976. A policy involving the encouragement to return home was put into practice. As a result by 1985 the number of guest workers was reduced to 40 per cent of the 1975 total number.

In Germany the share of immigration in the total population has increased constantly from about half a million in the 1950s to some 5 million in 1989. At the outset, migration was mostly caused by the government’s recruitment of guest workers until 1974. After that most immigration was caused by family reunification. -The guest workers history has played a central role in shaping immigration laws and immigrants rights in Germany. For example, special agreements have been signed with Turkey to protect Turkish workers securing them residence after only four years of employment. In this country the rights of guest workers to establish residence and seek family reunion did not come about until the 1970s and 1980s bringing new challenges to the previous citizenship laws\textsuperscript{47}. The most striking change is the new law on citizenship of 2000 which introduced a modification to citizenship as based on the territorial principle rather than on descent.

The other road to immigration in both Austria and Germany has been asylum. The end of the World War II was a turning point in the German legislation concerning asylum rights. These rights became fundamental rights exceeding the Geneva Convention. Austria was one of the main receiver and transit countries for refugees from Communist regimes between 1945 and 1989. Austria and Germany have seen the rise in the numbers of asylum seekers since the mid 1980s and a fierce anti-migration response among sectors of the indigenous population, especially in the case of Austria. This country hosted approximately 1.4 million foreigners, including foreign workers after the end of the WWII. While many foreigners and prisoners of war were quickly repatriated to their countries of origin, over 500,000 displaced persons\textsuperscript{48} permanently settled in Austria\textsuperscript{49}. According to the 2001 census over 730,000 (9.1\%) of the total population were non-Austrian residents. German immigration showed almost constant increases from the 1950s reaching 7.3 million by the year 2000. It is the EU country with highest number of foreign, non-citizen residents, which amount to 8.9 per cent of the total population. To mention one example, of the two millions of Turks legally residing in Germany less than three per cent are

\textsuperscript{45} Austrian migration policy began taking shape through the \textit{Heimatgesetz} and the \textit{Ländergesetz} in 1938. The first one specified the residence rights of citizens and the welfare assistance to which they were entitled.

\textsuperscript{46} In the 1960s and early 70s, foreign workers came alone, i.e. one by one with no additional family members.

\textsuperscript{47} Morris, \textit{op. cit}, p.28.

\textsuperscript{48} The majority were ethnic German refugees from Eastern Europe.

\textsuperscript{49} Rodousakis, N., \textit{Migration in Austria}. EUROPUB.
citizens. Given the stratified system of rights conferred in the German system it is difficult to calculate the exact number of asylum residents. Only in 1992 the requests for asylum surpassed 400,000. The so-called asylum compromise passed in 1993 denied persons who had entered Germany through a safe third state the right to apply for asylum.

1.5.1.2 France and the United Kingdom: two roads to citizenship incorporation from a colonial past

France is a good example of a former colonial power with a natural and large influx of "French subjects" from Maghreb, West Africa, South East Asia and the West Indies. After the first wave of mass immigration, which took place between the first *jus soli* act of 1851 and the sharpened up second one of 1889, it paid for people belonging to the French Commonwealth to settle in France. This country opted for integration policies based on assimilation of immigrants, despite strong opposition of the Communist party. This party argued against integration of large numbers of immigration because it would threaten French workers rights. What has been called the “Frenchification” processes, based on cultural assimilation and on French *jus solis* citizenship has met with difficulties in its effort to eradicate the view of immigrants as foreigners in everyday practice despite several generations of formal integration. This shows a lack of recognition of immigration and cultural variety as part of the national identity.

In the past France was concerned, not exclusively but mainly, with ways of integrating migration flows coming from former French colonies, mandates, protectorates and departments. Economic and linguistic ties as well as affective and cultural reasons motivated these flows coming from North Africa (Algeria, Morocco, and Tunisia) and also from countries of sub-Saharan Africa. The flows of immigrants as salaried workers officially stopped in 1974 given the economic recession caused by the oil crisis. However, immigrants have continued to flow in the country showing diversification of origin, such immigration from India, Pakistan and Sri Lanka. Along with this diversification there has been an increase in the number of laws on entry and residence in the 1980s and on citizenship in the 1990s. Moreover, regulation on asylum has been modified with the implementation of European rules of Schengen (1985) and the Dublin Convention (1990). Despite attempts to restrict entry France is now considered as the second host country in Europe with 3.3 millions foreigners, 5.6% of its total population.

The United Kingdom’s immigration tradition is also defined by its colonial past. As France the UK has had a *jus soli* integration path to citizenship acquisition. However, the inclusive approach in this case not only conferred social and political rights but also favoured cultural distinctiveness with concern for ‘race relations’. In Britain, constitutional rights for ethnic minorities/migrants are rooted in the English common-law tradition. The common-law judiciary has traditionally upheld the principle of cultural pluralism. Under the common law, ethnic minorities have been exempted from certain legislation. Thus Sikhs

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51 Klasing, A. & Reidel, T., Migration policy at the national level. The case of Germany. EUROPUB.
52 Alcaud, D. & Pitsch, H. Migration Policy. The French case. EUROPUB.
are allowed to wear turbans and thus they are exempted from legislation that makes it compulsory for workers in the construction industry and for motorcyclists to wear safety helmets. Respect for cultural identity is reflected in the characterisation of census data. According to the 1991 Census 5.5 per cent of Britain’s population (3 million people) belongs to an ethnic minority group. Out of these 3 million people, half are South Asians (India, Pakistan, Bangladesh), 1.6% are ‘Black’ (Africa, Caribbean), 1.2% (Chinese and other groups). The 1962 Commonwealth Immigrants Act was tightened during the following decades partly to control family reunification. Since 1962 most of the immigration rules introduced were aimed at reducing the number of asylum seekers which increased significantly at the end of the 1980s/beginning of the 1990s. European integration has had an important input in the shifts occurring in the British tradition. The legislation introduced in 1971 and 1981 meant a contraction of citizenship rights for Commonwealth country members arriving in the UK. In parallel the country developed the rights of free movement of EC nationals and a growing proportion of non-citizens, non-EU migrants and asylum seekers. The UK has also incorporated a human rights regime in order to cope with increasing numbers of non-citizens. “Incorporation of a human rights regime into domestic law represents a potential change in the character of the British system, which has rested to a considerable degree on ‘concessions’.” Family reunion source of immigration has been closely associated with human rights related law. The changing character of immigration in the UK during the 1980s/1990s has involved an increase in the number and diversity of refugees and asylum seekers in Britain, an increase in the number of spontaneous migrants and asylum seekers particularly following the war in Yugoslavia, but also from other countries such as Sri Lanka, Somalia and Turkey. Thus in recent years most migrants have been asylum seekers. Government measures have aimed at controlling and restricting the effective immigration to the country. As in other EU countries success in this direction has been only partial with increasing numbers of illegal immigrants living in the country. As in Germany and other EU countries British business sector demands further incorporation of foreign cheap labour as well as high-skill professionals in Information Technology.

1.5.1.3 Three models of immigrants incorporation: Sweden, Spain and the Czech Republic

Sweden has been a country of emigration mainly to the USA, which in the end created a shortage of labour. The first Aliens Act at the end of the World War I restricted the settlement of workers in the country. Refugee policy remained restrictive after World War II accepting only 5,000 refugees from Germany. In the 1950s immigration policy started to change as immigrant workers were increasingly accepted to the country to respond to the demand of labour. In fact the 1960s became years of large scale labour immigration. Since then Sweden has been changing from a homogeneous country into a multiethnic

53 Parau, C., Migration Policy at the National Level. United Kingdom. EUROPUB.
54 Parau, C., op.cit.
55 Morris, op.cit. pp.80-
56 Morris, op.cit, pp.80.
country. Sweden’s policy of immigration changed into a policy of integration. In 1975 the main policy objectives were: equality, freedom of cultural choice and cooperation and solidarity. In 2001 the proportion of foreigners amounted to 5.3 per cent, one of the highest in the European Union\textsuperscript{58}.

The concentration of immigrants in peripheral neighbourhoods of the largest cities – Stockholm, Gothenburg and the Västra Götalands Regionen- prompted an internal debate and subsequent policy of social integration. In 1986 Sweden adopted a law to combat discrimination against immigrants in the labour market. This law, the Act on Discrimination at Work was complemented by the establishment of the Ombudsman office Against Ethnic Discrimination\textsuperscript{59}.

Immigrants to Sweden come from Africa, Latin America and Asia as well as from the Middle East. The largest group from South-Eastern Europe comes from ex-Yugoslavia, Bulgaria and Romania. It is important to distinguish the labour recruits from Central Europe, Southern Europe from the refugees coming from a wider array of world countries. The first attempts to social integration were not free from acculturation involving more than language training. This may help to explain the current debate on multiculturalism. However, social integration was not always easy to achieve given the segregated housing location of immigrants in suburban “banlieus”. In these peripheral neighbourhoods there is a relatively high concentration of unskilled and unemployed people which has lead to the recognition of structural discrimination among the political class. “It was a common experience among highly qualified refugees from Latin America and Eastern Europe already in the 1970s that the official at the Labour Exchange would tell them not to present any plans involving a continuation of their professions”\textsuperscript{60}.

Spain has been traditionally an emigration country, which means that legislation concerning immigration is very recent. Nor has there been a clearly defined policy of integration. In this sense current debates are more revealing than historical considerations. In 1985 the Spanish government introduced the first law on migration. This law, known as ley de extranjería (Law on aliens) enumerates the rights and duties of non-citizens residing in Spain. However, in the Spanish case there is an important informal dimension in the migrants’ incorporation and in the support they received that can be explained by the poverty of the structure of formal provisions. The restrictive character of the law locates large numbers of immigrants in the margins of legality as residents and as workers with the consequent high levels of exploitation attached to it. In numerical terms Spain has a low proportion of immigrant population and a relatively high proportion of EU citizens living in the country. In fact until relatively recently the foreigner was seen popularly as someone of a relatively high status. The increase in immigration has been fast in the last few years. In 1996 the total proportion of immigrants in Spain was 1.5 per cent of total population, by the year 2001 the proportion reached 2.7 per cent. This increase means that immigration, the way it is managed and the tensions caused by defective integration measures have become issues of public concern\textsuperscript{61}.

Immigrants in Spain constitute mainly cheap labour although their school qualifications would allow them to work in higher-skilled jobs that the ones they usually hold. They mainly work in services with a high proportion of them – mainly women - working in caring

\textsuperscript{58} Jederlund, L., From immigration policy to integration policy. Swedish Institute. 1998

\textsuperscript{59} Jederlund, L, op.cit.

\textsuperscript{60} Peterson. M., Immigration Policies in Sweden. EUROPU.B.

\textsuperscript{61} Pradel, M., Immigration policy in Spain. EUROPU.B.
personal services. The informal economy is a source of employment for them allowing for exploitation and making more difficult the formalisation of their residence status. The combination of a very restrictive Aliens law and the large extent of their incorporation in the informal economy rather than in the formal labour market contribute to their “criminalisation”. The majority come from Latin America, Morocco, Philippines, Pakistan, and in less proportion from Central and South Eastern Europe, Sub-Saharan Africa and China.

The Czech Republic immigration history is characterised by the changing of national borders. First the Creation of Czechoslovakia with the amalgamation of the Czech Lands with Slovakia, a former part of Hungary with a population of Slovaks provided an impetus for the increase of immigration of Slovaks to the Czech part of the Republic. WWII changed the panorama as the population was homogenized (Germans were forced to leave and Jews were either killed or left the country). After 1948 and under Communism a new wave of emigrants left the country. Moreover, one of the main flows of migration has been between Slovakia and the Czech Lands. With the end of the Communist regime foreign immigration increased again officially mainly because the Slovaks started to be considered foreign migrants to the country. By the year 2001 foreigners in the Czech Republic were of three categories: (a) foreigners with a permanent residence permit, who are holders of the Aliens’ Passport and who enjoyed basically the same rights that Czech citizens excluding political rights; (b) foreigners with a long-term residence permit, who are holders of over 90-day visa cards; and (c) foreigners with a permit for short-term visit of up to 90 days. The proportion of immigrants in the country has changed more due to the change of definition of who is a migrant than from a factual mobility of persons.\textsuperscript{62}

The sharp increase of immigrants between 1991 and 1996 resulted in a total number of foreigners reaching 200000\textsuperscript{63}, which represents about 2 % of the overall population of the Czech Republic However, it is estimated that there are similar number of illegal immigrants. From January 1\textsuperscript{st} 2001 some provisions of the new Law on the on Residence of Aliens in the Territory of the Czech Republic came into effect that made the stay of foreigners in the Czech Republic more strictly regulated.

Three quarters of the immigrants come from Europe, somewhat less than one quarter from Asia; the number of migrants from the other continents is negligible. The members of several nations dominate in terms of numbers. These are Slovaks (26 %), Ukrainians (25 %), Vietnamese (12 %), Poles (7 %), and Russians (6 %). The majority of immigrants consists of economic immigrants, who either seek employment by companies in the Czech Republic (43 % of all registered foreigners work as employees) or are involved in their own business (26 % of all registered foreigners). The demographic structure of immigrants corresponds to the above-mentioned fact: the absolute majority of immigrants are aged between 25 and 45, the number of children is very low, and two thirds of the immigrants are male. Most immigrants are concentrated in the Prague region.

\textsuperscript{62} Kostelecký, T., Migration Policy in the Czech Republic.

\textsuperscript{63} From these numbers, Slovaks represents only about 10-15 %. The increase is not caused by the change in the definition of Slovaks as foreigners in 1993. See Kostelecký, \textit{op.cit.}
The second source of immigration is asylum seeking. Most asylum seekers were originally citizens of poorer East European post-Communist countries. The majority of the new asylum seekers come, however, from Afghanistan, India, and Sri Lanka. Overall numbers of asylum seekers have increased since the late 1990s. In 2001, the number of asylum seekers exceeded 18000 as a number of the foreigners interested in work in the Czech labour market used the asylum procedure as a possibility to legalize their stay in the Czech Republic at least temporarily (before the asylum procedure is completed and a decision on asylum is issued).

1.5.2 Main recent changes in the national legislations: a process of approximation within the EU?

In Austria the legislation reforms concerning immigration have been increasingly restrictive. The Foreigners employment reform of 1990 established a federal maximum number which determines that only 10% of Austria's total workforce could be non-nationals. The 1992 Residents Act established specific contingencies for various categories of immigrants in a restrictive way, linking the annual quota to the economic situation. This law established the obligation to obtain a residence permit before travelling to Austria. This permit is valid for six months and extensible for six extra months. Is possible to obtain a permanent permit but can be confiscated for various reasons. The same year an Amendment of the previous asylum law was introduced to reduce the unfounded asylum applications and to accelerate the adjudication procedures, creating new mechanisms for the asylum process.

In the 1993 Aliens Act further immigration controls and tightening regulations were introduced concerning entry and residence of foreigners in Austria. Furthermore an “Integration package” was added to the Aliens Act with recommendations on integration measures. This integration involved the acquisition of German and adapting to Austrian culture. The law also established the principle of successive consolidation of residence and imposed new restrictions on family members of migrants. More recently in 2002 the Aliens Reform has introduced reduction of immigration for economic purposes to key personnel and highly qualified employees and self-employed persons. No immigrants apart from those categories can acquire a permanent residence in Austria.

On the reformation of the Citizenship legislation: the 1998 Naturalisation Act fixes the criteria for citizenship acquisition and maintains the *jus sanguinis* system plus a waiting period of 10 years. It stipulates the prohibition of dual nationality and the functions of the different government levels in the naturalisation process.

In Germany two EU factors -The Schengen and Dublin agreements- and one internal factor –the German unification- have marked the changes in immigration legislation. In consequence several laws and decrees modifying regulations for working and residence permits and access of different groups were introduced in 1991. In 1993 the individual right to asylum granted by article 16a of the German constitution was drastically restricted by the so-called asylum compromise. As a consequence the deportation of rejected asylum seekers was facilitated. In 1997 the Foreigner Law “Ausländergesetz” established

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64 For details see Annex 2.
a dual approach of bettering the status of legal foreigners and facilitating the extradition and deportation of those rejected on legal basis.

Germany is facing the different logics referred to above. The market logic prompted in 2000 Green-Card Arrangement provides the possibility of issuing working and residence permits for up to five years to 10,000 (later 20,000) Information Technology and Communications Technology experts). The security logic has provoked an sharp debate on immigration. A new immigration law proposed by the Government in 2002 has become problematic as the conservative opposition has rejected it in the Bundesrat, where it has the majority. The CDU has tried to force stronger security measures while the Greens brought negotiations to a standstill arguing that easier detentions and expulsion will subvert civil rights protection.

The most important change, however, has been the New Law on Citizenship of 2000. This law involves the introduction of the *jus soli* principle. More specifically it involves a cut in the necessary period for naturalisation from 15 to 8 years of residence. Children of immigrants born in Germany after 2000 can automatically obtain the German citizenship if one of their parents has been residing in Germany for at least eight years with a temporary, or three years with an unlimited, residence permit; through that, multi-nationality is possible (although by the age of 23, people with two citizenships have to decide which nationality they prefer).

In France the constant pressure of the National Front, the economic recession in some traditional industrial sectors and the pressures to restructure the welfare state led to a restrictive policy on immigration from 1986 to the late 1990s. The 1986 “Loi Pasqua” and the 1989 “Loi Joxe” related to conditions of entry and residence of foreigners. Emphasis is on restriction of the category of foreigners who can obtain automatically a permit or residence and of the protection against the expulsion of those who have personal or family liaisons in France. This line of legislation has been redefined in subsequent laws in 1993 and the Bill of immigration of 1996, which reinforced the deportation procedures for illegal immigrants. New laws were introduced in the two following years and again more recently in 2003 always in relation to entry and conditions of residency. These laws reflect the increasing sophistication of control measures as well as the government’s concern to prove that illegal immigration is controlled. Just to mention the 2003 “Loi Sarkozy” that emphasises the creation of a file of fingerprints and photographs of everyone entering France, the widening of the retention time and specific conditions on family reunion and marriage. Family reunion policy is more restricted in France than the European Commission Directive on family reunion recommends.

The other important legislation concerns the rights of citizens, such as the 1993 “Loi Méhaingerie” and the 1998 law providing the possibility for children born in France of foreign parents to request French citizenship at the age of 13 with the parents’ authorisation and at the age of 16 without it.

As other EU countries France has been making specific provisions that apply to some statutory professions. Apart from EU and EEA citizens others need special temporary residence permits. However, France as other EU countries is trying to find workable measures to reconcile the market logic with the national identity-welfare logic. As immigrants’ origins diversify, on the one hand, and the EU Treaty imposes multicultural values as part of identity (with anti-discrimination legislation), on the other, the government is receiving considerable pressure from diverse social and political groups. Moreover, France has the largest concentration of Muslims in Europe (four million) and
many of them find it difficult to enter the labour market while being French citizens. In this contest the legislation on social integration appears relatively poor –especially if compared with countries like Sweden. The reason for this is to be found in the national political debate.

In the United Kingdom recent legislation has been focusing on conditions of entry and social support for refugees and asylum seekers due to the fact that they have become the largest category of immigrants into the country. Between 1990 and 2001 the number of asylum application to the UK almost tripled. Four laws have been introduced since 1993 related to refugees and asylum seekers. The 1993 Asylum and Immigration Appeals Act, which tightened immigration rules and curtailed asylum seekers’ rights. The 1996 Asylum and Immigration Act, which differentiated between different categories of immigrants (e.g. economic migrants and those fleeing their home countries because of persecution); this law also placed more responsibility on employers to control the status of employees and it made more difficult for migrants to gain accession to social support (e.g. housing). The 1999 Immigration and Asylum Act, which further curtailed welfare arrangements for refugees and asylum seekers, tightened border controls and excluded all asylum seekers from accessing social security benefits (food vouchers, housing). Finally, the 2002 Asylum and Immigration Act, which was mainly concerned with speeding up the asylum process.

A second batch of legislation has been concerned with the integration of minorities in the country following a long tradition of respect for ethnic and cultural minorities. Already the Race Relations Acts of 1968 and 1976 dealt with anti-discrimination policies in housing, employments and insurance and promoted equality. Further, the 1996 Local Government Act provided responsibility and support to local councils to train immigrants. In 1997 a report on immigration policy called for higher degree of social inclusion of ethnic minorities. The multicultural approach to immigration is at present under discussion. Integration policies have also been specifically directed to newcomers. In 1999 a voucher system was introduced for asylum seekers. Further mobility policies have been introduced in order to promote a process of dispersion from the London and South-East England area to other parts of the country. Concentration in London especially has contributed to the increase of poverty in the city. The pressure from the right-wing media and sectors of the Conservative Party has led to relating issues of integration with security. Thus, a third area of immigration policy deals with security; a good example is the Home Office White Paper of 2002 on Secure Borders and Integration with Diversity in modern Britain. The United Kingdom general policy has been to tighten external controls and to relax controls in internal mobility. As other EU countries, the UK is facing the problem of controlling illegal immigration.

In Sweden, apart from the Terrorist Law of 1991 controlling foreigners and the 2000 Regulation on Schengen information systems, most legislation has been aimed at integration and anti-discrimination policies. Some of these laws culminated in the new Law on Citizenship (2001:82) and in the Regulation (2001:720) on treatment of personal issues in relation to foreigners.

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The year 1994 saw the introduction of several laws. Asylum Laws: Law on reception of asylum seekers; Laws regulating remuneration as introduction to Sweden; Regulations (1994:361) on reception of asylum seekers, home and housing equipment; and Laws on Care (medical care) and on care expenses. Regulations on learning Swedish. Following the concern in this country for integration of immigrants further legislation was introduced with the aim to provide state support for religious orders in 1998 and 1999. Also Work: Law (1999:678) concerning where to place immigrant employees. These were followed by legislation in 2000 (Laws on Organisation of Life regarding the funding of organisations which promote social integration of immigrants.

The other main bulk of legislation relates to the responsibility and obligations of municipal and provincial authorities in implementing integration policies. This legislation often concerns financial matters and to anti-discrimination programmes. Discrimination; Law (1999:131) on the establishment of an Ombudsman against Ethnic Discrimination; Regulation (1999:171) on instructions for the Board of Agency against Discrimination.

Spain constitutes a contrasting case to Sweden. In this country legislation on immigration was first introduced in 1985 a year before accession to the EU. The law aimed at control of immigrant flows based on quotas. Further changes have taken place from the first reform of the law in 1999 until 2003. Basically the end result of four years of discussions has been a clear-cut distinction between legal and illegal immigrants. A work permit is necessary in order to become a legal migrant. This strict filter has not necessarily decreased the numbers of illegal immigrants. Moreover, restrictions have been introduced for family reunion. There is, however, a tension between the demand for cheap labour in agriculture, the construction industry and personal services and the restrictions involved in the law. All efforts by employers and civil society organisations as well as by some political parties have proved unfruitful until the change of government in March 2004. The new Socialist government has promised a revision of the law.

Integration policies are basically organised at the regional and local level. City councils respect the right to education of immigrants’ children whatever their legal status. The previous government did not regulate the support provided by city councils to the integration of immigrants nor the allocation of resources for the implementation of integration policies. In fact, it can be argued that the very restricted law in force locates institutions and NGOs helping illegal immigrants at the margins of the law.

Until the 30th September 1992, the residence of foreigners on the territory of the contemporary Czech Republic was regulated by the Communist Act No.68/1965 Coll. This law was replaced by the Act No. 123/1992. More recent legislation has introduced two complementary processes. The first corresponds to legislation introduced to reduce numbers of immigrants partly as a reaction to the economic problems of 1997-1998, partly as the result of EU pressure to introduce stricter new legislation. The EU complained that the too liberal migration laws of the Czech Republic enabled many migrants from the East to migrate to the neighbouring EU states and urged the Czech Republic to apply stricter measures. This led to the preparation of completely new legislation, which would assure a higher level of control over international migration and compliance with EU regulations. The new legislation has been therefore heavily influenced by the acquis to accession countries following the migration regulation of the EU. As a result, since 1999, the Act on Residence of Aliens in the Territory of the Czech Republic was amended several times. The limitation of numbers of immigrants was also applied to asylum seekers. Although the numbers of applicants continued to increase those who eventually received asylum slightly decreased.
The second policy process (Government Resolution No. 55 from 13.1.2003) has been informed by the potential lack of qualified workers in specific positions. In response to this and because of the aging of the population, the Czech support immigration that is considered “beneficial for the economy and the demographic situation. This policy favours a system of quotas in order to attract educated immigrants.

The third policy objective is migrants’ integration through introduction of measures to promote social inclusion and multicultural integration. This policy is in line with international human rights standards and respect for ethnic minorities. Thus cultural diversity is formally acknowledged as a desirable policy objective.

1.5.3 Policy structure

1.5.3.1 Government: national, regional and local levels

The management of immigration policy falls largely on national governments, even if it may be of great significance in certain areas at a local level. While national governments are responsible for managing the flows of immigrants and control of the borders, local governments assume responsibility for the integration of immigrants. This distribution of immigration control is officially established in some countries like the Czech Republic; in others, as is the case in Spain, Sweden and the United Kingdom, it is dealt with unofficially.

It is therefore important to bear in mind the different national contexts when it comes to the distribution of control between the different administrative levels. As we have seen, national governments have had a tendency to link the management of immigration with questions of security, something which has been translated into a substantive advance in European policy of border control and in common foreign policy, with member states maintaining their autonomy (see 2.1). This idea has marked the distribution of the powers regarding control of immigration in different countries. This distribution of powers affects the different levels of government as well as the ministerial distribution of powers and the opening up to other institutions.

In this way we can see how in the United Kingdom the main protagonists in immigration policy were the local governments up to the 1980s, the time when Margaret Thatcher cut the powers of the town councils and gave them to the central government, making it impossible for local governments to develop immigration policy, which up to that moment they had been doing. Nevertheless, in the United Kingdom, immigrants have consolidated their participation at a local level by means of occupying positions in town councils and other institutions like universities. In other countries regional or local governments have official powers in certain areas. In the Czech Republic local organisations play an important role in the policies of immigration, although they are subordinate to governmental control. In this country agencies have been created to review the situation of the immigrants and to co-ordinate the different organisations and associations involved in the integration of foreigners into the country. In countries with a more corporatist

66 Parau Cr. op.cit.
67 Kostelecký, T. op.cit.
tradition, like Austria and Germany, the federal and provincial governments are consulted by the central government when it comes to decision-making and they have certain relevance in matters of immigration within the self-same state-structure.

In France, on the other hand, the powers of immigration policy fall on the central government but they are widely shared among different ministries, each one of which is responsible for covering one aspect of immigration policy; these are the foreign ministry, the ministry responsible for overseeing residence permits, asylum and border control, while the ministry for social affairs, employment and solidarity is responsible for policies of integration. In Spain the decisions in matters of immigration are the exclusive domain of the central government. The Autonomous Regions and the local governments have no official powers in this area. Nevertheless, the local governments see themselves obliged to work towards policies of integration for the immigrants due to the fact that they are the administrative body that has to deal with the problem. In addition, the change in focus in immigration policies which are now linked with security has brought these from being in the hands of the ministry for employment and social affairs to being under the control of the interior ministry.

And so we can see how there is a fairly centralised distribution of power with regard to the national governments, although the local governments participate officially or unofficially in the integration of the immigrants, this being also the area in which the latter can develop their participation in political life.

1.5.3.2 Court of justice and ombudsman

The judicial bodies have had a determinant role in the defence of the rights of immigrants in some countries. In this sense the courts have relaxed the rules passed by the governments when these went against the principles of the constitution. Three cases stand out as to how justice has defended the rights of immigrants, namely the United Kingdom, Germany and Spain. In the United Kingdom the courts were opposed to a law which gave rights to the authorities to deny immigrants access to social welfare. In the same way in Germany the courts ruled that the right to protection of the family, laid down in the German Constitution, also extended to immigrants, in such a way that family reunification should not be restricted. Finally, in Spain, the courts rejected various articles of the law pertaining to aliens after considering them to be unconstitutional, obliging the government to revise the law. And so, it can be seen that the courts have their importance in the process of creating policies of immigration, relaxing those harder aspects of the law.

In other countries, such as Sweden, the ombudsman is important when it comes to defending the rights of immigrants. The ombudsman is important in guaranteeing that justice is applied correctly and avoiding any discrimination. However, the use of this person is linked to the level of education of the immigrant and some immigrants do not use him/her because they are unaware of his/her existence.

68 Peterson, M. Op. cit
The position of the different political parties with regard to immigration depends to a large extent on the political system of the country, on its party system and its culture with respect to the question of immigration. Nevertheless, there are some general characteristics which can be seen by means of the left-right axis. In this way we can find one position linked to conservative parties and another linked to progressive parties.

The general position of conservative parties has been the link between questions of immigration and questions of citizen security. This is the case of the French parties UMP and UDF and of the British Conservative Party. Behind this link we find the idea of immigration as a phenomenon that can undermine the national cohesion of the country. This idea of immigration has, as will be seen later, led to the imposition of strict policies to curtail legal immigration and asylum, as well as stricter control over illegal immigration, on the part of these parties.

Depending on the national contexts, the conservative parties adopt one type of discourse or another. In France, the UMP adopts a strong stance based on security, but at the same time regulates integration as it is understood in this country (as we have seen, as an adaptation to French culture). The German conservative party, on the other hand, do not recognise that Germany can be a country of immigration and consequently maintain a defence of a restrictive legislation with respect to this theme.

For their part, the progressive parties (social democrats, communists, and greens) have tended to link the question of immigration to that of integration and multiculturalism, looking for policies to accommodate this. Within this spectrum there is room for differences between the social democrat party, with widespread electoral support, and the minority parties like the greens or the communists. The stance of these parties advocates humane treatment for immigrants, the free movement of people and the obtainment of equal rights for everyone. As we have seen above in the case of the French Communist Party, this position is relatively recent among the communist parties.

It also has to be pointed out that the progressive parties that have held power in the different countries studied, despite advocating integration, have in fact applied restrictive measures of immigration. This is the case of the British Labour Party which, in spite of campaigning in favour of integration for immigrants, has adopted the “community ideology” to deal with immigration issues. According to this principle immigrants and refugees are not initially legitimate members of the community, and as a result do not have the right to social welfare. They have also limited the possibilities to apply for refugee status and have taken other measures to restrict immigration. The Spanish Socialist Party has had a similar experience despite not being in power. After a period marked by a strong bid for integration, PSOE entered a realistic period in which it reached a consensus with the party in government on measures approving a very restrictive law of aliens.

An exception to this change of approach on immigration policy is the case of Germany, due to a large extent to the influence of the Green Party. This party, which forms part of the government along with the social-democrat party, has fought to impose programmes based on the concession for greater rights for immigrants, combined with a control of

\[69\] Parau Cr. op.cit.
immigration where possible and necessary\textsuperscript{70}, in such a way that currently makes it one of the few countries studied that does not regulate its immigration by means of a quota system.

Finally, it should be pointed out that in some countries, France and Austria in particular, extreme right-wing parties have appeared, whose central mandate is to oppose immigration. These parties are based on strong nationalism which considers immigration as a threat to the country and the control of immigration as it has been carried out up to now as an act of treason against the fatherland. Although these parties exist in almost all countries studied, only in Austria and France are they politically relevant. The existence of these parties, and their popular support, show the desire to restrict the entrance of foreigners by some sectors of society, who look with fear at the arrival of immigrants as a threat to their country. It must also be pointed out that these parties have a great ability to attract the attention of the media\textsuperscript{71}, and that their stance has repercussions on the rest of the political scene. The extremely small Freedom Party in Denmark managed to influence the Swedish Liberal Party, which introduced some of their ideas to its programme. As a result, the Swedish Liberal Party rose in the opinion polls by between 5\% and 15\% in just two weeks\textsuperscript{72}. This radicalisation of the programme made a significant impact on society, which interpreted it as a great political pact which was anti-racist and anti-discriminatory in character.

1.5.3.4 Trade Unions

The trade unions have very distinct positions in the different countries. We can trace a line from the opposition to the arrival of immigrants to the position in favour of immigration and the policies of integration. In Austria, the trade unions have traditionally played an important role in employment policies, even if recently they have lost certain powers in this area. Nevertheless, currently they are still involved in decision-making with regard to the job market and the relationship this has with immigration. The position of the trade unions in Austria is to restrict immigration so as to give priority to the native workforce. In France the trade unions and the communist party held a similar position during the 1970s and 1980s. Other countries in which trade unions do not hold as much decision-making power have tended to consider the grievances of the immigrants within their actions, participating in activities and movements of organisations in favour of immigration.

1.5.4 Other Civil Society Organisations: NGO’s and immigrant defence associations

The role of civil society organisations depends, to a large extent, on the internal institutional structure of each country. In those countries with a more corporate tradition such as Sweden, Austria and Germany, civil society organisations are recognised by the government as worthy interlocutors and collaboration is widespread. In other countries, such as the United Kingdom and France, this collaboration is given in specific cases at local level while in countries such as Spain or the Czech Republic these organisations have less relevance in immigration policies. We can distinguish different types of organisations. Firstly, there are the social agents which have a role in the labour market

\textsuperscript{70} Klasing, A., Reidel T. op.cit.
\textsuperscript{71} Parau Cr. op.cit.
\textsuperscript{72} Peterson, M., op.cit.
and which can affect the labour aspects of immigration policies. Secondly, we find those non-governmental organisations oriented to giving support to immigrants in a variety of ways and which fight for the rights of immigrants and their integration into society. The position of these organisations can be more of assistance (in the teaching of languages, help in legal processes) or more political (the fight for rights) although both dimensions are present in the majority of cases.

A network of associations which defends the rights of immigrants has arisen in all countries and they implement different forms of assistance. In the more traditional corporative countries, Austria, Germany and Sweden, these associations have actively participated in the institutional policy even though in some cases they are starting to lose relevance in this area. In Sweden civil society has been organised under an umbrella organisation with representation in regional government and it collaborates both at this level and at the local level in the fight against discrimination and racism. Germany follows a very similar model, with a large organisation that acts at the level of the Länder and at a local level giving judicial support and assistance to the refugees, the principal category of immigrants in Germany. In contrast, in Austria, with a right-wing government in power since 2000, the civil society organisations have lost influence, in that the government has them less in mind when it comes to making decisions. Nevertheless, one has to mention the case of Vienna, where civil society organisations actively collaborate at a local and regional level in the development of integration policies.

In the countries where a culture of consulting organisations does not exist, the civil society organisation is not very important in institutional policy, but plays an important role in the development of integration policies, given that responsibility for this aspect falls largely on it. Hence, it must be pointed out that they act at a local level and even often collaborate with local governments in the development of initiatives, although, as we have already seen, these local governments do not have powers in these matters (this is the case in Spain and France). In France groups of second generation immigrants are emerging who play an important role at local level and develop campaigns to promote the rights of immigrants, social and cultural integration, and against racism. These groups have gained importance and collaborate with local governments on programmes against marginalisation, violence and exclusion. In Spain the civil society associations have been able to establish a dialogue with the government by means of an institutional body. Nevertheless, many of these associations have undermined this forum and have abandoned it, participating only at local level. In the United Kingdom communities of immigrants have tended to organise themselves and adopt town councils as their interlocutors, after a period when institutional bodies were created which, as in the case of Spain, were not effective. In this country there are also organisations with a clearly political orientation geared towards fighting racism and xenophobia.

Finally, the importance of the church in upholding the rights of immigrants cannot be ignored. In Spain and in Germany the church has declared itself against the more restrictive immigration laws and has even participated in campaigns in favour of the rights of immigrants.

1.6 Policy process

In the foregoing sections we have looked at the different cultural traditions in immigration policies which exist in different countries, as well as the main legislation that each country
has developed with regard to immigration. The main questions arising in national debates will now be discussed below.

1.6.1 Debates with regard to immigration policies: restricting immigration or integrating the immigrants?

As we have already seen, during the nineties, the countries studied were very active in producing legislation pertaining to immigration. With the exception of Germany and, to a certain extent, Sweden, all the EUROPUB countries opted for restrictive measures with regard to legal immigration. These restrictions were accompanied by a strengthening of the measures to control illegal immigration and an attempt to regulate the situation of illegal immigrants already living in the country. This policy was based on two basic principles: to put an end to the mass arrivals of immigrants and balance the arrival of immigrants with the necessities of the labour market on the one hand, and, on the other, to regulate the situation of illegal immigrants living in the country (or by default repatriate them to their country of origin). In this way France, Spain, the United Kingdom, the Czech Republic and Austria have progressively restricted the number of immigrants entering their countries to the point of creating a single mechanism, the quota system.

And so an important question which has arisen with regard to immigration is the political focus which should be given to the matter. With the exception of Germany and Sweden, the governments in all of the countries studied, have linked immigration to security and have implemented restrictive immigration policies. Nevertheless, these countries have had internal debates on the subject of the integration of immigrants and their acquisition of rights. The left-wing parties have tended to emphasise the integration of immigrants and acquisition of citizenship, looking for support from the immigrant communities. On the other hand, the conservative parties have tended to understand immigration as a threat to the country and have used nationalist discourse to justify the restrictive policies which they have applied. In the different countries studied, the debate has centred on the usefulness of the restrictive measures in the face of a phenomenal increase. In France this debate has been very heated, given the high numbers of immigrants who are organised and ask for many rights at a time, with the result that one sector of the population is afraid of this immigratory reality. Incidents such as the urban disturbances in Bradford, in the United Kingdom, 2001, or the attack in El Ejido (Spain) against the Moroccan immigrant community in 2000 have brought to the foreground the debate about immigratory policies and the perspective which they should be given in these countries and also in the rest of Europe. On the other hand, conservative governments have argued that a liberal legislation with regard to immigration would act as a wake-up call with regard to the advantages that the legislation would offer, and result in immigrants arriving in massive numbers to a country. This argument was used by the Spanish conservatives to modify the law of aliens while the Czech Republic felt obliged, as a candidate for EU membership, to limit its immigration policy.

National governments have observed that a very restrictive policy against immigration is not effective because it infringes human rights and is not in keeping with the needs of the labour market but, at the same time, they have found themselves under pressure from certain parts of civil society that are calling for a halt to new influxes of immigrants. A clear example of this situation can be seen in France. The policy adopted by the French government in 1993, which aimed to reduce immigration to zero, failed. Moreover, a

73 Entzinger, H. op. cit. pp. 102
sector of French society, which is represented in the political arena by the National Front, sees immigrants as a threat to their culture and their jobs. In Spain immigration is a recent phenomenon but there have been movements of opposition to the arrival of new immigrants and the same government has quickly changed its position with regard to the increase in the immigration phenomenon. In Austria, one of the members of government, the Freedom Party (FPÖ), of which Jorg Haider is the leader, has upheld a clearly xenophobic stance, and has obtained a lot of popular support, while in other countries such as Sweden, Germany or the United Kingdom, these movements are more in the minority. However, their existence does reveal the feelings of a certain sector of society.

And so, to conclude, the position with regard to immigration is something which clearly differentiates the left from the right. These differences are not only limited to confrontations over restricting or being more open to immigration, but also affect how integration is understood within a country. In this way the progressive view understands integration as multiculturalism while conservatives understand integration as immigrants assimilating the culture of the host country. We find many aspects to this debate, some of which are important, for example linguistic or religious issues.

Adopting restrictive measures in Austria, Spain, France and the United Kingdom has not been without controversy and has resulted in movements by organised civil society in defence of the rights of immigrants. On the other hand, Germany and Sweden have established themselves as distinctive models that emphasise the acquisition of rights for, and integration of, the immigrants. Nevertheless, the debates have been similar. In Germany the fundamental question has been whether the country is, or is not, a country of immigration, and the expediency of maintaining a system to acquire citizenship based on a *jus sanguinis*.

Another important issue in debates has been that of Asylum. Where there had been a tradition of admitting asylum seekers, there has now been a tightening of the laws, due to this having become the main way of entering a country. In this way the United Kingdom, Germany and Austria have restricted the conditions under which refugee status can be obtained, while at the same time, this refugee status suffered a loss of rights in relation to those previously granted. On the other hand, those countries which did not have a tradition of asylum, such as Spain and the Czech Republic, have developed very restrictive criteria for asylum seekers. Restricting the numbers granted asylum has been achieved by means of creating a more tightly controlled application process. Nevertheless, in Germany, a debate arose recently (2001) on reforming the asylum laws with the aim of widening them to include domestic violence as a reason to grant asylum, and improving social welfare for asylum seekers. This debate centres on a proposal by the federal government which is still being debated and includes other controversial issues such as increasing the rights for family reunification. A key factor in understanding the existence of this debate in Germany is the position of the German Green party which has strongly bound itself to the immigration question. This party, called “Die Grünen/Bundnis 90”, supports an immigration policy based on integration and as a minority member of the government it has been a driving force behind these measures oriented in the way we have previously mentioned. Nevertheless, the conservative majority in the upper house (Bundesrat) makes it difficult for these measures to be passed. The willingness of the greens to adhere to their proposed law without negotiating with the conservatives has brought about a confrontation between the two members of government, namely the social-democrat party (SPD) and the green party, which has yet to be resolved.
1.7 **Conclusions**

The process of European integration gradually involved a free movement of workers. With the Maastricht Treaty the incorporation of the principle of the citizen of the Union rights were conferred to those citizens of Member States residing in other country of their own. However, European citizenship has not gone beyond the national definition of citizenship and as a result millions of denizens live in the Union at present. This democratic deficit mainly affects Third Country Nationals. Migration policy was institutionalised in the Treaty in the Title VI Provisions with Cooperation, Justice and Home Affairs.

Parallel to the establishment of fluidity of internal borders and the proclamation of European citizenship there were signs that a Fortress Europe was emerging in which external border controls were going to make immigration into the Union increasingly hard. The Unification of Germany and the prospect of EU enlargement as well as the conflicts taking place in South-Eastern Europe and in the rest of the world prompted a serious concern about the extent of immigrants. The Schengen and Dublin agreements were engineered in this direction. Member States have embarked in a policy process following a security logic that was given further impetus with the event of the 11\textsuperscript{th} September in 2001 and 11\textsuperscript{th} March in 2004.

There are other logics operating in relation to immigration. One is the market logic. Economic competition is requiring both low skilled and flexible labour force as well as high skilled IT professionals. This logic is leading to a system of quotas by which workers are called on temporary basis. The other logic is the welfare logic which is prompting social actors in Member States to be increasingly reluctant to admit dependent families of immigrant workers. There is an assumption of wanting to have immigrants as producers but not as fellow citizens. Finally the human rights logic exercises pressure in relation of family reunification, conditions of entry and expulsion mainly for asylum seekers.

With this context Members States have discussed immigration policies on the basis of intergovernmental agreement until more recently there are attempts to develop the Open Method of Coordination for migration. One of the arguments against is that national traditions are too diverse to come to a closer policy. We have seen in this report that this is the case. However, we have also seen that a process of approximation has been engineered in later years in relation to border controls. All Member States have been applying restrictive policies and have developed very close legislation about how to deal with entry applications. Still considerably different are the policies of integration of immigrations, the citizenship laws. Moreover, national political debates are also divers according to political party positions in government and the existing formalised opposition by extreme-right wing parties, which are influencing conservative parties for further restrictions.

With Amsterdam treaty a new framework has developed that can lead to a common migration policy. This treaty means a stronger effort to consolidate common
positions on migration in many ways, not only border and migration flows control but also migrants’ integration and rights acquisition. Although the results achieved so far don’t mean the existence of a consistent common policy, they are an important step to the future consolidation of this policy, and create conditions for a deeper development.

The complexity of EU framework has created different categories of people with different rights: EU citizens, Third Nationals, mid term migrants, illegal immigrants, asylum seekers all generating a fragmentation of civic and social and political rights that are questioning the democratic legitimacy of the European Union. Member States once more have in their hands the challenge to direct policy in one direction of another in the mist of a very complex playfield.
Table 1: Legislation on migration and EU integration

<table>
<thead>
<tr>
<th>Year</th>
<th>Document</th>
<th>Main contents</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1958</td>
<td>Treaty of Rome</td>
<td>The Treaty provides the Free movement of goods, capital and workers.</td>
<td>Art. 14</td>
</tr>
<tr>
<td>1992</td>
<td>Treaty of Maastricht</td>
<td>Immigration becomes a common interest topic. The European citizenship is provided to all Member States Nationals, which are no longer immigrants in the EU. Four freedoms.</td>
<td>Articles 13 and 14</td>
</tr>
<tr>
<td>1997</td>
<td>Amsterdam Treaty</td>
<td>Immigration Policy becomes a full EU responsibility</td>
<td>Title IV Art. 61-69</td>
</tr>
<tr>
<td>1998</td>
<td>Vienna Action Plan</td>
<td>Fixes de main guidelines to adopt the Title IV of the Amsterdam Treaty.</td>
<td>23/01/99 Official Journal C 019, 23/01/1999 p. 0001-0015</td>
</tr>
<tr>
<td>1999</td>
<td>Tampere council conclusions</td>
<td>Strict deadlines are established for introducing the necessary agreements and legislation to put in place a common immigration policy.</td>
<td>Part A: a common EU asylum and migration policy.</td>
</tr>
<tr>
<td>2000</td>
<td>June</td>
<td>European Race directive</td>
<td>COM 2000/43</td>
</tr>
<tr>
<td></td>
<td>European Commission proposal for a debate</td>
<td>Debate proposed as a first step trough a common immigration policy. All the EU institutions, Member States and Civil Society should participate.</td>
<td>22/11/2000 COM (2000)757</td>
</tr>
<tr>
<td></td>
<td>November</td>
<td>Community action programme to combat discrimination</td>
<td>27/11/2000 2000/750/EC 32000D0750</td>
</tr>
<tr>
<td></td>
<td>December</td>
<td>Charter of Fundamental Rights of the European Union</td>
<td>Article 21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establishes the prohibition of any kind of discrimination, including the racial and national discrimination</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Document</td>
<td>Main contents</td>
<td>Articles</td>
</tr>
<tr>
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</tr>
<tr>
<td>2000</td>
<td>July</td>
<td>EC proposal for an Open Method of Coordination (Communication from the Commission to the Council and the European Parliament on an open method of coordination for the community immigration policy)</td>
<td>Proposal based in six guidelines based in the previous agreements in Tampere and Laeken: developing a comprehensive approach to immigration, improving information on legal possibilities for admission, fighting illegal immigration, establishing the opening of the labour market to the third nationals, ensuring the development of integration policies for third country nationals residing legally in member states, and work with the countries of origin. 09/07/2001. COM/2001/0387 final. 52001DC0387.</td>
</tr>
<tr>
<td>2001</td>
<td>November</td>
<td>Laeken: presidency’s conclusions on justice and home affairs</td>
<td>As the results were not the expected, a new impulse through a Common migratory flows policy is proposed. The document proposes the creation of different instruments such as exchanging information ones or common standards on procedures for asylum, reception and family reunification Part IV: strengthening the area of freedom, security and justice (articles 37-42)</td>
</tr>
<tr>
<td>2002</td>
<td>November</td>
<td>Return action programme</td>
<td>Programme that develops various measures including common minimum standards in the field of return of illegal residents</td>
</tr>
<tr>
<td>2003</td>
<td>February</td>
<td>EC proposal for a directive of familiar reunification</td>
<td>Commission proposal that defends giving more facilities to the familiar reunification, as longer visas or include new kinds of families 02/05/002. COM/2002/0225 final - CNS 1999/0258. 52002PC0225. Official Journal C 203 E, 27/08/2002 P. 0136 - 0141</td>
</tr>
<tr>
<td>July</td>
<td></td>
<td>Commission proposal for an Assisting third countries</td>
<td>Proposal for a regulation establishing a programme for financial and technical assistance to third countries in the area of migration and asylum.</td>
</tr>
</tbody>
</table>
### 1.9 Appendix 2: Legislative background of the different countries

#### Table 2: Austria

<table>
<thead>
<tr>
<th>LAW</th>
<th>YEAR</th>
<th>MAIN ELEMENTS INTRODUCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geneva Refugee Convention</td>
<td>1951</td>
<td>Persons who applied for asylum within two weeks of arrival in Austria were granted unlimited residence</td>
</tr>
<tr>
<td>Settlement Decree</td>
<td></td>
<td>Decree that establishes the maximum number of Settlement permits to be issued in the forthcoming year</td>
</tr>
<tr>
<td>Alien Police Law</td>
<td>1954</td>
<td>Stipulates minimum administrative control for the establishment of residency in Austria.</td>
</tr>
<tr>
<td>Employment of foreigners law</td>
<td>1975</td>
<td>Establishes the necessary conditions to employ a foreigner in Austria. The right to work is linked to the residence permit. The law establishes short-term permits and exemption for those who have lived 8 years in Austria and have worked 5 years. One of the primary control mechanisms of the employment of foreigners in Austria.</td>
</tr>
<tr>
<td>Law on ethnic groups</td>
<td>1976</td>
<td>Recognizes Slovenian, Croatian, Czech and Hungarian minority groups and establishes their rights and their representative organisms</td>
</tr>
<tr>
<td>Foreigners employment law reform</td>
<td>1990</td>
<td>Establishes a federal maximum number, which determines that only 10% of Austria’s total workforce could be non-nationals.</td>
</tr>
<tr>
<td>Asylum Law</td>
<td>1992</td>
<td>Amendment of the previous asylum law in a restrictive way: reduces the unfounded asylum applications and accelerates the adjudication procedures, creating new mechanisms for the asylum process</td>
</tr>
<tr>
<td>Residence Act</td>
<td>1992</td>
<td>Establishes specific contingencies for various categories of immigrants in a restrictive way, linking the annual quota to the economic situation. The law establishes the obligation to obtain a residence permit before travelling to Austria. This permit is valid for six months and extensible for six extra months. Is possible to obtain a permanent permit but can be confiscated for various reasons. The main aim of this law is to restrict immigration</td>
</tr>
<tr>
<td>Aliens Act</td>
<td>1993</td>
<td>Reform the law of 1954. Advocates for immigration control and tightens the regulations on entry and residence of foreigners in Austria</td>
</tr>
<tr>
<td>Aliens act reform “Integration package”</td>
<td>1997</td>
<td>Reform to merge the Aliens Act and the Residence act with the aim of integrate the foreign residents rather on the immigration of new foreigners. This integration involves the acquisition of German and adapting to Austrian Culture. The law establishes also the principle of successive consolidation of residence as well as imposes new restrictions on family members of migrants.</td>
</tr>
<tr>
<td>Naturalisation act</td>
<td>1998</td>
<td>Law that fixes the criteria for citizenship acquisition maintains the jus sanguinis system and a waiting period of 10 years. Stipulates the prohibition of dual nationality and the functions of the different government levels in the naturalisation process</td>
</tr>
<tr>
<td>Aliens Act Reform</td>
<td>2002</td>
<td>Reduction of immigration for economic purposes to key personnel and highly qualified employees and self-employed persons. No immigrants a part from that can acquire a permanent residence in Austria</td>
</tr>
<tr>
<td>LAW</td>
<td>YEAR</td>
<td>MAIN ELEMENTS INTRODUCED</td>
</tr>
<tr>
<td>-----</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>Passport-Law of the Norddeutsche Bund (Northern German Alliance)</td>
<td>1867</td>
<td>Very liberal laws after the foundation of the German Empire, only restriction is the duty of a valid ID</td>
</tr>
<tr>
<td>World War I (no special law)</td>
<td>After 1914</td>
<td>The war worsens foreigners’ positions and allows easier extradition.</td>
</tr>
<tr>
<td>--</td>
<td>After 1918</td>
<td>Nine decrees by the Prussian Minister of the Interior for an easier extradition of unwanted foreigners, but still legislation is very liberal, oriented at the law from 1867.</td>
</tr>
<tr>
<td>Republic of Weimar</td>
<td>1919</td>
<td>The 1867 laws were mainly taken over; only until 1925 residence permits for foreigner workers were restricted.</td>
</tr>
<tr>
<td>Prussian foreigners and police decree (Ausländerpolizeiverordnung, PrAPVO)</td>
<td>1932</td>
<td>Still liberal and friendly tendencies, although Eastern immigration after the law forces to restrict immigration, introduction of overall residence permits for Foreigners.</td>
</tr>
<tr>
<td>Reichs-Ausländerpolizeiverordnung (APVO)</td>
<td>1938</td>
<td>Is the introduction of the PrAPVO throughout whole Germany PrAPVO was only valid in Prussia. Unemployed workers can be expelled.</td>
</tr>
<tr>
<td>The end of the 2nd World War was the first introduction of international agreements as basis for German foreigner laws.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constitution</td>
<td>1949</td>
<td>Art. 16 / 2 / 2 states that politically persecuted persons have the asylum right, exceeding the Geneva Convention by regarding the asylum right as a fundamental right, that is or can not be politically restricted, meaning in fact, that any asylum seeker has the right for juridical revision of his case.</td>
</tr>
<tr>
<td>New passport law</td>
<td>1952</td>
<td>Duty to have a valid ID with photo when crossing borders.</td>
</tr>
<tr>
<td>European agreement on the regulation of passenger traffic</td>
<td>1957</td>
<td>For residence of less than 3 months, a valid ID is sufficient; passport then is not required (inside EU).</td>
</tr>
<tr>
<td>Foreigner Law (Australgesetz)</td>
<td>1965</td>
<td>The Federal Commission for Foreigners (Administration) can decides upon residence permits and expulsion. Thereafter the residence of the foreigner ‘must not disturb the interests and concerns of Germany’; the paragraph is not further explained. First structural confinement of foreigners’ rights, including the right to expel already accepted asylum seekers (But there have been several constitutional court decisions that have confined the right to expel accepted asylum seekers back to their country of origin). Introduction of custody pending deportation.</td>
</tr>
<tr>
<td>End of guest workers recruitment (Anwerberstop)</td>
<td>1973</td>
<td>Restriction of working permits for foreigners that want to work in Germany for the first time (excluding youths that had moved to Germany before 30. November 1974 (period had been adjusted until the 31. December 1976), and for sectors were there was a certain need for workers)</td>
</tr>
<tr>
<td></td>
<td>1974</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1978</td>
<td>Changing of residence and working permit regulations for foreigners (unlimited residence permit after 5 years of residence and residence right after 8 years of residence; and unlimited special working permit after 8 years of residence) Introduction of a Federal Commissioner for the integration of foreign workers and their families.</td>
</tr>
<tr>
<td>LAW</td>
<td>YEAR</td>
<td>MAIN ELEMENTS INTRODUCED</td>
</tr>
<tr>
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<td>--------------------------</td>
</tr>
<tr>
<td>Foreigner Law (Ausländergesetz)</td>
<td>1979</td>
<td>Replacing of the access ban to the employment market for relatives of foreign workers with a waiting period system.</td>
</tr>
<tr>
<td>Foreigner Law (Ausländergesetz)</td>
<td>1980</td>
<td>Governmental decisions on the continuation of the foreigner policy and elaboration of an integration-concept for foreign workers and their relatives. Exemption of the waiting period system for trainees (of foreign descent), foreign children with a German school degree or a German Training, or graduates of a ten-month career-school-program. Measures for a faster asylum process, denial of working permits for asylum seekers in the first year, visa-duty.</td>
</tr>
<tr>
<td>Foreigner Law (Ausländergesetz)</td>
<td>1981</td>
<td>Codification of the limitation of immigration as one intention of the law. Further regulations for the access of relatives of foreign workers and of immigrants to the employment market, exemptions for German resettlers.</td>
</tr>
<tr>
<td>Law on illegal employment (Gesetz zur Bekämpfung der illegalen Beschäftigung) / New law on the regulation of the asylum process (Gesetz zur Regelung des Asylverfahrens) / Foreigner Law (Ausländergesetz)</td>
<td>1982</td>
<td>Doubling of administrative fines for employers that employ foreign workers without working permit.</td>
</tr>
<tr>
<td>Law on promoting the willingness of foreigners to return</td>
<td>1983</td>
<td>Several regulations, tax-relief and monetary incentives to further the willingness to return.</td>
</tr>
<tr>
<td>Foreigner Law (Ausländergesetz)</td>
<td>1984</td>
<td>Suspension of the waiting-period-system for access to the employment market for asylum seekers from former Eastern Bloc states.</td>
</tr>
<tr>
<td>Foreigner Law (Ausländergesetz)</td>
<td>1986</td>
<td>Foreign workers from non-EG-states already acquire the special working permit if they had had a legal job that required a working permit for at least five years within the last eight years. Flight-passengers from certain problem-states with an intermediate landing in Germany need Transit visas.</td>
</tr>
<tr>
<td></td>
<td>1987</td>
<td>Enforcement of the Bundesrat-decisions on accelerating the asylum process.</td>
</tr>
<tr>
<td>Foreigner Law (Ausländergesetz)</td>
<td>1990</td>
<td>Repeal of the visa-duty for Hungary and the CSSR. EU Dublin-Agreement. EU Schengen Agreement.</td>
</tr>
<tr>
<td>Foreigner Law (Ausländergesetz)</td>
<td>1991</td>
<td>Several new bye-laws and decrees to the foreigners law, slightly changing regulations for working and residence permits and access of different groups.</td>
</tr>
<tr>
<td>Constitution asylum-compromise Foreigner Law (Ausländergesetz)</td>
<td>1993</td>
<td>Changing of Art. 16 and 18 of the Constitution, restricting the right for Asylum and thereafter. Introduction of a law on changing the asylum process and citizenship concerning decrees and bye-laws, and therefore these processes and access to them.</td>
</tr>
<tr>
<td>LAW</td>
<td>YEAR</td>
<td>MAIN ELEMENTS INTRODUCED</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>central foreigner registry law (AZR-Gesetz)</td>
<td>1994</td>
<td>Introduction of a new law on the establishment of a central registry for foreigners.</td>
</tr>
<tr>
<td>Foreigner Law (Ausländergesetz)</td>
<td>1997</td>
<td>Juridical codification of the Federal Commissioner for Foreigners, and bettering the legal status of legal foreigners, and also easing extradition and deportation.</td>
</tr>
<tr>
<td>New law on citizenship</td>
<td>2000</td>
<td>Changes the basis of citizenship from the <em>jus sanguinis principle</em> to <em>jus solis</em> one. The measure cuts the period for naturalisation from 15 to 8 years and allows multi-nationality until 23 years old.</td>
</tr>
<tr>
<td>Green-card agreement</td>
<td>2000</td>
<td>Provides the possibility of issuing working residence permits for up to five year to 10,000 (later 20,000) technology experts. This regulation is the first official immigration recruitment since 1973.</td>
</tr>
<tr>
<td>LAW</td>
<td>YEAR</td>
<td>MAIN ELEMENTS INTRODUCED</td>
</tr>
<tr>
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<td>--------------------------</td>
</tr>
<tr>
<td>Creation of the ONI (National Office of immigration)</td>
<td>1945</td>
<td>Three residency permits created 1, 3 and 10 years; immigration of whole families is favoured in order to populate the country. Access to French citizenship is liberalised.</td>
</tr>
<tr>
<td>Law of 1981</td>
<td>1981</td>
<td>Expulsion can take place only if the foreigner was condemned to a penalty at least equal to one year of imprisonment; guarantees of the procedure concerning without a conviction; foreigners underage can no longer be the subject to expulsion measures, and those which have personal contacts or family in France can be expelled only in the event of top priority, when the situation constitutes a pressing need for the safety of the State or for public safety.</td>
</tr>
<tr>
<td>Law 86-1025 “Loi Pasqua”</td>
<td>1986</td>
<td>Law concerning on the conditions of entry and residency of foreigners in France. It returns to the prefects the right to pronounce the “take back” to the border if the immigrant hasn’t chosen the legal way to get into the country; it restores the mode of expulsion such as it existed before with the law of October 29, 1981; it restricts the list of foreigners who obtain automatically a permit of residence and that of those protected from expulsion measures.</td>
</tr>
<tr>
<td>Law 89-548 “Loi Joxe”</td>
<td>1989</td>
<td>Law relating to the conditions of entry and residencies of foreigners in France, known as “law Joxe”. It ensures protection against the expulsion of the people having personal or family liaisons in France; it founds a preliminary control on the prefectoral decisions of a rejection of residencies in France, which must be subjected to a “commission of stay” that consist of three magistrates, and a jurisdictional recourse against measurements of “take back” to the border.</td>
</tr>
<tr>
<td>Law 93-933 “Loi Méhaingerie”</td>
<td>1993</td>
<td>Law reforming the right of citizenship, and the laws known as “Pasqua laws”, facilitating the identity checks.</td>
</tr>
<tr>
<td>Law 93-1027</td>
<td>1993</td>
<td>Law that limits the conditions of delivery of a residence permit, in particular of a full residence permit, it envisages the rejection and the withdrawal of the foreigner’s residence permit (and with their couple) polygamous and withdrawal of the residence permit delivered with a refugee in certain cases. It limits competencies of the “commission of stay”, which henceforth does not emit any more than one advisory opinion (which is not necessarily binding for the authorities delivering the residence permit), adds new conditions to family regrouping and reinforces expulsion measures. Constitutional Council declares that law contrary to the constitution. A new law is presented in December to reintroduce the provisions censured by the Constitutional Council.</td>
</tr>
<tr>
<td>Bill of immigration</td>
<td>1996</td>
<td>Presentation in the Council of Ministers of a bill carrying various provisions relating to immigration. It reinforced in particular the deportation procedures for illegal migrants, the legal sanction of these people, the capacities of the Criminal Investigation Department near the borders, the capacities of the mayor in the proceedings for granting of the certificates of lodging and the means of solving the administrative status of the non-expellable people who do not have the right get a residence permit.</td>
</tr>
<tr>
<td>Document Type</td>
<td>Year</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>------</td>
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</tr>
<tr>
<td>Law 97-396</td>
<td>1997</td>
<td>Constitutional Council declares two provisions of the bill on immigration (consultation by the police force of the file of the applicants of asylum and the absence of &quot;full&quot; renewal of the chart of 10 year old resident) contrary to the Constitution (Decision n° 97-398 cd. of the 22). 24th, promulgation of the law n° 97-396 bearing various provisions relating to immigration</td>
</tr>
<tr>
<td>Circular to the</td>
<td>1998</td>
<td>Circular to the prefects organising the return of those foreigners without proper papers who have to go back to their country: financing of the return journey by a sum of 6500 F per adult (and 900F per child) and the possibility of “psychological” and social help. The Office of international migrations (OMI) is charged with the implementation.</td>
</tr>
<tr>
<td>Prefects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Law 98-170</td>
<td>1998</td>
<td>Law relating to citizenship: Possibility for the children born in France of foreign parents to request French citizenship at the age of 13 with the authorisation of their parents, and at the age of 16 without any authorisation.</td>
</tr>
<tr>
<td>Law 98-349</td>
<td>1998</td>
<td>Law relating to the entry and residency in France of foreigners and their right to asylum after the constitutional Council (decision n° 98-399 of May 5) declared the law in conformity with the Constitution (only article 13 on the penal immunity of associations assisting foreigners is declared in non-conformity) (OJ n°109 of the 11-12).</td>
</tr>
<tr>
<td>Decree 98-502</td>
<td>1998</td>
<td>- Decree n° 98-502 removing the lodging certificate, founded in 1982; the certificate is replaced by a certificate of reception which is certified either by the town hall, or by the qualified police station or gendarmerie squad. It is a simple formality whose objective is to check the identity of the signatory and the documents in proof of housing designed to accommodate the foreign visitors</td>
</tr>
<tr>
<td>“Loi Sarkozy”</td>
<td>2003</td>
<td>Adoption in the Council of Ministers of a bill relating to the control of immigration and the stay of foreigners in France: it envisages the lengthening of the duration of retention of migrants, the creation of a file of fingerprints on visa applicants, a more strict control of certificates of reception, the reinforcement of the control of certain mixed marriages, a hardening of the conditions of obtaining residence permits and an installation of the “double sentence”.</td>
</tr>
<tr>
<td>LAW</td>
<td>YEAR</td>
<td>MAIN ELEMENTS INTRODUCED</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Commonwealth immigrants Act</td>
<td>1962</td>
<td>Restrict the entrance to the United Kingdom very narrowly. This act was further tightened during the following decades. The aim was to reduce the number of asylum seekers.</td>
</tr>
<tr>
<td>Immigration Act</td>
<td>1987</td>
<td>Aimed on reducing illegal immigration. Under this act carrier companies that brought in the UK passengers without proper/legal documentation were liable to fines.</td>
</tr>
<tr>
<td>Asylum and Immigration appeals Act</td>
<td>1993</td>
<td>Stipulates measures on controlling asylum and immigration: fingerprinting, returning asylum seekers to a third country, curtailing asylum seekers’ rights and increasing the fines to carriers stipulated in 1987 Act</td>
</tr>
<tr>
<td>Asylum and Immigration Act</td>
<td>1996</td>
<td>This Law differentiates between different categories of immigrants and introduces a voucher system. Establishes that is compulsory for employers to check the legal status of their employees Establishes also a list of safe countries making more difficult for nationals of these countries to obtain a legal status in the UK. The law restrict migrants’ access to social support</td>
</tr>
<tr>
<td>Immigration and Asylum Act</td>
<td>1999</td>
<td>These law curtails welfare arrangements for refugees and asylum seekers, tightens border controls and excludes asylum seekers from accessing benefits</td>
</tr>
<tr>
<td>Asylum and Immigration Act</td>
<td>2002</td>
<td>Speeds up the asylum process</td>
</tr>
<tr>
<td>Law</td>
<td>YEAR</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------</td>
<td>------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LO 7/1985</td>
<td>1985</td>
<td>Law on Aliens that stipulates narrow rights for migrants (law based on emigrant tradition)</td>
</tr>
<tr>
<td>LO 4/2000</td>
<td>1999</td>
<td>Law that stipulates the rights of migrants in Spain. It provides right to vote in local elections, equal social rights for immigrants and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spanish citizens (association, syndication, etc.), warrants access to the public welfare system: education, health and special access to justice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and juridical advice.</td>
</tr>
<tr>
<td>LO 8/2000 (reform of 4/2000)</td>
<td></td>
<td>Reform of the law that restricts the rights of the previous law. The law makes a distinction between legal and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>illegal immigrants, and provides rights following these criteria. The law ensures also the Government capability to control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>immigrants movements and if it is considered necessary, to prevent it.</td>
</tr>
<tr>
<td>De facto modification of</td>
<td>2001</td>
<td>Council of ministers decision on restricting migration entailing the legal entrance of migrants with a quota restriction</td>
</tr>
<tr>
<td>the Law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third reform of the law</td>
<td>2003</td>
<td>That law establishes a Legal permit for work necessary to enter to Spain (to achieve this permit is necessary to have a job offer from Spain)</td>
</tr>
<tr>
<td>(in process)</td>
<td></td>
<td>the permit is arranged by the country of origin government which must concrete agreements with Spain. The capability of using the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>municipal census to control the immigrants and the Repatriation of the criminal immigrants</td>
</tr>
</tbody>
</table>
### Table 7: Sweden

<table>
<thead>
<tr>
<th>LAW</th>
<th>YEAR</th>
<th>MAIN ELEMENTS INTRODUCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982:316</td>
<td>1982</td>
<td>Law against circumcision of women</td>
</tr>
<tr>
<td>1986:856</td>
<td>1986</td>
<td>Regulation on State Authority responsibility for immigrants</td>
</tr>
<tr>
<td>1988:895</td>
<td>1988</td>
<td>Regulation instructions for the establishment of Ombudsman against Ethnic Discrimination</td>
</tr>
<tr>
<td>1991:572</td>
<td>1991</td>
<td>Terrorist Law</td>
</tr>
<tr>
<td>1994:985</td>
<td>1994</td>
<td>Regulation on learning the Swedish language</td>
</tr>
<tr>
<td>1994:519</td>
<td>1994</td>
<td>Regulation state allocations for education of Swedish children abroad</td>
</tr>
<tr>
<td>1998:201</td>
<td>1998</td>
<td>Regulation regarding instructions for the State Integration Agency</td>
</tr>
<tr>
<td>1999</td>
<td>1999</td>
<td>Law concerning where to place immigrant employee</td>
</tr>
<tr>
<td>2000:386</td>
<td>2000</td>
<td>Regulation on Schengen information system</td>
</tr>
<tr>
<td>2000:216</td>
<td>2000</td>
<td>Regulation regarding funding of organisations promoting integration</td>
</tr>
<tr>
<td>2000:415</td>
<td>2000</td>
<td>Regulation regarding state allocations to municipalities and provincial administrations for expenditures in connection with the implementation of integration policies</td>
</tr>
<tr>
<td>2001:720</td>
<td>2001</td>
<td>Regulation on treatment of personal issues in relation to foreigners and citizenship</td>
</tr>
<tr>
<td>2001:82</td>
<td>2001</td>
<td>Law on citizenship</td>
</tr>
<tr>
<td>2001:853</td>
<td>2001</td>
<td>Law on costs in connection with medical care</td>
</tr>
</tbody>
</table>
### Table 8: Czech Republic

<table>
<thead>
<tr>
<th>LAW</th>
<th>YEAR</th>
<th>MAIN ELEMENTS INTRODUCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act 68/1965</td>
<td>1965</td>
<td>Communist Act of residence of foreigners in the territory</td>
</tr>
<tr>
<td>Act 123/1992</td>
<td>1992</td>
<td>Liberalisation of the communist Act and openness of easy access to the foreigners to the Czech labour market</td>
</tr>
<tr>
<td>Act 325/1999 Asylum Act</td>
<td>1999</td>
<td>Gives right to asylum seekers to ask for asylum when they are not citizens of a safe country or when they are not entering from a third country that can be considered a safe country.</td>
</tr>
<tr>
<td>Act 326/1999 Residence of Aliens in the Czech Republic</td>
<td>1999</td>
<td>Very influenced by the <em>acquis</em> as the accession countries were obliged to adapt and follow the migration regulation of the EU fully. This law has been amended several times</td>
</tr>
<tr>
<td>Government resolution 55/2003</td>
<td>2003</td>
<td>Active immigration policy based on attracting qualified immigration. It launched programs that fixes the conditions of long term permits acquisition and family reunification for this kind of immigration</td>
</tr>
</tbody>
</table>
1.10 Bibliography

ALCAUD, D. Pitsch, H., Migration policy in France EUROPUB country report


CEREIJO, E., VELÁSQUEZ, J. Los determinantes de las migraciones en la Unión Europea in Revista del colegio de Economistas de Madrid, nº99, Madrid, January 2004


JEDERLUND, L, From immigration policy to integration policy. Swedish Institute. 1998


KLASING, A., REIDEL, T. Migration policy at the national level the case of Germany EUROPUB country report

KOSLOWSKI, R. European migration regimes in Jopke, Ch. (ed.) Challenge to the Nation-state Oxford University Press 1998

KOSTELECKÝ, T., Migration policy in the Czech Republic EUROPUB country report


PARAU, C. Migration policy at national level the case of United Kingdom EUROPUB national UK report

PETERSON, M., Immigration policies in Sweden EUROPUB country report

PRADEL, M., Immigration policy in Spain EUROPUB country report

RODOUSAKIS, N., Migration policy in Austria EUROPUB country report

1.10.1 Legislative background and documents


- Treaty establishing the European Community, Title IV: Visas, asylum, immigration and other policies related to free movement of persons, Articles 61-69

1.10.2 Internet resources

- European Commission: justice and home affairs documentation service


European parliament (freedom, Security and justice area): http://www.europarl.eu.int/comparl/libe/elsj/scoreboard/default_en.htm
Testing the EUROPUB democracy indicators: the case of EU trade policy

Anneke Klasing & Markus Knigge

June 2004

2.1 Introduction

Trade policy is highly useful for testing the EUROPUB European democracy indicators because (1) it is a highly contested policy area and has given rise to considerable public debate and (2) at the global level, the EU is a key player in this policy area. Public contestation of trade policy is most visible in the the anti-globalisation movement, including organisation such as ATTAC. Also, social, environmental and development organisations are highly concerned about trade policy’s negative impacts and try to influence and even impede further trade liberalisation. The public protests and collapse of the WTO negotiations in Seattle gave probably the most visible testimony to civil society groups’ concerns about international trade policy. The discussions and debates crystallise mainly around three partly overlapping issues:

- The social and political implications of trade liberalisation and economic globalisation, such as the threat to national welfare systems;

- The relationship between trade and the environment. This includes conflicts between international environmental agreements and national measures on the one hand and WTO obligations on the other; and

- The effects of trade liberalisation on development of third world countries.
As the EU has powerful influence in the area of trade policy, it is deeply involved in decision-making relating to all of these issues.

EU trade policy is often suspected of being opaque, of lacking participatory elements and thus, even of being illegitimate. This is due to a variety of reasons. First, the tactics of engaging in trade negotiations need - by their very nature - to be developed with a certain degree of secrecy. Furthermore, trade policy-making traditionally relies on mechanisms such as delegation and executive authority, which contribute to blurring the decision-making process. Also, groups gaining from trade policy decisions are generally much broader and more diffuse than groups losing from such decisions. This results in a stronger articulation of the groups negatively affected by trade liberalisation than of those benefiting. This so-called collective action problem leads to an unbalanced representation of interests on trade issues, which do not necessarily represent all social interests.

A number of arguments speak in favour of strengthening participation and transparency in trade decision-making. As mentioned above, trade policy touches upon a range of other policies, such as environmental, health and consumer protection policy. Often these policies follow a different reasoning than trade policy. Nevertheless, or rather precisely for this reason, it is the more important to create opportunities for other policies to voice their interests within trade policy by integrating them into trade policy-making. Trade-related issues often concern society in general and are decisive for the future development of Europe. Therefore, these issues have to be addressed through processes which are transparent, accountable and democratic. Within the European Union, the EU has the exclusive competence for trade policy, and the influence of Member State governments is therefore limited. This means that, although the delegation of trade competencies to the EU has been agreed on by the Member States, the day-to-day decisions on EU trade policy are not necessarily indirectly legitimised through the Member States. This fact stresses the importance of a democratic and accountable EU decision-making.

2.2 Trade policy and transparency

Trade is a policy area that frequently arouses suspicions of illegitimacy as trade policy-making has often given the impression of shutting off, by design, popular input from the process. This is due to its traditional reliance on delegation, executive authority and technicality. The main argument for this isolation is the so called collective action problem. According to trade theory, those who benefit from trade liberalisation are diffuse, and their gains are small, whereas those who lose from trade are concentrated and well organised in small, but effective pressure groups. Given this chronic imbalance between those who benefit from trade protection and those who pay the costs, participation of stakeholder groups may lead to undesired outcomes, not representing the social optimum. In fact, rent seekers were, however, frequently able to take advantage of their close links to trade policy makers and to influence trade policy to their benefit.

Also, there is a perceived trade-off between efficiency and legitimacy, as every enhancement in terms of broader participation and legitimacy would reduce the room for manoeuvre within negotiations and impede the negotiators’ ability to conclude complex international
agreements. However, the involvement of non-governmental actors in the making of trade policy is nothing new. Trade unions, industry associations and business groups have long lobbied on trade policy, at national, European and international level. However, concerns about trade policy making strongly increased in the last decade. Given the shift in focus of international trade policy from traditional trade barriers, namely tariffs and quotas, to new types of non-tariff barriers, trade policy has come under scrutiny from other interest groups. This trend was strengthened by the inclusion of sensitive issue areas, such as services and intellectual property rights, in the WTO, which created the perception of a gradual loss of national sovereignty over issues such as food safety and environmental protection. Moreover, anti-globalisation movement continues to point to a structural imbalance in the world trading system between the industrialised countries and the developing world. As a result, there is not only an increased awareness of the importance of trade rules, but also a louder and stronger demand for a more democratic and transparent trade policy making. These demands are aimed at the national level, the European Union and the WTO.

2.2.1 Trade policy in the EU

In contrast to foreign policy or security policy, external trade policy has been dealt with at the European level since the beginning of the European Community. At its creation in 1957, trade policy was assigned as a Community responsibility. It was recognised that Europe would achieve greater international influence if it were, among others, to negotiate trade deals with one voice. Moreover, a joint external trade policy was seen as prerequisite for a single common market with free movement of goods. As a result, the EU trade policy making process was highly centralised. However, the relationship between the Commission and the Member States has always been a standing debate.

In this regard, it is crucial to differentiate between two different forms of European trade policy making. The 1957 Treaty of Rome formally transferred the authority to negotiate and conclude international agreements on trade in goods from the individual Member States to the collective entity. This is often referred to as “exclusive EU competence”, which prevails in all negotiations on trade in goods and in certain services.

Under the EU trade policy, the Commission elaborates proposals for the initiation and content of international trade negotiations. These proposals are issued to the so-called 133 Committee. Composed of senior civil servants and trade experts from the Member States, as well as Commission representatives, the Committee examines and proposes amendments to Commission proposals on a consensual basis. Then, the Committee submits the proposal to the Committee of Permanent Representatives (COREPER) and subsequently to the General Affairs and External Affairs Council (GAC, GAERC) who deliver the negotiation mandate to the Commission. Legally, this mandate could be adopted by qualified majority. In practice, however, Member States have always managed to reach consensus on a common text at

76 See for example Meunier and Nicholaides (1999 and 2000), Young (2000); Leal-Arcas (2001); Smith (2001); MacLeod et al. (1996).
this stage of the process. During negotiations, the Commission acts on the mandate agreed upon by the Council of Ministers. Depending on the Council mandate, the Commission has an exclusive, highly autonomous authority, and Member States offer little input to discussions and negotiations. At the ratification stage, individual Member States no longer have the power to formally ratify international agreements, but instead delegate this power to the Council of Ministers, which approves or rejects the trade agreement by qualified majority. The European Parliament itself is completely absent in the process, with neither prior nor final say on the making of European trade policy.

In other cases, such as on issues of investment and certain services, trade policy is governed by the regime of “mixed competence”. In contrast to exclusive competence, all issues which fall under shared competence are negotiated by the Commission together with the Member States. Under shared Community competence, the trade policy making procedures work as follows: The negotiation mandate is initiated and elaborated by both the Council (voting unanimously) and the Member States. Although agreeing on the mandate follows a different procedure under shared competence, the proposal for such an issue is still taken to the 133 Committee. During the negotiations, the Commission still represents the Member States. However, Member States are more actively involved in the shared negotiation process than in the case of exclusive competence, and Member States and the Community are required to co-operate closely. Once negotiations are concluded, the resulting agreement is ratified by the EC voting unanimously in the Council, as well as separately by the Member States. Negotiations under mixed competence were frequently believed to complicate both their conclusion and their administration, and the Commission, with help of some Member States, has tried repeatedly to widen the scope of Article 133 TEC. However, others observe that mixed competence has not translated in the fragmentation of unity and loss in power of the European Commission.

2.2.2 Lack of democracy? NGO Criticism

One of the most frequent criticism of EU trade policy is that it has large impacts on other policy areas, such as the environment and consumer policy, but does not sufficiently take such concerns into account. In addition, it is perceived that the EU trade policy process is dominated by trade technocrats from the EU Commission and lacks democratic control. This is partly due to the lack of transparency and participation in trade policy making under both exclusive and mixed competence. Moreover, NGOs complain about the bias towards

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81 Leal Arcas (2001), p. 3.
economic interests, given the closer links and privileged consultation methods between the makers of EU trade policy and groups representing European business.84

At the centre of criticism is the Article 133 Committee, which prepares decisions on both shared and exclusive procedures. In the committee, matters tend to be discussed until a clear consensus or effective majority has been reached, and the Commission tends to follow its advice. Since the Article 133 Committee is an advisory body, no formal votes are recorded and its deliberations are not published.85 As a result, the Article 133 Committee is frequently regarded as a closed shop that considers voices speaking for non-trade-related issues, such as the environment only insufficiently. This view is underpinned by the perception that the 133 Committee is strongly influenced by Commission officials. Due to the Commission’s initiative in drawing up proposals and its greater technical expertise compared with national trade officials, Council representatives on the 133 Committee need to act strongly, usually with a group of countries approaching a qualified majority, in order to significantly change Commission proposals.86 Moreover, it is said that depending on the negotiation and the mandate provided by the Council, the Commission has considerable flexibility in deciding on negotiating tactics.87

Yet another criticism is that the allegedly undemocratic policy making process, and the extreme complexity of decision-making procedures of European Institutions, make EU institutions hard to understand for the citizens.88 The European Parliament – the only body that is directly elected – has limited powers in trade policies, as the European Parliament is not involved at all in the negotiation procedure, neither under exclusive nor shared competence.89 Additionally, national parliaments are not formally consulted on European policies for international trade agreements – they are merely informed. Given the complex technical nature of international trade issues and somewhat varying interests among the EU member states, there has been little formal involvement of national parliaments, despite the effects of international trade agreements on national policy issues.90

In regard to transparency, civil society actors also point to the slow flow of information that comes on a very short notice. In response to criticism, the 133 Committee has introduced a 10-day rule for consultation on proposals relating to the current WTO round. However, NGOs, including the Friends of the Earth, International Co-operation for Development and Solidarity (CITSE), GermanWatch and the WWF, perceive this as inadequate to permit proper consultation within the commission or Member States.91

2.2.3 Efforts to foster transparency in EU Trade Policy Making

87 Ahearn (2002), p. 3.
88 Meunier (2003), p. 2; See also: European Commission (2002)
90 WWF (2003), p. 15.
In order to rein in some of these critics and address its perceived lack of political legitimacy, the Commission has engaged in an ambitious program of consultation with civil society in the specific area of trade. Launched in 1998, the “Trade Dialogue with Civil Society” organised a larger number of general and thematic meetings. In this events on trade issues in Brussels, European Commissioners, senior officials and negotiators come together with representatives of NGOs, research institutes and other civil society groups. Usually there is exchange of views on current trade issues and the civil society groups are able to present to the Commission proposals of their own. However, some observers regard this process as merely a PR effort to convey the message that “civil society” is heard and is from now on included in the process. It is frequently claimed that the actual effect that this dialogue has on policy, if any, is most likely very limited.\footnote{Smith (2001); Meunier (2003), p. 13.}

Yet another channel of participation is the Sustainable Impact Assessments (SIA) Programme, which was launched in 1999 as an effort to better integrate sustainability concerns into trade policy making. Given the broad impacts of trade on environmental and social issues, it was acknowledged that public participation plays a crucial role in SIAs. However, it is again unclear how participation in SIAs feeds into the negotiation process and several NGOs are uncertain as to whether participating in SIAs is an effective and efficient exercise. While SIA processes theoretically might provide a structure and framework for an institutionalised public participation in the trade and sustainability area\footnote{WWF (2002).}, it is still too early to gauge the impacts of participation in SIAs on EU trade policy making.\footnote{Knigge and Leiprand (2003).}

2.2.4 Drivers of Change - Cancún, Enlargement and the EU Constitution

At present, several forces are pushing for reform of the EU trade policy making process.

- First, the anti globalisation movement continues to strongly criticise the international trading structures in place. WTO ministerial conferences are currently not conceivable without the presence of a large number of protesters and critics whose demands for fair trade, benefits sharing and transparency are difficult to be overheard.

- Second, the collapse of the trade negotiations in Cancún led to a period of intense discussion about the ways of international trade negotiations. This includes also the process of EU trade policy making and the relation between the commission and the member states during WTO negotiations.

- Third, the European enlargement in May 2004 will add new national traditions and interests to the existing union. With respect to trade policy, this increased diversity is likely to put a strain on the current institutional mechanism and voting procedures.

- A fourth strong push for reform stems from the debate about the future European constitution. Currently, the final constitutional draft mainly simplifies the Articles on Common Commercial Policy. Competencies mainly stay as before, with a slight shift towards centralisation. Trade in services and commercial aspects of intellectual property rights, as well as all foreign direct
investment, now regularly fall under the exclusive competence of the EU. Suggestions for stronger
democratic control by the European Parliament, for example through consultations in the drafting
process of the mandate, participation in the 133 Trade Committee or consultations before
approval of all trade agreements, were not considered to their full extent. The conclusion of
international trade agreements now requires the consultation of the European Parliament, and the
European Parliament will be immediately and fully informed at all stages of the procedure.

2.3 Trade Policy in the Member States

Although the extensive powers of the EU limit their own flexibility, the Member States are
heavily engaged in trade policy making. This is certainly true for all trade issues negotiated
under shared competence, such as investment and certain services. However, even under
exclusive authority, the Commission does not negotiate in isolation; rather, its mandate is
based on the priorities, knowledge and needs of the EU Member States. Thus, they remain
important actors in making European trade policy.

The member states’ interests and priorities in trade policy making hinge upon a large number
of factors, such as geographic location, natural resources, market size and economic
structure. In addition, different actors, institutions and decision making structures in place
have an impact on the relation towards European trade policy. The following gives a rough
overview of the variety of actors and institutions in place and a brief introduction into some of
the more important trade-related issues currently debated within the European Member
States.

2.3.1 Main actors involved in trade policy making

Trade policy making has sizeable impacts on other issue areas which are of governments’
concern, such as agriculture, consumer policy, the environment, health and development.
Given the distribution of knowledge and power over different ministries, a large number of
governmental institutions and actors have a substantial interest in participating in the policy
making process, where they attempt to ensure more balanced positions that represent a
broader set of societies’ needs and interests. Usually, the economic ministries are the main
governmental institutions involved, while other ministries only participate if their area of
interest is affected. On the national level the economic ministry remains the main
governmental institution in charge of trade policy. For instance, in Austria the most important
governmental actors aside from the Federal Chancellor include the Minister of Economics
and Labour, the Minister of Finance, the Minister of Social Affairs and the Minister of
Agriculture and Forestry. In the Czech Republic, the Ministry of Industry and Trade co-
ordinates bilateral foreign trade policy, as well as relations with the European Community,
the GATT/WTO and other international organisations, while, for example, questions related
to agricultural products are dealt with in cooperation with the Ministry of Agriculture. In Spain
the Ministry of Industry, Tourism in Trade is responsible for trade policies and foreign trade in
co-operation with other ministries, such as the Ministry of Agriculture. In Sweden, the main
government ministries involved are the Ministries of Trade and Economic Affairs, Labour
Affairs, and the Minister for Infrastructural Affairs. Here it might be noted that environmental
concerns in trade policy are only present in relation to labour law. In Germany, the Ministry of
Economics and Labour is in charge of trade policy. However, the involvement of other ministries was demonstrated, for instance, by the presence of a number of ministers, including the German ministers of the Environment, Agriculture and Consumer Policy as well as the German Minister for Development and Economic Co-operation, in Cancún during the 5th WTO Ministerial negotiation. In the United Kingdom, a number of institutions, such as the Department of Trade and Industry, Treasury, Foreign and Commonwealth Office and the Department for Environment, Food and Rural Affairs, are involved in the policy making process. However, the Prime Minister himself is the single most important part of the EU-oriented policy-making process, given his power to override all other actors at any point.

In order to better represent the national economic interest and to effectively influence trade policy on the European level, a number of member states have set up bodies with a central co-ordination function. For example, the Austrian ‘Center 2 – Foreign Economic Policy and European Integration’, situated within the Federal Ministry of Economics and Labour, has this function at the supranational and international level. Other states, such as the Czech Republic, have not set up any central authority of state administration to administer its relations with the organs and institutions of the European Union. Decision making processes have essentially been left to the relevant responsible ministries and other administrative offices, while the foreign affairs ministry has a co-ordinating function in the process. Moreover, the degree of participation of the Czech Republic in EU bodies is closely related to the fact that it has only recently become a member of the European Union.

With respect to democracy, national parliaments play a crucial role in decision making processes. Nevertheless, parliaments tend to be relatively uninvolved in the trade policy making processes on the European and national level. The German parliament, therefore, fears a shift from the legislative to the executive bodies on the national level.95 Parliamentarians see their fears justified because several submissions from the Parliament inter alia had little impact on the government’s position. Some of these proposals were to include the right to food in the preamble of the WTO96, and to include the Singapore issues (investment, competition policy, transparency in government procurement and trade facilitation) on the negotiation agenda only after achieving substantial results in the spirit of a development round97. Moreover, several German Members of Parliament perceive a general atmosphere of secrecy in the Ministries for Economy and Labour. In Sweden, the representatives of parliamentary parties are represented in a so-called EU Board, where government and parliamentarians come together. However, independent of their political convictions, opposition parties maintain that the EU Board is often used by the government to deliberately keep the opposition in the dark regarding potentially difficult and thorny EU issues. Moreover, even national governments do not feel adequately informed and involved. In a leaked internal UK Government report on the Ministerial negotiations in Cancún, frustration was expressed that “[t]he relationship between the Commission and member states came under strain at Cancun. Debate was stifled, and information flows were poor”98.

96 Bundestagsbeschluss (III/7 - 15/1317).
97 Bundestagsbeschluss (III/22 – 15/1317).
98 WWF (2003).
Still governments, represented through the different ministries, are the most powerful actors in national trade policy making, while several institutions and organisations are also involved that do not directly work for or in the name of the state, but nevertheless strongly support the objectives concerning external trade through their work with and for businesses. Several of these have direct or indirect links with governments and are of major importance given their experiences in policy implementation. Examples include foreign trade banks, such as the Banque française du commerce extérieur, and export credit agencies like the German Euler Hermes or the French COFACE (La Compagnie française d’assurances pour le commerce extérieur). In Spain, the Spanish Foreign Trade Institute promotes and facilitates international trade by providing information and legal advise. The variety of further institutions promoting foreign trade range from networks of foreign trade advisors in France to Chambers of Commerce Abroad to German embassies and consulates which support German exporters in the respective countries.

Yet another important player is the broad range of non-governmental actors, such as labour unions, business associations and development and environmental NGOs. The degree of institutionalisation of these groups and their influence on trade policy making differ widely among Member States. This is also true for the presence of institutionalised structures for stakeholder participation in trade policy making. In France, the strongest and loudest lobby groups seek to preserve the status quo in the major economic sectors, namely agriculture, culture and services. Particularly well known is the FNSEA - Fédération Nationale des Syndicats d’Exploitants Agricoles - which is well organised and fights to preserve the high subsidies provided by the French government. German farmers, though not as forceful as their French counterparts, also play an important role in "agri-trade" policy formulation processes on the national level. On the European level, national farming lobby groups combine their voices in the COPA (Comité des Organisations professionnelles agricoles de l'UE). Swedish Industry (SI) as an interest group calls consistently for a removal of barriers to trade, including customs duties on Swedish exports and red tape. In these areas, the differences between the Confederation of Trade Unions and the SI on trade policy tend to be insignificant since primarily Swedish employment is at stake. In most countries, as in Austria or Germany, trade unions are concerned about the effects of trade liberalisation on national employment and social standards. In addition, there is a large variety of organisations lobbying for more development-, socially- or environmentally-friendly trade, such as Fair Trade organisations in Germany, Austria and the UK. Next to social and environmental organisations, business advocacy groups certainly play a major role in influencing trade policy making. For example, in the United Kingdom the International Financial Services, London (IFSL) represent a crucial actor, promoting the further liberalisation of financial services.

### 2.3.2 Member States’ interests and positions in trade policy

Generally speaking, all Member States defend a liberal stance in trade negotiations. In the past, Member States have embarked on a process of economic liberalisation and privatisation due to EU requirements, external pressures and global competition, as well as ineffectiveness under former economic systems. Based on the positive effects of trade liberalisation within the European Union and with its trading partners, governments tend to agree that the reduction of tariffs and other trade barriers is in most areas beneficial to national economies. The differences in economic structure, trading links and market size
among the member states are mainly expressed in the priorities setting. In 2002 during its presidency, Spain for example pushed forward the trade negotiations with Latin America, one of its traditionally most important trade markets.

However, fears persist about trade impacts on economies and areas of national policy. For instance, there is a frequently mentioned fear that foreign companies will buy up industrial branches and brand names in order to move them to third world countries, with their comparatively low labour costs, less powerful trade unions and few environmental regulations. This is also frequently expressed by trade unions trying to maintain national jobs. Other fears include the decline of national public services or the reduction of national health safety and security standards. Against this background, some countries, such as Austria, banned certain agricultural products from their market, which have in the meantime been approved by the European Commission. Also, the Austrian government has ruled out lifting the ban on imports of cattle treated with hormones, regardless of whether the ban is lifted by the EU. Similarly, Sweden applies protectionist measures with regard to alcohol and farm products. In sum, it seems fair to say that all EU Member States try to benefit from trade in terms of economic growth and positive effects on the national labour market, and thus support a process of continuing liberalisation mainly through multilateral negotiations. However, given the fears mentioned above, governments also seek to protect certain sensitive sectors from liberalisation.

Agriculture is one of the most sensitive issues dealt with in European trade policy. Depending on the role of agriculture within Member States’ economies, their positions on the liberalisation of the agriculture market differ slightly. For example, France is the largest agricultural producer in the EU, and the industry’s interests are advanced by a strong farming lobby. With its large part of workers employed in the agricultural sector, Spain benefits strongly from the European Common Agricultural Policy (CAP) and is thus in favour for the current system in place. Also, Sweden takes the view that unless agrarian resources are produced in Europe, there will be a potentially very serious loss of self-subsistence and the vanishing of an agrarian culture with open and well-managed landscapes. Austria, for instance, sees itself committed to negotiations on additional liberalisation efforts in the agricultural sector. However, this is only conditional on other issues, such as the continuation of safeguarding for small family farms, which are the norm in Austria. Yet another proposal was supported by the German Ministry for Development and Economic Co-operation, which publicly demanded a fast and complete phasing out of cotton subsidies in OECD countries and China.

Particularly closely watched by almost all Member States are the negotiations under the General Agreements on Services (GATS), given their potential impacts on sensitive public services such as water, energy, education and health, but also television and tourism. In WTO negotiations, the European Union regularly asks some countries to liberalise certain markets and open up their service sectors to foreign competition. However, at the same time, most European Member States consistently resist a liberalisation of their own markets. Moreover, a broad coalition of actors and institutions, ranging from water and waste services to education, environmental NGOs and Members of Parliament, accuses the GATS of subordinating environmental protection, regional and developmental policy, co-determination and democratic participation, and equal rights for women. Many of these actors are organised in the ‘Stop GATS’ campaign on the international level. However, while there is a relatively loud voice within national social lobbying groups in this matter, the influence on national or European policy making is yet to be seen.
Yet another issue debated in the area of trade is core labour rights and social standards, which are frequently viewed as a means to improve the quality of life for all and contribute to global sustainable development. In this area, the Austrian government is pushing for the social dimension to be included in the WTO negotiations and strongly supports the creation of a Joint ILO/WTO Standing Working Forum to deal with the issue of core labour rights. Also, Germany pushes strongly to integrate further thematic issues into the WTO. In particular, it is attempting to solve potential conflicts between international trade and other societal interests, such as environmental protection, labour standards and rights, health security, and consumer protection, which are all gaining increasing attention in the negotiations. However, a large number of developing countries fear that labour and social rights, once included in the trade agenda, will be used as a new trade barrier. However, improving trade relations with the developing world is a concern shared by many Member States. Currently, international trade policy is frequently seen as a negotiation process through which rich countries force poor countries to open their markets, rather than providing the opportunity to develop their own economies. Developing countries’ economies thus become unsustainable and export-oriented, which leads to environmental destruction and poverty. Against this background, France emphasises co-operation with and help for developing countries, Africa in particular. Issues of particular interest are access to medication and the basis for private sector engagement. The Austrian government continuously demands that developing countries be fully included in the WTO negotiation process. Moreover, the Austrian Ministry of Finance supports the demand by developing countries to simplify and standardise trade and customs practices, as well as better integrate these countries into world trade.

Although trade policy embraces too large a number of issues to be analysed here in greater depth, a number of observations can be made. In general, there is a consensus about liberal trade policy among moderate political parties and Member States’ governments throughout Europe. Given the reliance of several European countries on exports and open markets, many European Member States supported the introduction of the so-called Singapore Issues, namely procurement, investment, competition, and trade facilitation into the current WTO negotiations. In particular, Germany was one of the main driving forces behind the EU demand to include negotiations on investment in the Doha round. With regard to non-governmental actors, most environmental and development organisations are today subscribing to more liberalised trade, emphasising the role of the state and the necessary framework conditions which have to be in place. Compared to the other member states, France seems to face the strongest anti-globalisation movement, rendering it difficult for France to balance public opinion and international trade policy. However, as elsewhere there is a cross-party consensus between the main parties not to change trade policy, but to combat people’s fear of a huge and chaotic world, as expressed in the anti-globalisation movement, through information and education. The fact that trade plays such a decisive role in the development of the state’s economy has - so far - led the Czech Republic to consistently adopt a liberal approach to matters and commit itself to the elimination of tariff and non-tariff barriers, not only on a multilateral basis, as part of GATT or more specifically the WTO, but also on a bilateral basis.
2.4 Bibliography


WWF (World Wide Fund For Nature) 2003: *A League of Gentlemen - Who really runs EU Trade Decision Making?*: WWF

Health

Health Care Policies general report

Martin Peterson

July 2004

BACKGROUND

3.1 Diachronic perspectives on health care policy structures

Health care became an issue with a profound social content only towards the end of the 19th century. The German *Workers’ Sickness Insurance Act* of 1883 provided for access to medical services and income maintenance during illness and all industrial wage earners were statutorily obliged to join. Workers paid 2/3 of their insurance premium and employers 1/3 and both parties were represented proportionately on sickness fund boards (Leichter 1979, pp. 100-124 and above all Richard Freeman 2000, pp. 21-23). Bismarck’s attempt at centralising the administration of the scheme was vehemently resisted by the Social Democrats. Only in 1923 did the Social Democrats accede to federal regulation of sickness insurance contracts but then as a result of negotiations between physicians and funds.

The great mental and socio-cultural transformation occurred among liberal doctors who saw the connection between ill health and social conditions. This category of liberal physicians with a social conscience aimed deliberately at removing fatalism as well as high handed patronising from the realm of medicine. But most important of all they pointed at the causes between health, deprivation and deficient infrastructure.

Health care had cultivated a culture of its own which did not reflect much in the rest of society. At the same time much of the legislative measures taken on medical issues mirrored quite well the state of democracy in the respective nations. Only in the UK there was a Ministry of Health although most of the power and influence regarding the direction of health care remained with municipalities in an untidy mix of private care, philanthropic care and public care. While the privileged layers bought their care and the working classes organised insurance funds, so called Friendly Societies, it was the middle class that got squeezed and had most to gain from the post-war NHS order. So when the highly centralised NHS system was introduced by the Labour government and was enacted by Parliament in 1946 it came as an abrupt change that was welcomed.

In Sweden on the other hand reliance on provincial administrations for the running of health care had historically grown at a gradual pace. The Swedish post-war health care regime was duly based on the provincial administrations (for running of hospital care) in tandem with the Ministry for Social Affairs (overall strategy and clinical research) where the responsible minister during certain periods used to be called Minister of Health. The difference in coming into being for a welfare state health care system could hardly have been greater considering the social democratic aims of these two regimes, the Labour government in Britain and the Social Democrats in Sweden.
From a perspective of democratic accountability requirements the NHS initially tried out two solutions. Two main ideas dominated among policy makers. One was indeed based on a decentralised solution with all responsibility put on the municipalities. The other aimed at nationalising the entire health care system with the entire responsibility resting with the central level of political administration that is the Ministry. The democratic gain in having a democratically elected assembly to be held accountable spoke for the first idea. Many heavy weight institutional interests spoke for at least regional control of health care by two longstanding rivals - the county councils and county boroughs, while a wartime White Paper had aimed at just that.

The ruling Labour party was split on the issue. The municipalities and regional administrations were also for a decentralised solution. However, the municipal handling of health care had traditionally had a low legitimacy with the users, the population at large and not the least among the most powerful group of them all, the physicians. Another potent factor turned out to be the new regard for the state and moves such as nationalisations among the influential and huge British working classes. When the state now proved that it in practice could serve the interests of the working classes there was a rally behind Aneurin Bevin who launched the NHS.

The Minister acquired an advisory agency – The Central Health services Council that rallied the required support from Standard Advisory Committees. In addition the fifteen Regional Hospital Boards concentrated each on a University clinic with medical education and each administered by a Board of Governors. The local health care authorities had in turn special Health Committees running more elementary health care issues such as vaccination, maternity and child care issues. At the same time voluntary hospitals were also incorporated into the NHS system. Discussions on the organisation of the NHS were however perennial and in 1973 came the first attempt at an overhauling of it through the National Health Reorganisation Act, which aimed at more of efficiency and organisational democracy.

Around two hundred Community Health Councils were instituted in order to democratise the system. The intention implied was both increased efficiency and user influence. Only a couple of years later a new government committee set out to elaborate a new consultative document, Patients First, which was presented in 1979. Its aim was to slim bureaucracy and to be sensitive to user demands. The paradigmatic change of regime in 1980 – the transition from a Keynesian world to a neo-liberal one – finally put an end to the unanimity around NHS from the consensus years. The resulting Griffiths report suggested a new managerialism, which meant new criteria for running the NHS what with the language and organisational structures.

The Consultative document introduced by Thatcher in 1989 – The White Paper called Working for Patients – was largely implemented during the 1990s under the label Internal Market. The demand for health care was then separated from the performance. The order of care did not go anymore with the handling of care. Local health care authorities became ordering agencies while the hospitals were transformed into self-managing Trusts.

Then during the 1990s the NHS was centralised through the Ministry that took a firmer hold of the organisation while a decentralisation catered to the users, who got more actual power. At the same time efficiency models fetched from private sector models were implemented.
3.1.1 Examples of application of policy processes

The construction of NHS has implied that the claim for accountability is very evident and visible, but in reality is hard to effectuate since in the end it is the Minister who is ultimately responsible and who would then have to go. However, the loud and clear claim for accountability in the UK renders a conflict orientated perspective to the NHS and British health care system. In the Swedish case on the contrary a harmony-orientated perspective prevails since any claim for accountability in the Swedish health care system remains unclear to a degree of invisibility since the relevant agencies and associations speaking for users and the general public are subordinate in the decision-making process. The same goes for France, where the political culture resembles a harmony-orientated perspective and the state is openly flaunting a top-down strategy on policy making. In the French Health Care policy report it is suggested “in order to avoid strikes and other sanctioning measures from disappointed interest groups, the French state subsidises two-thirds of the interest groups to ensure their co-operation through the logic of an ideology of national solidarity”. Apart from smacking of an appeal to the old Chapelier laws of 1791 it demonstrates the hierarchical attitude to policy making formed by the very old raison d’état orientation of French politics. The Government has the agenda setting prerogative and every opportunity to influence any parliamentary debate on the topic. The comprehensive state apparatus of expert technocrats initiates and formulates new policies in secret as a service to the executive branch whereupon parliament and interest groups are faced with what amounts to a fait accompli.

The implementation of the policy process is controlled by a central agency, the Direction Générale de la Santé (DGS) that consists of a large staff from a number of different but relevant national institutions such as DDASS, DRASS, health insurance companies, and health sector user associations. The DGS covers the running activities by analysing needs, conceiving new policies and monitoring the implementation and evaluation of these policies. Since user interests are represented on DGS they are directly involved as strictly non-confrontational stakeholders. Another agency, the Haut Comité de la santé publique (HCSP) monitors the mechanics to find and to define public health objectives. The HCSP provides direct assistance in problem solving to the Minister of Health.

In Sweden the Minister is similarly provided assistance while the Ministerial position is never questioned however devoid of proper policy the Minister may be. Even a Minister, whose knowledge of the sector may be rudimentary and scant, is by definition above any questioning and listened to in awe by the staff of the Ministry and relevant agencies. Such observations have been pointed out during interviews even by leading health care policy makers in the Swedish system. Criticism of a Minister may be massive from the opposition and various parts of the media but this will only have gradual and often much protracted effects. To underline that however overarching the role of the Minister accountability does not rest with an individual Minister but with a regime including a whole range of civil servants.

In the British system the Minister of Health is the only one to be held accountable before parliament if anything in the NHS goes wrong. But even if the relevant Minister is exposed to a barrage of difficult questions in the House of Commons this does not bring patients any short-term comfort at the grassroots level. Only in a long-term perspective may users experience any qualitative change. The British system is at this juncture exposed to several decisive questions regarding health care policy for the immediate future. During the next election campaign the leading parties have already announced that they will slug it out over
this issue, where choice is the big buzzword and patient empowerment an old/new ideological tool of the left. The citizen user should have power or be empowered to confront state or any other bureaucracies. The Labour health secretary pledged to stand by this old doctrine of the left.

On June 23 2004 the Tory opposition presented its major plan for the NHS, which emphasised patient choice as its piece de resistance. But the Tories would sweep away far more health service targets than Labour is prepared to do, including the controversial hospital star rating system and rather let hospitals themselves set their own targets to allow doctors and consultants to focus on their patients rather than bureaucracy. Labour is similarly committed to choice but insists that it would only work on condition that NHS capacity is expanded rather leaving it, as the Tories pledge, to extend the powers of foundations hospitals to do their own borrowing and investing in increased capacity. Both speak for a patient centred health service but Tories advocate a system of flexibility, whereas Labour is more inclined towards at least a degree of central control in balance with patient empowerment.

On June 24 2004 the health secretary of the incumbent Labour government presented a five-year improvement plan for the NHS much catering to the idea of patient choice. Some other notable features concerned giving more weight to chronic diseases such as diabetes, asthma and epilepsy; by 2008 time on the waiting list should be cut to 18 weeks as the upper limit, ensuring an average wait of around nine to ten weeks; by 2008 patients would also be offered a choice to be treated at any NHS or private hospital meeting NHS standards and providing care at the NHS tariff price; an increased role of the private sector will provide up to 15% of operations and increased levels of diagnostic services; fatal diseases will be cut further by 20-40% while cancer death rates have fallen by more than 10% since 1997 and cardiovascular death rates are down by more than 23%.

These tendencies would less be affected by political regime, although some effects may follow, than by overall symptoms. Changed habits such as reduced consumption of tobacco, increased rates of exercise whether as intense workouts or just walks and swims, an awareness of health diets and the steep rise in consumption of anti-depressants have all contributed to a changed picture of health risks. Colon cancer and diabetes due to obesity represent the overshadowing new risk syndromes, just as lung cancer among women and new diagnoses of burnt out cases leading to fatal depressions. If the vast new supply of anti-depressants have prevented a rise in suicides and possibly a major societal disaster they have also in too many cases brought about the reverse. Patients may easily be wrongly diagnosed. The sensitivity of the situation makes it all too often extremely hard to judge the state of an individual correctly. It takes exceptional skill to do that. Hence the present NHS goal is to reduce suicides by 20% as a first step. Nobody appears to believe this to stop depression from becoming a dangerously widespread disease and a number one menace to civilisation (see the WHO prognosis saying that mental health disorders will become the second most common cause of death and disability by 2020 quoted in F. Furedi (2004) Therapy Culture. Cultivating vulnerability in an uncertain age. London, Routledge).

Why one may ask is there not an immediate goal to stop suicides 100% and why are there no discussions why the state of society and culture have brought about such explosive increase in mental health disorders not the least among an alarmingly large percentage of young people, who cannot make it or function without anti-depressants? Such pertinent questions are never raised in NHS improvement plans or any other national health care plan.
The same goes for other equally sinister issues such as the frequency of and the reasons for MRSA and anti-biotic resistant bugs, which constitute real threats and have caused much fatal havoc and destruction across Europe during the past seven to ten years.

Anti-biotic resistance will require a coordinated European strategy. Everyone will have to share a common approach since if one fails the battle against resistant bugs is lost and costs in both lives and the building up of new health care systems will spiral away. The costs to fight MRSA are similarly intimidating. It takes vastly increased and skilled laboratory capacity into responsibility to trace the fatal hospital bug and comprehensive hygienic regimes in order to come to grips with MRSA. Trust and system credibility are at stake. For instance the University clinic Sahlgren in Gothenburg mobilised its entire staff in an intense campaign period some years ago in order to get rid of MRSA. It is now putting pressure on corresponding clinics in Sweden and elsewhere to forestall any dramatic return of MRSA, which is on the rapid increase in the Stockholm region.

The more than 600% increase of MRSA occurrences in the UK during the past decade is causing much of acrimonious political mudslinging. The aged mother-in-law of the Tory leader died during the spring of 2004 where MRSA appeared to be the main culprit. The Tories were not late to make political capital of it. The most recent report says that there are 100 000 new cases of MRSA in the UK each year of which 5000 are fatal. One cause was regarded to be the urge to speed up processes and cut waiting lists, which only resulted in crowded waiting rooms and corridors where the infectious bug spread the more rapidly. The remedy for all political parties would be Choice – in the case of the Tories Choice as a big idea, whereas Labour backbenchers would opt for Choice as a little idea and the Labour government Choice as a middle-sized idea. The Tories want to introduce Choice as a matter of ideological principle in order to provide competition between hospitals that will not only eradicate waiting lists but also other evils such as MRSA. The Labour government sees Choice as an important element in alleviating system pressures from bulging from area to area. The Health Secretary John Reid has announced that MRSA has to be met with strict application of hygienic measures plus the calling in of foreign experts with first hand recent experience of its eradication.

In France the number of MRSA casualties are proportionately less but on the rise. In combination with the large amount of diseased during the extraordinary heat wave during the summer of 2003 many question-marks appeared around the “best overall health care system” as the WHO ranked it in 2000. The Netherlands is the one nation where MRSA seems to have been contained due to a well-balanced and controlled health care system. Certain hospital regimes in other nations could provide expertise to MRSA troubled health care systems. This could be a practical start at the European level of both finding common interests between nations and helping each other out with the aid of a division of labour.

In our interviews most policy-makers and medical experts played down the class issue as a determinant of health. Social justice is seen as so embedded in most societal systems especially in one where the democratic aspect is considered to be overriding. For any welfare state to be credible everyone regardless of social background should by definition have the same access to top quality health care. Even when it comes to legal decisions in case of for instance wrong treatment or flawed diagnosis no class distinctions were made. It is, however, apparently a slightly different matter with ethnic backgrounds as determinants.
The more remarkable it is to see the British health secretary expressly tackle the health gap between rich and poor. Two major killers, cancer and heart disease, are still much more frequent among the working classes in the UK than among the middle classes where they tend to be falling to quite some extent. The middle classes are not exposed to conditions, which cause the working classes to smoke more (reducing life expectancy by 7 years), have a less healthy diet and not so readily think of consulting the doctors. Often it is a matter of attitude to pain (in the case of cancer), which the working classes tend to endure longer often until it is too late, before they consult a doctor. Obesity is also hitting the poorer classes due more to disharmonious conditions.

Health care spending must be much better targeted in order to alleviate this class determined health gap. Interestingly enough it is only Dr John Reid, the UK health secretary, who is making these clear inferences. He is also making them now at a time when the all too obvious class aspect of the state of health for some time has been slipping out of the hands of the current Labour regime as a potent political card. It is to be noted that no similar arguments are put forward by social democratic regimes in the rest of the EU, where health care has ceased to be a class issue in the public rhetoric. It can equally well be inferred that those systems (notably the British NHS and the Swedish one), which are driven by principles of equality and rationality also are the very ones most likely to be undermined by the failure to realise them (R. Freeman (2000) p. 49).

The superstructure of these systems remains but the rules have changed. Much of the framework and administrative infrastructure have become fictitious while the new discourses of purchases, providers and contracts, of commissioning and service agreements have taken their place. In Freeman’s benevolent interpretation this describes a transition from a paternalist, professional ethos to a technocratic, managerial one (R. Freeman ibid). The transition could also be seen as the break-up from a hemmed in hospital world to an institution more open to public accountability. Such a process would facilitate any move towards a European health care culture.

### 3.1.2 Current General Issues

In any report on health care policy there is a framework consisting of four cornerstone questions: What is done, How is it done, What is the efficiency and What is the quality?

Four perspectives on system rule should follow: 1) The economic perspective; 2) the research and quality perspective; 3) the operational perspective; and 4) the personnel perspective. The economic perspective obviously has to do with efficiency and use of resources. The research and development (R&D) perspective is the main component of quality criteria. The activity and operational perspective represents the flow of treatments and the personnel perspective is once again linked to efficiency regarding those employed in the medical and health care system as well as demand on their respective competences.

All over the EU and indeed the OECD area the spiralling costs in the health care domain represent another capital issue. Since the 1970s health care costs have increased more than in any other sector irrespective of policy (private or public) regime. Attempts to contain costs have invariably failed. Cost cutting in one end has only entailed other expenses since demand for health care has increased incrementally with the sense of better health as not only a democratic right but as an aspect of welfare and well-being. In short the incentives
that encourage medical over-consumption have not been removed. The growing volumes of demand cannot be handled by some technical device or system change. On the other hand there seems to be an agreement that an application of co-ordinated IT systems may substantially rationalise and reduce costs.

However, the hospital world is still following archaic patterns in most places. Through the gains in sight by way of avoiding for instance medication errors, which take several thousand lives annually, IT could provide unified cost cutting journal and laboratory systems through computerised systems including electronic patient cards. Both expenditures and health among patients would improve since accuracy of doses and a check on the overall drug picture among patients would become precise and prevent waste of a risky and costly kind. Electronic patient records would also facilitate an integration of medical services between primary care GPs and hospital specialists.

So far the California Kaiser system has achieved a greater degree of integration than the NHS with the same resources but without the proper aid of IT. This means treating patients at the most cost-effective level of care, reducing substantially the expensive time in hospital. The admittance rate is higher in NHS and once there, patients tend to spend longer sequences of time in hospital beds, whereas in Kaiser the patient’s journey through hospital up to discharge is well planned in advance. Hence Kaiser has appealed to a number of policy makers in EU nations but it has stumbled on the opinion of physicians who have rejected the Kaiser form of managed care, which has cut into both their wallets and their independence. So this much spoken of managed care revolution appears to be a dud already at its inception.

The most apparent obstacle remains the archaic patterns of the European hospital world, at least in most places, where each fiefdom is holding tight to its prerogatives. Thus one profiled clinic will inevitably refuse to share journals or other computerised facilities with others whatever gains may be made. There is usually no cohesive power yet to enforce a common communication system since there are no obvious common platforms from which to operate. The process is however slowly edging ahead in bits and pieces where the space of adjacent systems hooks into each other. In due time this process is forecasted to be speeded up since national policy makers announce heavy investments (1.8 billion euros in Germany alone) to develop electronic cards for each patient from 2006. In France the Minister of Health will computerise health records in order to reduce consumption of health care and excessive pill popping by demanding patients.

So far little has been achieved in terms of rationalisations to come to grips with spiralling costs in spite of the introduction of competitive elements in the combined supply of both private and public health care. The result has only been sharply increased volumes of demand. At the same time it is undeniable that some private organisations have managed to curtail costs by sticking to regular shift work schemes whereas overtime charges are set in system by physicians at public hospitals, who use their thus acquired leisure time to private earnings at a reception of their own. Reforms of the supply side in terms of prospective payment systems for hospital service are introduced in Sweden and on their way into the UK and Germany as well. But the German Medical Association and a health-policy think-tank in the UK paint doomsday for hospitals. Hence in Germany the government is promoting care programmes where primary and hospital sectors are well integrated into new medical groups.
However, there are vast demographic differences between nations. Against this framework a geographic & demographic test matrix may be applied to these four perspectives in order to reveal pertinent contrasts between nations and regions within nations. It will then rapidly become evident that the four perspectives apply to a geographic & demographic area that comprises Sweden, Norway, Finland, which in this respect are on the same level as the Archangel’s region and Siberia. This means that the distance and transport issues put challenges to other issues pertaining to concentration of competence. Long distance transports constitute a persistent problem in the Nordic ambit. A number of structural changes have taken place during the past few years.

In early 2004 several political decisions were taken with far reaching consequences. This was largely a result of a system failure that amounted to a major cost derailment. In two metropolitan Swedish regions, the Stockholm Region and the Skåne Region, the idea was to combine public health care supply with private options. However, the volume increased exponentially since private health care seemed to be regarded as a supplement on top of the regular public health care output. In other words the demand for health care appears limitless. Alternative supplies inflated volumes rather than discharge public health care of certain demand. This was a result that was as unintended as it was unanticipated.

In the Västra Götaland Region (VGR) on the other hand the derailment was contained in time. Hence the overall health care deficit rate is only one third of elsewhere in Sweden. Still there has been uproar among the population everywhere with mass demonstrations against the closing down of hospital clinics and local health centres. Heads of local clinics have turned to torch bearers by appealing in front of TV cameras that so and so many deaths are going to be caused by the much longer transport of patients to more centralised clinics. Top health care technocrats branded such performances cheap populist shots. A comprehensive political debate on future orientations took place in the regional parliament where those political parties who had allied behind structural reforms – the Social Democrats, the Liberals and the Centre party – spoke a completely different language than those parties – the Conservatives, the Christian Democrats, the Leftists and the Greens – who spoke against reforms. A vocal newly formed regional party calling itself the Health Care Party joined the three opposing parties.

The tone and content of discourse could not have contrasted more. It was as if two entirely different reality perceptions presented themselves. The majority reform line represented cool rationalism with no emotional overtones or appeals to human conditions. The minority opposition, which contained strange bedfellows using exactly the same discourse and even vocabulary, spoke of the loss of security and identity of the gravest kind for those groups and layers of the population most in need of local health care institutions. The old, the debilitated and the handicapped and in short everybody else needed a health care institution around the corner in order to feel safe and with retained dignified identity in the welfare state where taxes to the health care system were much higher than anywhere else.

It would be morally indefensible to force people to depend on long difficult transports, which on top of it would be expensive. Health care, the argument ran, is a matter of trust. When trust is gone democracy is in danger since an identity-less and distrustful people would be seized by anomie and could go in any existential direction. For instance, sit-in demonstrators have occupied the district health care centres in the immigrant dense and segregated suburbs. This mobilisation from below has had a notable political impact on public opinion but left the reformers and the technocrats in charge overwhelmingly cool. The reformers on
the other hand argue that with structural rationalizations now including the closing down of hospitals and health care centres, which they admit may hit certain groups, an improved health care system may well see the light of day in some years time.

3.2 **Health care ideology**

The central ideological approach to health care everywhere in Europe remains *égalité* and *liberté* for users of the health system with *fraternité* representing the democratic co-decision-making component still being far away. The medical and health care sector has been subjected to constant restructuring since the inception of modernity. Among factors of change there are on the one side economic, epidemiological and demographic issues and on the other medical and technological development, i.e. R&D, with the hiring and firing of competent personnel swivelling in between. Those set of factors, which cause palpable change into new directions, do all pertain to medical and technological development. The other factors such as economic ones have only marginal effects. Hence the public sphere debate on health care ought to take its point of departure in the classical dichotomy between an application of logical empirical methods to bio-medical phenomena and the holistic approach called for by Ivan Illitch et al. some forty years ago recognising that ill health in our time is more complex and border transcending than previously.

Another basic problem concerns openness regarding what is known and certainty about scientific results, which hardly ever are made available to public debate. A prominent teacher at Harvard Medical School put the issue succinctly when he stated that

“teachers in medicine know that they always are lying half of the time but an even bigger problem is that they never really know which half may be true and which false.” Patients need to be reassured that a diagnosis is meticulously correct. Uncertainty undermines the state of health. Hence bio-medical specialisation to a small field has taken hold of health care in order to reinforce certainty with the consequence that the border transcending treatments of more complex cases that supersede the competence of GPs are limited to some advanced clinics where specialists know enough of each others fields to be in constant dialogue if need be.

In the main it is within the bio-medical infrastructure that explanations of disease and ill health are sought. This has been dependent on significant development of knowledge during the last few decades with regard to the basic biological functions such as genetics and cells.

The other syndrome concerns stress, which constitutes the strongest symptom of ill health today. Little is known about the overarching steering of biological functions that in turn affects stress. It is well known from recent estimates by the WHO that up to ten percent of the population in the industrialized West suffer from debilitating depressions. Physiological processes must interact with mental processes in order to retain homeostasis. Otherwise the system is easily disrupted and a syndrome produced by diverse nocuous agents results in stress, which was discovered and described already in 1936 by the Hungarian born medical scholar Hans Selye.

In 1946 the WHO redefined health as a “state of complete physical, mental and social well-being, not merely the absence of disease or infirmity”. This definition struck a note for what
would follow. The feel good factor that has dictated much of the postwar period mentality
developed into the experience industry with post-modernism, IT and virtual reality as back
up. However half a century after this WHO definition of health it published a report saying
that one in four experience mental illness at some point in their lives. Moreover it is
estimated that by 2020 mental health disorders will become the second most common cause
of death and disability. Over 90% of British school children suffer from school-related stress
according to one survey published in September 2002.

Still it is a riddle why the Swedish population of all should be the one worst hit by stress. 20
percent of the active population are early retired or long term burnt out cases. The Swedish
situation has been notorious since 1997. It is not a new phenomenon. A similar situation
arose during the 1980s and on several occasions previous to that. For instance from the
mid-1980s there were as many women as there were men illness absentees in spite of
female presence on the labour market only reached 2/3 of male presence. In the year 2001
the number of female sickness absentees were twice as many as the male ones. Among
women the age group 18-34 is the one hit the worst. Several new early retirement categories
were added where the female share also was salient.

The difference between the present situation and the one some decades ago is that there
are a large number of unanticipated and unprovoked burnt out cases, which have
punctuated the lives and at least the working lives of sizable populations. The situation is
grace everywhere but the Swedish situation is far worse than anywhere else. There are
general structural explanations but they do not account for the specific national differences,
the causes of which have to be sought in culturally generated factors. How come that the
orderly welfare state is so hit by what seems like a post-industrial welfare disease? Or is the
specific welfare system the problem? Well, clearly not in itself since the welfare state was
dramatically curtailed in its most essential functions from the early 1990s. Rather it was the
dwindling trust in a credible welfare state that triggered an extra stress function. The total
costs of early retirement or long term sickness leave due to burnt out cases were around 14
billion euros in 2002 to be compared with the 16 billion euros for the entire health care
expenditures. But only burnt out cases represented a three times larger cost than defence
and twelve times larger cost than culture.

Even though in a statistical sense the main infra-structure of social welfare policies were
intact the actual frame of the social construction fell apart like a house of cards since a
general indifference followed by inactivity spread throughout the whole fabric of social
institutions. With cutting downs in essential protective measures a lack of both morale and
trust spread like wildfire. Social rights began to falter and become uneven and erratic.
Dedicated social agents could still maintain an apparent standard and keep hope alive but
such gallant idealism and bravery became by necessity increasingly selective. The stark
facts of severely damaged people are still there. These are burnt out and bullied people, who
in only highly exceptional cases may rise out of their stigma that after some time is
aggravated by their becoming increasingly self-imposed.

In Sweden the burnt out cases are primarily found in a relatively large but young segment of
the population such as women between 25 and 45. This is serious since when these
strategic age groups have lost faith in the workings of society and regard themselves as
perpetually lost then much important legitimacy goes down the drain. Then democracy also
becomes severely damaged. Instead words such as syndrome, stress, trauma, trust and
self-esteem have increased in usage several thousand times over during the past two
decades. The individual becomes more occupied and obsessed with how he may fit in than he asks what he can do for others. He is faced with a string of new diseases he has never before heard of such as Post-Traumatic stress disorder. In the UK alone at least four million people are living with severe disorders.

In France a discussion on medical philosophy or existential medicine has got its expression in a major encyclopaedic work (Dictionnaire de la Pensée Médicale (2004) ed. D. Lecourt, PUF) where western medicine today is said to suffer its worst crisis during its short history. Shaken by a triumphant biology that is often incapable of steering the consequences of major progress that it has accomplished especially during the second half of the 20th century and accused of being directly responsible for the irresistible inflation in dependencies on medicine for well being at the same time as this condemned medicine is able to provide results. But more and more frequently medicine is dragged into court since mounting numbers of patients and their families claim their flawed if not always fatal consequences.

But drugs have become the often too quick answer to inherently impossible questions to solve through therapy and at the end of life. It may also hasten the process of emerging rights for patients and the improvement of the therapeutic relation that now is threatened to become another piece of merchandise. However, in France where the principles inherent in public health doctrines – precaution and zero risk – are considered to be dangerously in fashion the family doctor has it seems definitely disappeared. Public hospital attendants (doctors and nurses) and administrators no longer know exactly what their mission is. And in general all symptoms are there to predict that the foundations of the current system of distribution of health care will collapse unless of course it is decided to provide well-trained and well-paid nurses and physicians.

Who remembers today when psychiatry and insanity were the subjects of debate? Today psychiatrists are seen as tired and the consumption of pharmaceuticals among all social categories is much higher than ever, especially in France and Japan where consumption is more than 30 percent higher than in Germany that comes next in rank. The psychiatry reform of the early 1990s entailed dreadful disasters. Psychotic people remitted to normal life and living would seldom be controlled as to quantity and variety of medicines they took to stay upright. Some could make do and make good as a result. The majority would be called upon to testify about their symptoms. Some never got near any adequate treatment or were even listened too. Some committed horrific unprovoked murders steered by voices from somewhere in a psychotic mind. This has become the new post-modern face of a society awash with medical drugs and pharmaceuticals.

3.2.1 Health care legislation

The basic framework law regarding health care was enacted in 1982 with amendments in 1985, 1992 and 1998. The ambition of this law was to render municipalities and provincial assemblies substantial autonomy. At the same time it is stressed in this law that the right to safety in health care and the right to care on equal conditions require the state to maintain an overarching overview concerning operational activities as well as those persons working in health and medical care. The state has also regarded it important to work out and elaborate authorisation rules for health and medical personnel. Due to care quality requirements and the safety of the individual further laws have been instituted implying also more detailed rules and regulations the more important of which are the law on patient journals (1985:562), the

Care and treatment shall to the greatest extent be designed and carried out in consultation with the patient according to the legal amendment (1998:1659) that became valid from the 1st of January in 1999. Every patient is entitled to individually adjusted information regarding his/her state of health from a medical point of view and alternative forms of treatment. In case the patient cannot receive information it may be given to any close relative or friend, who on the other hand has no influence on decisions regarding care and treatment. These specified regulations are relevant to both public and private care suppliers. This has caused the volume inflation in certain provinces and regions during the past decade.

Health care technocrats with high medical positions are complaining that a rationalisation of the health care sector is hampered by the double control of the sector. One set of decision-makers emanate from the county council politicians and the new regional assemblies, which have proven to apply the whole spectrum of rational to populist discourse. The other emanates from the state that controls research supply and keeps an eye on the county councillors and regions, which have the essential budget responsibility for health care expenses. 90 percent of the county and regional budget is allocated to health issues. However, in order to design a rationally functioning model answering to contemporary demand and satisfying the difficult aspect of making priorities as much as possible only one decision-maker was relevant, according to the technocratic medical experts. In this way resources can be concentrated to places where they are most needed, more relevant and where research has reached a more advanced degree of cross-fertilization. This may also become a putative argument for Europeanising health care specialisation in accordance with clinical specialisation and the state of general research.

There are 18 county councils apart from the few but significant regional experiments in Sweden. The county council hospitals are obligated to carry out research but the university clinics are then charged with those expenses. Those who are thus employed in the health care sector have essentially two principals, one state principal through the universities and one county council or regional principal. This is not unique for Sweden but a fairly common phenomenon across Europe. Many EU nations have been hit by similar system shortcomings as syndromes. In the UK for instance the NHS had become burdened with system imbalance that developed during the Thatcher years.

The combination of highly specialised health care and clinical research appears to require exceptional decision-making power on the part of those in charge. The state through university clinics and the county councils have fundamentally different management and economic systems and even the incentives to pursue highly specialised care tend to differ. Hence two principals can never fulfil the visions and goals they are set to realize together. If one falters, normally the county council, the other is equally affected. However at the VGR regional level some new steps forward have been taken. At the same time as rationalisations have to be carried out with certain concentration of specialised care to a few hospital clinics the drain-pipe model has to be overcome.

Such things as horizontal priorities simply do not exist within medical society. In the region so far sector councils are handling priorities in accordance with field expertise, which easily assume the drain-pipe model. But if the health care sector should live up to its commitment
to patient participation not to speak of CSO participation a horizontal model is urgent in order to raise trust, which now is dangerously low among the general public. A European Observatory poll during the autumn of 2003 showed that of all EU nations the health care sector topped the concerns of Swedes far outdistancing unemployment, education and crime. It was important elsewhere too but nowhere near so. But maybe paradoxically the preconditions for a horizontal model regarding priorities would be only one principal and the preferably the structure of the university clinics. There is an overwhelming unity among those in charge of university hospital that highly specialised cared should be pursued by them with the new regional formations as a basis but under the state as principal.

Where then is user or patient interest entering the fray? In the Swedish context there exists since 1980 an Agency responsible for health and medical care. This fulfils the role of a court of appeal on the part of the patients when someone files a complaint about wrong and harmful treatment. It has been less common that this “court” – one chairman, who must have been a judge, and eight members appointed by the government – will try to redress a case by paying remunerations. Recently a case with far reaching consequences for the European context took place at the university clinic in Gothenburg. A patient suffered from rheumatic problems, which would not go away with any treatment. She demanded an operation but the university clinic said no since it would take unreasonably long to plan it.

She then turned to a clinic in Germany, where she got her operation but at a cost of some 75 000 euros. Since she did not have the money she demanded that the Swedish authorities, which had denied her the right of treatment, should foot the bill. The case went to the highest legal instance in Sweden, the supreme administrative court, where the plaintiff won. Those in charge at the Gothenburg university clinic claimed that all the facts had never come out into the public sphere. The clinic had never denied her the right of operation. The waiting list was there and so were the risks involved. There were apparent dangers that secondary effects of a serious nature might ensue. It would be a greater risk to operate than not do it, according to those who took the decision to say no. But the media had it that the legal community had run over the medical one, which implied a biased interpretation of the medical side of the affair.

This affair may be seen as the introduction of a European health care concept. Considering the strong identification on the part of the Swedes with their own system of welfare, wherein both social policies and health care policies are included, the inception of a Europe wide health care must then be regarded as very notable. The process was on the other hand started by a biased and in the end deficient media reporting, which only demonstrates the difficulties to bring the more subtle nuances to the fore in a matter that involves all the aspects of a burgeoning European sector culture such as the health care one. The needs to create similar treatment standards both with regard to strict hospital care and via pharmaceuticals have become increasingly evident when Europeans move across borders to a much greater extent.

Obviously there are many more elements speaking for the European health care approach, which will be discussed further on. Suffice it to add here a further complication developed in one critical study of the impact of the EU on social policies in member nations. The study written by Paul Pierson and Stephan Liebfried argued that the successive expansion of influence on the part of the EU on welfare policies during the 1990s had in effect decreased the autonomy of member nations in the social field. This highly critical study maintains that a
common social policy has increased adjustment to rather than countering the effects of the market economy.

This literal undermining of national welfare policy sovereignty is based on the impossibility to limit social rights to citizens of one nation only. On the contrary social rights must be extended to anyone meeting the demands on social allowances. Economic and social favours and advantages must no longer be confined within the borders of a nation and both migrant labour and their professional qualifications cannot be checked at the border anymore. This whole discussion has acquired a new content and taken unexpected twists of vehemence some weeks before the accession states are about to join the EU. The Pierson & Liebfried critique, which was very recently regarded very highly by national welfare state policy advocates, has suddenly turned into a widely rejected state nationalism and chauvenism.

The EU has influenced the integration of social policy in three aspects: one indirect referring to adjustment measures by governments and economic actors with no direct bearing on welfare policy but with an impact upon their preconditions; direct positive effects such as the social protocol and the Amsterdam Treaty that increased measures on the part of EU agencies – the Commission, the ECJ, the CoM, the EP – promoting a common social policy. There is also an innate resistance against giving up those welfare gains that are conceived to be national welfare gains. Active social policy at a federal level is today only identified with employer and commercial interests. The conservative slant to a federal social policy is reinforced by the inertia in finding common social regulations and new political initiatives that may easily be blocked by anti-change groups. In that context the ECJ has acquired a vastly greater role also within the ambit of health care. An increasing number of regulative cases with a deregulating effect have come to be decided at the ECJ. There is no inevitability in this trend, which could have been the reverse.

The big issue from a political headline point of view has obviously been how much welfare will be cut away for the sake of competitive competence. The mainstream interpretation has it, that differences in expenditures on welfare between EU member states do not matter as long as they are compatible with the sustainability of their respective economies and as long as they do not lead to social dumping. At the same time it seems that in most nations factors such as price stability and growth have more clout than employment and egalitarian distribution. However, the consensus around basic welfare values has never been questioned. The tide may easily go in a different direction considering the fickleness of the public debate on values within the ambit of the European system. To what extent the public sphere may then be served is a moot point.

One thing remains relatively certain however. Health care is not the first target for cuts. Swedish health care expenditures are not large compared to other European ones. On the contrary many articulate medical experts consider them to be insufficient and wrongly spent. According to the OECD Health Data 2003 the Swedish figure for expenditure in percent of GNP was 8.7 compared to 9.5 in France and 10.7 in Germany but 7.7 in Austria, 7.6 in the UK, 7.5 in Spain and 7.3 in the Czech republic. The differences are in no sense dramatic. Sweden stands in between a group of somewhat higher and somewhat lower expenditures. We find the same proportions in relation to per capita expenditures. As to number of physicians per 1000 inhabitant all figures the highest figure is found in the Czech republic with 3.4 followed by Germany, France and Spain with 3.3, Austria 3.2, Sweden 3.0 and the UK 2.0 being the only deviation and a moderate one at that. But in terms of number of
hospital beds per 1000 inhabitants Sweden is by far at the lower end with 2.4, the Central Europeans Germany, the Czech republic, Austria with 6.3, 6.5, and 6.2 respectively and the western nations Spain, France and the UK around 4. In the Swedish case the dramatic reduction of hospital beds (80% in 25 years) went much further than in other countries.

By and large conditions are palpably similar across Europe. There are variations in approach, which are cause for debate. There is no consensus as to which nation might stand as a model. France has prided itself of the finest health care system in the world, at least up to the present crunch like cross roads situation, which was manifested in the new health care policy proposal put to l’Assemblée Nationale in January 2004. The UK has considered the NHS a jewel in the welfare crown. Its primary care is based on a broader supply of GPs than in most other nations, except in the Netherlands. Most are agreed that the Dutch system is the least expensive and still highly cost efficient due to better proportions between Hausartz and hospital care. Both the British and the Dutch are appealing to quite a few opinion and policy makers in for instance Sweden, where the Hausartz reform met an initial resistance from the profession but has settled in a form of primary care the result of which has turned out to be uneven. Sweden has a much larger proportion of hospital specialists than comparable nations in the EU. So many authoritative voices in the debate have argued for a scrapping of primary care and an all out concentration hospital consultations.

The German reforms of recent years have neared that system to the others in the EU. The Spanish have an increasingly more successful health care system and the one in the Czech republic is notably ambitious considering her conditions. In all there are far more similarities than separating factors, which makes it increasingly sensible to speak of an emerging European health care system. The concept as such is still hard to digest for most national experts, but there is no denial that it has to be taken into account.

To continue with the recent evolution of the Swedish health care system it should be noted that in 1987 an important agency that grew out of another was formed. The new agency was called SBU or the state preparation for evaluation of medical methodology. During its first six years it was directly linked to the government chancellery but then in the name of governance it became an autonomous authority. Its \textit{raison d'être} was that developments in medical science were perceived to develop so quickly that steadily more demanding methods tended to require steeply rising costs. Some methods were seen as more valuable than others. SBU had as task to critically scrutinise circumstances in an impartial way and relying on an extensive network of medical experts including expertise in medicine, ethics, economics and epidemiology.

The very fact that an independent agency of this sort acquired steeply rising significance within the medical profession itself had interesting ramifications. It meant that questions on methods were elevated to an international level not only in medical research, where it had always been strongly international, but now in terms of health care treatment at the clinical level. Resistance against integration of social policy, one from the defenders of welfare state policies and one from employer interests, points in the direction of demand for new solutions. The introduction of new technologies, in particular IT, will require a redefinition of the means to achieve welfare state goals of absolute justice in health care.

3.2.2 Main actors and policy structures
The set of main actors involved in health care say a lot about both policy structure and policy process. There are certain distinctions to be made between national approaches. As already noted the NHS represents the most obvious case fulfilling a politically accountable centralised system. It still meets most of its founding principles in spite of being exposed to attempts at overhauling during the Thatcher regime. It remains the world’s third largest employer with 1.4 million employees. Only the Chinese Red Army and India’s railway system are bigger. This makes NHS into an awesome contemporary model with its successful contribution to the remoulding of health care ideologies not only in the UK but also across Europe.

The Secretary of State for Health has chief responsibility for policy-making and is held ultimately accountable if anything goes wrong. His deputy, the Minister of State stands for the running and functioning of the administration and organisation of the NHS. Both have to answer to Parliament, which is the third instance being accountable to the public on health care through the NHS that represents the taxpayers’ money. The British Medical Association is the chief professional interest organisation and as such a regular backbone of the NHS and its primary care GPs. About half a dozen relatively large trade union organisations are involved representing the vast array of NHS employees. Considering the relative autonomy of British unions in forming their own policies with often limited regard to the TUC’s overall policy on sensitive matters such as health care it takes industrial action by one to grind vital parts of the system to a halt. Trade union resistance to what is regarded as a growing element of management-operations of strategic parts of the public sector has manifested itself repeatedly during recent years with the frequency of privatised contracts issued from the NHS. At the same time the NHS is scrutinised by Prospect, representing inspectors of occupational health, and the large CSOs giving NHS employees a boost for keeping the system within the public sector. In this context the main patient organisation Patients’ Forum has so far had little space to make it heard or seen and its influence is regarded to lie in the future. That is quite equivalent to the status and conditions of patient organisations in general across the EU. It is certainly true that certain groups of patients, i.e. mostly those afflicted with high profile diseases, have begun to acquire more of a say than they ever were in the vicinity of previously. The other side of this increased public role is that it represents a kind of competition with other high profile diseases about priorities in health care policies.

The one system closest to the NHS appears to be the Spanish SNS or Sistema Nacional de Salud. This system has gone as far as to expressly adopting the NHS model. It came into being while the PSOE under Gonzales was in power in the mid-1980s. Among further similarities it was exposed to the same onslaught under PP and Aznar as the NHS came under during Thatcher. The difference with the NHS is however the dependence of the SNS on how health care is run in the Comunidades Autónomas. Hence several national CSOs are operating with vigour in order to give the SNS a proper backing through Consejo Interterritorial del Sistema Nacional de Salud, Instituto Nacional de la Gestión Sanitaria, Organización Nacional de Trasplantes, Instituto Nacional de Consumo etc. In this respect Spain is rapidly acquiring a reputation of a most vivid and vigorous health care nation.

When it was created in the mid-1980s the SNS was created as an obvious contrast to its predecessor under the Franco-regime. Its double strength remained its being a progressive contrast modelled on a conspicuously legitimate public sector and welfare state success story. The Swedish system has similar features in its ideological ambitions, which has grown successively rather than being created abruptly as the NHS and the SNS. The Swedish case sees a similar delegating of political authority to regional/provincial administrations. In the UK
Regional Health Authorities were in 1995 replaced by half the number of Regional Offices of the NHS Executive. In Germany the federal government managed to get enhanced control of the Länder health policy making by means of macro economic policies. Similar but less clear features were repeated in Austria. In the Czech Republic the degree of centralisation increased after initial attempts at providing regional and local authorities with certain autonomy.

In spite of the superficial differences in health care systems, which may appear as obstacles to any transnational approach, there are sufficient degrees of similarities to vouch for a common European health care policy. However it must be noted that there exists a clear distinction between the overwhelmingly centralised and largely tax financed systems on the one hand and those systems more based on social insurance. For instance there is a contrast between the NHS where central control of health service finance amounts to effective control of the volume of service production yielding a perceived problem of underfunding and the French and German systems where the governments have no such controls and the result instead is overspending.

Furthermore it may be noted that there are higher levels of personal spending and lower levels of public spending in France and Germany compared with the cases of the UK and Sweden where tendencies are the reverse. However, personal spending is never so high and state spending never so low as to justify any questioning of these systems’ predominately public character. They are not in the least sense privatised even though social insurance systems are not public in the same sense as the national health services are. Moreover every health care system offer increasingly more of private options whether non-profit or profit driven. It seems also to be in the nature of social insurance systems that they exhibit lower levels of institutional integration than national health services.

The relationship between the state and social actors is peculiarly dominated by ambiguity and tensions. It is notably never the same in every nation. In France there prevails a curious stalemate between free health and socialised health care, which makes French conditions more complicated and less systematic than anywhere else. A lesser degree of complications in however equally undetermined relations can be identified in the other EU nations. The question why freedoms are asserted and protected is less difficult to answer than how they are asserted and protected. Similarly one may ask why and when such freedoms may be compromised and withdrawn.

France and Germany have both linked the rise of health spending to the growth of GDP. Only in France overspending is regularly subject to stabilisation Plans every 18th month in order to rescue programmes, whereas in Germany the Health Insurance Cost Containment Act of 1977 launched an income-based expenditure policy that has become elaborated several times with some years interval. Structural reform of a more overhauling kind has been attempted with four years’ interval. In periods of financial constraint a degree of contained instability makes itself palpably reminded since the relative political strength of different political actors becomes more distinct.

There is an inherent instability and what may be called fluidity in the health care systems of France and Germany. Compared to the UK and Sweden as well as to Spain these two nations, Germany and France, can be gauged from four associated and essentially institutional factors (see R. Freeman, 2000). The first concerns the large number of actors in the health care domain. Inevitably this makes decision-making process inordinately
cumbersome and complex. The frequently advertised free elements of these systems are bound to function in a reality of systematic organisational uncertainty. This state is largely to be blamed on the insurance funds, which are not single unequivocal institutions but both fragmented and segmented sets of organisations that collide and compete as much as they collude and cooperate.

Secondly the funds, which constitute the essence of the system, have a both legally and politically uncertain status. They are not public but rather semi-public in their functions and at the same time entirely separate bodies the important consequence of which is that their gradual depoliticisation leaves a power vacuum at the centre. Thirdly social insurance institutionalises capital and labour much more directly and thus creates more porous boundaries between the health system and other spheres of economic and public policy. This represents a clear contrast to the British, Swedish and Spanish National Health Service regimes. Fourthly the role and the position of the state are unclear and largely undefined and with this uncertainty its relation to the funds does not vouch for any greater certainty. While the state is both legislator of health care systems and executive in operating the health sector it has simultaneously stake and interests as an actor. Who should be held accountable in particular as the Ministries of Health in both Germany and France have palpable lack of capacities, which make them inherently unstable compared to National Health Service nations. Neither the state nor the market will stand out as hegemonic. This might be perceived as a creative and critical state. However it has turned out to be very costly and critical debates have indeed occurred in abundance in France but to little avail with respect to cost cutting.

In the French model the state is a guarantor of space for negotiations and in Germany the government creates the framework for health policy negotiations. The actors are however weak and tend to conflict with one another rather than seeking any consensus, even though corporate actors in Germany provide more ground for stable policy making than the absence of ordered pluralism may do in France. In recent years French governments have from the Plan Juppé made ambitious plans such as to clarify health policy accountability and a stronger role of the state in controlling the funds. Last winter, January 2004, saw the most recent attempt to find a viable cost cutting model while maintaining France’s reputation as having the second to none health care system in terms of overall quality (see appendix).

The relation between the state and the medical profession is marked by attempts to convert political problems into clinical ones. Medical autonomy has used to be functional to state interests. Key decisions in the health sector are depoliticised when they are referred to a local and professional domain. At the same time public agencies are using regulatory means, such as affecting clinical freedom and income, to put pressure and influence on professional activity. On the other hand requirements on the state to live up to welfare state agendas remain in the hands of the performing physicians who decide upon what medical treatment for individual patients when and how (Wilsford 1991, 1995; Freeman 2000). Since there are set limits to public means and the demand for health care shows every sign of being limitless the medical profession is dependent upon the state for a legal monopoly of medical practice when this profession makes efforts to meet demand.

Under the present crunch conditions of health care within EU nations when a new preferably common strategies are to be chosen all actors within the health care sector are more than ever before on the alert to secure gainful reforms. Medical professionals are about to lose substantial bits of autonomy whereas the state and the polity at large at the present are up
against new sorts of social and political conflicts over health care policies. Sweden saw vehement clashes over health care strategies (see above). The political right and left spoke with one populist tongue against the centrist parties who advocated far reaching rationalisation programmes for the prevention of collapse now and promotion of improved supply of health care in some years’ time.

Grass-root protests against the closing down of primary care centres and many local hospitals in the provinces. Relations between two ideological rather than political cultures became intransigent. In the UK similar clashes were funnelled through institutions such as trade union organisations and political parties signifying a particular political culture. In France grassroots and the medical profession acted with demonstrations and short strike manifestations during early 2004.

Conventional wisdom has it that in the light of post-war corporatism the interest representation of doctors has exerted more influence than any other organised interests put together. With the sharp increase in the amount of doctors, often specialists at the cost of ambulatory ones, in most EU nations, and in particular those relevant here, this organised interest representation has gradually diminished in influence, which may seem paradoxical but is more in tune with Gresham’s Law on currencies. Organised doctors in France have a low rate of membership (less than 40%) and are highly fragmented along occupational geographical and ideological lines. Three main unions compete – Confédération des Syndicats Médicaux Francais, Fédération des Médecins de France and Médecins généralistes de France. Lobbying societies promoting medical science are also significant in France.

In Germany there are two organisations with complementary rather than competing tasks. The Hartmannbund acts as an interest group influencing the policy making process whereas the Marburger Bund has direct trade union functions in looking after employment conditions of salaried employees in the health care sector. In the UK the British Medical Association negotiates for all doctors while its membership rate fluctuates between 50-80%. A smaller Medical practitioners’ Union is affiliated to the TUC. The sheer concentration of organisation in both the UK and Sweden where the Swedish Medical Association has a consistent membership rate of 90% and has had wielded a monolithic position.

There are some distinct differences in patterns. The UK is the most integrated system with the lowest number of doctors and notably also specialists but a high number of GPs. By contrast Germany has the least integrated system but a high number of doctors and a very high proportion of specialists. France in turn has the lowest number of hospital specialists, which reflects the centralised public control of its hospital sector. Sweden represents an exception with its high number of hospital specialists and its division of authority between the state and the county (now increasingly regional) councils. Health politics everywhere but more notably in France and Germany are easily explicated in terms of the relationship between the state and organised interests. This has so far not been in favour of interest groups in France who occupy a less favourable position in the policy structure when state policies are about to be implemented. Interest groups are invariably faced with a fait accompli. They are normally “confronted with the complete text of the law, decree, reform etc. and must react after the fact. In most cases, to contact an interest group means to inform them about what is going to happen and not to invite them to take part in the formation process.” (see D. Alcaud French National Report 2004). Depending on a topic an interest group leader may be invited to give an opinion in order to broaden the basis of the
decision-making process. But as pointed out already above the French state is subsidising two-thirds of the interest groups to secure their collaboration in the spirit of the Chapelier Laws (see above). The indication is that patient interests are in the same fold.

There prevails a fairly low opinion of user/consumer/patient potentials in terms of having any sort of organised impact on policy-making processes. The British patients’ Charter of 1991 was created from above under the auspices of the Department of Health. It represented a broader attempt to define and specify the rights of public service users and in particular with the express aim to reduce waiting times. Where user interests are mobilised from above an obvious instrumental reason is behind. The one important change in preconditions is that medicine no longer is about realising “national health”. On the contrary, the national perspective has been replaced by the individualisation inherent in human body focusing the last domain not yet colonised by the state system. In this light health care policies are seen as the servicing of human bodies under a series of specific agreements between purchaser (the state), provider (the physician) and the consumer (the patient) where the intervention of law becomes a way to limit the apparently infinite demand for a health care that represent a collective panacea (Dingwall 1994).

The NHS has for most of its existence been reviewed by peer experts and evaluated by ministerial staff as well as independent consumer groups. The consumers or patients have only recently found a voice. It is often told that at its foundation the NHS had every interest represented at the negotiating sessions with the Minister of Health except the patients. Now the service has become explicitly patient-centred. Into this scope comes the new choice debate (see above), which is presented as a new patient favour. Patients referred by their GP for surgery will have a choice of 4 or 5 hospitals (see C.Parau, UK National Report 2004). If proper surgery cannot be offered either at these hospitals or within reasonable time there is the further option of going abroad for treatment in France or Germany. Virtually the same philosophy has been up to debate in the Swedish context, where Germany has become a refuge for a growing number (see above).

There are somewhat diverging views on the effectiveness of rights and the use of law when applied to health care. In many circumstances rights to health care are primarily rights to consultation rather than to treatment. Effective provision then tends to be determined by medical professional judgement rather than by law and in this context patient complaint against doctors rests on a very insecure and shaky basis. The medical profession has in a remarkable way taken responsibility for self-regulation. This seems notably axiomatic in every national context. Responsibility for complaint investigation remains with doctors’ chambers in Germany. In the UK there was a period in the 1980s when complaints increased by a factor of five in frequency and three in severity. The rate has slowed down since then.

In Sweden an investigation initiated in 2001-2 by the National Board of Health and Welfare, which is the agency responsible for the accountability of the medical profession, found that complaints filed by patients against doctors were about 3500 out of 200 million encounters between patient and doctor. Of these more than 9 out of 10 were absconded. In reality only 0.3% of the negligible amounts of negligence claims led to an internal indictment of the doctor followed by disciplinary measures. Patient complaints are filed with the National Board. The reason for the relatively few cases and the dramatically low amount of indictments must be sought in the fact that patients with a complaint have not been informed before an operation about the relative risks involved. In Germany all patients are informed...
beforehand about possible risks and their own rights involved. In the Ley de Autonomía del Paciente of 2002 Spanish patients’ rights are regulated. It spells out rights on the part of the patient before the doctor such as pertinent pre-treatment information as well as access to one’s own medical records.

3.2.3 Policy process

By necessity there are some overlap between actor, structure and process. It can be observed that a great deal of concentration in terms of both structure and process is going on everywhere with the purpose to acquire an improved overview and hence efficiency of health care systems. In the UK the Labour government has made several efforts to rationalise in this sense. Relations and communications between local authorities and the central state were facilitated by a reshaping of the local process where Primary Care Trusts were reinforced and the 99 District Health Authorities were merged into 28 Strategic Health Authorities for an enhanced quality control of the PCTs.

British policy formation regarding health care is organised through the Dept. of Health in a Synopsis of Planning and Performance Management System, which steers the NHS through 28 Local Delivery Plans (LDPs) of the SHAs and LDPs of the PCTs which monitor the implementation of the Ministry’s 44 national targets for 2003-2006. This means that the famous local autonomy of the UK, which was shattered during the Thatcher regime, has become cemented as subject to conditions where local performance, that is meeting the 44 targets, is decisive for a so called “earned autonomy” or an exemption from micro-management. The Labour government has assigned two Commissions to evaluate the functioning of the NHS, one on Health Improvement and one on Healthcare and Audit and Inspection. These inspectorates have a critical function to the extent that evaluation is extended to the involvement of the public giving a patient’s perspective on the NHS through patient forums and staff opinion surveys of NHS as employer (see C. Parau, UK National Report May 2004).

While the Labour regime in the UK has pursued a continuous reinforcement of central control over local processes the issue of resource management in Spain has represented conflicts and controversies if not an outright tug-of-war between the Federal Government and the Autonomous Communities about who should shoulder responsibility for a deficit spending. Those Communities with a recent management jurisdiction have fared worse since they have had to shoulder a health care debt incurred by the state (see M. Pradel, Spanish National Report 2004). A similar conflict developed in Sweden where certain resource strong county councils had to pay for the costs of weaker ones.

The strategic debate in both Spain and Sweden has concerned reduction in pharmaceutical spending, priority care, productivity increase and cohesion of the health care system. All nations are acutely aware of the necessity to reduce both pharmaceutical cost and usage. There is widespread abuse among increasingly younger age groups, a fact for which the health care system bears a heavy responsibility. This has created a new conflict with the big pharmaceutical companies since health care system is trying to prescribe older medicine with roughly the same qualities as the new ones minus some refined and duly expensive component. This does obviously hamper planning for new costly investment on the part of the dominating companies. The Spanish Ley de Calidad y Cohésion has had its counterpart in the basic Swedish health care act of 1982.
In Germany the KAG (Concerted Action on Healthcare) assembles twice a year representing all pertinent actors – the Federal Government, the Länder and municipalities, employer and employee unions, the pharmaceutical industry, hospitals and physicians as well as private health insurance funds and CHIFs. Only rarely had any conflict arisen between Federal and Länder interests. The German system represents a more elaborate cohesion with a built in balance in the policy process: “The functional organisation of the health care system is largely based on federal rules, but the estates have the institutionalised veto power through the second parliamentary chamber, and hence the Federal Government is unlikely to create direct confrontations with Länder interests and would rather avoid direct intervention, which has resulted in a “structural inertia” and a defensively status-quo-oriented policy making process” (A. Klasing & K. Wagner, German National Report, 2004).

A similarly cohesive system is valid for the French policy process where dozens of committees, councils and panels in each area are consulting with the relevant Ministry. In accordance with the French elite technocrat tradition a small circle of experts within the administration generally take the initiative to form a new reform or a change of law. But the very implementation of the policy process is the responsibility of the Direction Générale de la Santé (DGS). It has a similar character and function as the KAG in Germany since it includes all the relevant health agencies at both national and regional levels and actors, not the least health sector consumer associations (des établissements de santé des associations d’usagers), in France assembling in all 320 people. The main tasks of the DGS, apart from monitoring implementation processes, also concern evaluation as well as analysing the needs of health care and policy frames. With its very substantial administrative machinery at its disposal the DGS is in a sense doing the dirty work of the government. Significantly the DGS is in turn under surveillance and control at peak political level meaning the Ministry of Health and the Ministry of Social Affairs.

At the other end of les affaires d’état the Haut Comité de la Santé Publique is under the presidency of the Minister of Health. Its tasks are qualitatively somewhat different. Its responsibility is to monitor the mechanics of the French healthcare system in order to define and single out public health objectives and what kind of innovative measures may be required. It is more of a direct policy instrument of the Minister of Health. Instead of to one inclusive National Action Plan French policy makers have given priority to high profile diseases such as one National Plan for Cancer, one for pain treatment (migraines etc.), Aids, as well as preventive care programmes (see D. Alcaud op.cit.).

In the UK Health care remains both a monolith and firmly embedded in the Department of Health in spite of the recent introductions of devolvement. The current NHS Plan of July 2000 reconnects with much of the founding principles of 1948 but there has evidently not appeared to be any need for one National Action Plan. Instead the Labour government introduced an NHS Plan for the 21st century with the aim to set national standards, improved facilities for team-works, new incentives to raise productivity, devolvement and empowerment of patients. These noble goals are equally relevant in the Swedish setting, where a National Action Plan was launched for specific health care purposes rather than an inclusive one. In the UK there are similarly a National Action Plan for Tuberculosis Surveillance, an improved National Cancer Plan to attain Continental standards, improved neurological services in connection with an Epilepsy Action Plan, and now also a Hospital Plan against MRSA.
Common among most nations surveyed is the presence of national priority measures, which in many cases also have become regional schemes with regard to treatment priorities. It should facilitate a priority discussion for the European level in particular after the entrance of ten new members of the EU on May 1st 2004. Another circumstance worthy of notice concerns the relative migration of doctors and nurses between nations. A surplus of Spanish nurses have come to the UK and Polish doctors have for some time arrived in Sweden and can now be expected to do so at a greater rate. With a degree of migration and a growing number of treatment cases abroad new targets for an integrated European health care culture should be set rather sooner than later.

The preconditions for an Europeanising of the health care sector are closely linked to the practise of transnational borrowing, co-ordinations and convergence. There is no overarching co-ordination programme for specialist treatments or surgery. Harsh British critics of their own perceived shortcomings blame this on the NHS being an anomaly, or, possibly, an anachronism or in short one expression of British exceptionalism (see R. Klein, 2001). If on the other hand include the uncoordinated, spontaneous convergence of national reforms with other nations certain trends unmistakably emerge. In this respect there exist uncoordinated examples of clear convergence features between European nations with trends toward standardisation and quality control, customer-orientation, incentivising local productivity improvements usually with for instance budgetary inducements by the centre, a degree of planning for and managing of non-medical influences on health, distinct interest in promoting and developing alternatives to hospitalisation, such as more sophisticated primary care, more critical evaluation of technology, and basing medical practice on updated (latest) research results (see C. Ham, Management and Competition in the NHS. Radcliffe Medical Press, Oxford 1997).

With regard to the open presentation of health care programmes, strategies and policies during the last few years in EU nations there is no question that the debate has never been more open heated. In the UK the leading political parties have announced that healthcare will be the decisive issue during the next election campaign. In France health care has been at the centre stage of not only ideological and highly technical organisational debates but very much over pointed existential questions. In Sweden the debate has reached an open character of unprecedented dimensions much thanks to the devolvement of health issues to the regional level and away from the Ministry or county council controlled levels. The media, in particular the broadsheets, have been very active all through the first half of 2004 to follow up every new twist in developments and debate pages have been full with intense debates by specialists. These are only some examples, which were repeated in every nation.

The Czech Republic, finally, represents an extremely interesting example in its own right. In certain respects the Czechs are ahead of other western EU nations, in other ones they have been on a sidetrack and are working themselves toward convergence. At the same time an inevitable development toward marked centralisation created preconditions, which had to be successively addressed in order to secure greater devolvement and subsidiarity. The first strategic documents on health care policy in 1990 (Proposal for a new Health Care System) and 1992 (Project of a Medium-term Health Restoration and Promotion Strategy) were ambitious endeavours stressing the importance of society-wide restoration of health.

In 1995 the Ministry of Health presented a National Programme of Health – a Long Term Strategy. This document was strong on analysis of current and existing problems and the
urgency to address them. However, it was formal and technocratic since there was no felt need to give it any wider public audience since political interest in health care issues were so negligent at this time. A shift occurred already the following year when the Czech Republic (CR) decided to opt for membership of the EU, which also set in motion a process of harmonising the Czech legal system with that of EU nations. Thus many a statute related to health promotion were gradually changed for the better despite the absence of the necessary development of knowledge. But the Ministry of Health was for instance still faltering ineffectively to find appropriate health policies. The degree of self-criticism remained quite substantial in the CR up to now. So for instance is it stated as derisivelylate when school curricula in 2002 introduced health promotion into the education process. Many nations, including Sweden, are still working on a launching of a satisfactory school programme of the proper sort.

The National Council of Health was established in the early 1990s as a counterpart to the German KAG and the French HCSP. But it never became an intersectoral forum for making health promotion policy at the national level. It failed however and petered out of itself. At the same time the government missed an opportunity to create a holistic approach to medicine. Public debate was still absent much due to a low level of theoretical knowledge. Then in 1998 the Ministry of Health presented a new Environment and Health Action Plan and its corollary became at once a Council for health and the Environment, which replaced the National Council of Health. It consists of administrators and top Officials and hence has very little of either transparency or accountability.

Relations between the state and the regions and municipalities have drawn much attention in recent years. In 2003 the regions took over much of state involvement at the local level. The results are not clear yet. But a step in a direction of balancing CR health policies was taken last year. Hygiene Service has since 1990 been a CR feature not obvious in the West. Its top executive body is named National Institute of Public Health (NIPH) and it gathers a number of Centra such as Health Conditions, Environmental Hygiene, Work Hygiene and Occupational Diseases, Epidemiology and Microbiology, Food Chain Hygiene, Quality in Health Care. The NIPH still leaves much to be desired, according to critics.

The CR has failed to take advantage of creating regional level health plans that might become active components of a comprehensive national health plan. The Ministry instead introduced the Czech version of Health 21 in 2002, which was not helpful in creating a planned meeting with western counterparts. But this document (Health 21) was also targeted severely for serious shortcomings. Again mostly top technocratic officials from the Ministry took part. The current situation in the CR has appeared not very adequate in its mastering of “management of interfaces” between the central regional and local levels. Participating actors do not make use of social sciences and the modernisation of the East meets inevitable obstacles. Civil society is still in its infancy and the state does not provide it with the support it needs. A cultural explanation has it that the small degree of readiness to take in literature may lie in the small degree of readiness for cooperative action. Media policy for instance also lacks developed independent approach based on objective findings (see Dr Petr Hava, CR National Action Plan 2004).
3.3 **Bibliography:**


A.J. Culyer (1991) Health care and health care finance in Sweden: the crisis that never was; the tensions that ever will be. Summary of an International Review of the Swedish health care system. SNS Stockholm


H.M. Leichter (1979) A comparative approach to policy analysis. Health care policy in four nations. CUP. Cambridge


Statens beredning för medicinsk utvärdering (SBU) (The Swedish Council on Technology Assessment in Health Care) SBU:s sammanfattningar och slutsatser (summaries and conclusions) 2003 Stockholm

SOU 2000:114 Vårdens ägarformer – vinst och demokrati (Profit or Not-for-profit in the Swedish Health System)

SOU 2000:91 (English version) Health on equal terms. National goals to put the health Final report by the Swedish National Commission for Public Health

SOU 2003:52 Ökad patientsäkerhet på läkemedelsområdet (increased patient security regarding drugs and medicines)


Socialdepartementet Ds 2003:63 Den svenska sjukan – regelverk och försäkringsmedicinska bedömningar i åtta länder (The Swedish disease – rules and judgements on medical insurances in 8 nations Stockholm 2003


3.4 Appendix

3.4.1 STATE OF THE ART: THE HEALTH SECTOR.

By Martin Peterson UGOT

Western medicine stands right now at a difficult cross-roads and in a very major crisis.

This report is divided into two distinct sections. One deals with society as a syndrome. It is reflected in stark colours today in the appalling figures on sick leave, early retirements and burnt out cases. It is no secret that societies in western Europe representing the EU have these seemingly quite unnecessary problems to cope with on top of endemic unemployment difficulties. It may seem like an extra irony that at the same time as migration and integration policies have failed dismally in some flagship progressive nations then EU nations in general may be forced to recruit labour, in particular skilled labour from Third World nations, in order that EU nations may retain their present standards, which are in jeopardy due too many burnt out cases in the present population.

The Swedish health care system has for a long time been regarded as one of the jewels in the crown of the Swedish welfare state. Like the British NHS it was above questioning. Even if there existed sporadic eruptions of criticism no serious debate did ever emerge concerning the health care system as such. In neither the British case nor the Swedish one did it enter any column of debate of the major broadsheets. It was only after the major system shift in
1980, which was tantamount to a paradigmatic shift in a literal sense that new ideas with regard to primarily the financing of the health care system were brought to the fore. Two issues were in particular raised. One concerned the costs and the other the often unbearable and in many cases indefensible waiting lists for treatment.

Interestingly there continued an exchange of ideas and direct borrowing between the UK and Sweden even after the arrival of the Thatcher regime. Oddly enough Thatcher's administration borrowed certain privatisation methods from the Swedish Social Democratic regime, which was more often than not branded as socialist at the same time as it favoured an ultra competitive market economy. It was a public sector obligation to provide for an infrastructure that in the end should serve to enhance the competitive edge of the Swedish export sector, which in turn paid for the welfare system and in particular what was conceived of as the peak medical care system. However, the issue of financing grew increasingly more problematic as the erosion of the Swedish economy became more transparent. The series of drastic devaluations, especially the one in 1982, to keep the earnings from the export sector in tact at the same time reduced the value of the Swedish currency to the extent that as deregulation of the currency became reality in the late 1980s the inherent weakness of the economy plunged Sweden into an economic and social payment crisis from which the nation has still not recovered.

However, long before it was realised that the foundation of the economy was more brittle than anticipated experiments in privatisation were introduced in order to come to grips with the annoyingly long waiting lists. This was an uncontroversial experiment since it eased somewhat the waiting without in any sense influencing the frame of the system. During a very comprehensive state investigation in 1987 concerning the scope for an extended industrial sector the medical sector was subject to much scrutiny and debate since the potential of the pharmaceutical sector was increasingly realised. During the course of the investigation the entire raison d'être of the Swedish system became subject to intense discussions on new ideas to reduce the waiting lists. But there was never near any suggestion of an overhaul. Inevitably, though, and somewhat ironically private insurance systems were presented by professed Social Democratic economists, who excelled in Friedmanesque rhetoric.

One central image was presented as a frame for policies. It represented two pictures: one with a giant bicycle and a small person sitting on it, the other a small bicycle with a giant person on it. This contrast constituted the vision of 1987 and the future. Health care policy should aim for less focus on technology and more on the “holistic” state of the patient. It was recognised that very little time had thus far been devoted to follow-up care. For instance, after an operation the patient would be sent home after due recuperation. Too often the patient would come back with ailments connected to the first instance. Such relapses may be more costly in the end than a follow-up policy.

The grand vision of prophylactic measures to drastically reduce time-consuming and resource-testing psychosomatic disorders by giving priority to the whole human rather than to application of technology to one sore spot represented a dignified and idealistic attempt at a final break with a Cartesian approach, which had ruled medicine for centuries. There were two concrete reasons for this strategy. One concerned over all costs, which in the end could be substantially reduced with a wise holistic approach. The other was a reaction to an increasing number of bad-press cases, where the media had tracked down mistakes due to the medical profession’s supposed indifference to patients as humans.
The health care policy committee of 1987 revealed an unanticipated hypersensitivity on the part of the health care sector to negative images in the media. However, the negative and during some years regressing economy of the 1990s put a quick end to visionary strategies. If anything more of technology should solve productivity questions, which much of the issue was reduced to. One unwanted and unanticipated effect was the very drastic increase in sick-leaves and early retirement towards the end of the 1990s. This has constituted the overriding problem of Swedish society during the past five years clearly overshadowing the problem of unemployment. In 1998 focus was upon National Action Plans for employment. Since 2001 the order of the day has been National Action Plans against sick leave and stress related diseases.

The incentive question was given fresh attention. However, competitive insurance, whether public or private, seemed to contain too many risks for it to be worth serious consideration in Sweden with her particular political culture. So the proposed insurance methods were modest for starters. However they provided an indication of future privatising. Nevertheless the example of the US system was held up as a deterring one by the leading gurus of Swedish medicine. Then were more arguments for special earmarked “health taxes”, akin to insurance premiums and determined according to income. The complex questions raised about the optimal nature of the funding of such “national insurance” (fully funded, pay-as you-go, subsidised or not subsidised) had to do with its proposed amalgamation with the Swedish Social Insurance Board in order to present a comprehensive approach to health care and its corollaries – unemployment depressions and work injuries.

Clearly there could be no talk of any system change in Swedish medical care. One reason, and the most powerful one, was that the Swedish hospital world was if not a recluse so very much a world unto itself. It lived by the rule that what had been done successfully a hundred years ago could very well and with advantage be repeated also now. The investigative committee of top ranking physicians and medical experts emphasised unilaterally that American hospital culture was impossible to emulate since it promoted qualities and features, which were fundamentally different compared to most European ones. In fact less than 20% of the around 5000 US hospitals are profit driven private ones. Almost 60% are private non-profit hospitals and publicly owned institutions run the rest or slightly more than 20%. The trend however in both the US and Canada is a growing share of commercialised hospital care.

The democracy factor is commonly brought up as a decisive one. Nobody subjected to the health care system questioned the quality of the care as such, which the public both rated and recognised as a peak one in global comparisons. Hence the quality of the service was immensely trusted and implicitly relied upon. The medical profession was not a vocation except for the dedicated minority, which is standard in any qualified métier. Since the 1950s it was possible for any young legitimate physician to make a quick buck as stand-ins at other hospitals during the long summer vacations. Then the powerful Medical Association guaranteed a substantial regular salary, which could easily be increased via sidekicks. Under these circumstances the medical profession did not need the carrot of profits. There were many ways to enrich oneself through the existing non-profit channels and the less than transparent relations with pharmaceutical companies. Such standard features across non-profit Europe notwithstanding the medical profession in Sweden and elsewhere was considered by the public to be endowed with a high ethical norm.
With the present focus upon trust in the social sciences the democracy argument, which stresses the basic accessibility for everybody to peak medical care, is falling back upon some innate historical trust factor in the medieval communal system or village council. Swedish social historians and social scientists have not been late in explaining the Swedish health care model with its long historical communitarian roots. Since the state of civil society explains virtually nothing of the trust factor in the political culture of a nation it is believed that some deep cognitive patterns may be found in history to explain why the tax paying rate is close to 99% in some nations and only at best 25% in others.

A comparison of insurance and tax financed health care systems respectively with regard to the degree of central planning and control shows that political cultures matter. A general observation is that central planning and control is more common in insurance financed health care systems. Otherwise such diametrically opposed systems at least on the surface as the US and the Swedish do both represent systems with no central planning or control or national budget ceiling as regards hospitals and no establishment control or set patient fees at the primary care level whereas Canada, the UK, Germany and the Netherlands are examples of the opposite.

In the case of the UK an advanced contract culture between authorities and health care organisations has provided financial security and potentials to extend the activities with the risk that the original goal setting may get lost. Hence there exists an explicit wish by the political class that a partnership dialogue between government and organisations remains active and vital. Roles, goals and forms for dialogues and follow-ups are made clear in special Compacts. A similar development is to be noted for Germany but from a diametrically opposed angle. In the German case religious, humanitarian and other organisations own big shares of hospitals and other health care institutions. The profit-driven care enterprises are increasing their share while the not-for-profit-driven hospitals have a clear difficulty to make it in the process of restructuring that is going on within German health care. Norway has central planning but none of the other features such as budget ceiling or central control of primary health service. Only a couple of years ago the Norwegian health care system made the transition from local regional to state control.

Annual per capita health care expenditures between 1988 and 1998 show a modest increase in the case of Sweden but a substantial increase in the cases of both Denmark and Norway, where they virtually doubled, to mention two nations that are readily comparable to Sweden. The UK has also increased expenditures palpably more than Sweden and to a much larger extent so have also the Netherlands and Germany. Also the amount of care places on offer per 1000 inhabitants had at the end of the 1990s become dramatically reduced in Sweden and belonged to the lowest rung in a European comparison. This reflects the serious set back on the part of the Swedish economy during the 1990s, the ramifications of which could be seen in all central welfare sectors including the health care sector that normally was in a class of itself. In order to maintain health care at an acceptable level relatively speaking expenditures still by far exceeded the mark of what orthodox economics might accept.

A severe cost problem had become evident as regards the health care system. Its financing had traditionally been placed at the provincial level since municipalities did not have the economy to cope with a more sophisticated and cost demanding system. As one patient might cost five million euros annually a larger budgetary system would have to shoulder the financing. At the same time the state washed its hands off this onerous responsibility. Without central planning and control as well as budgetary ceilings the provincial
administrations were left with health care as its towering task but also had a comparatively free hand to handle it. This meant that care costs could become sky high in some provinces whereas other provinces had little to offer. In any case the provinces with the biggest economies were, according to this financing system, obliged to pay for the care expenditures in provinces with smaller economies. Only recently major protests have been mounted against this system by political opinion in the bigger economies as well as, and perhaps more importantly, from the central ideological offices of the governing Social Democratic Party.

The financing issue had suddenly become a democratic problem. Several non-profit private clinics have cropped up in recent years. Their presence has on the other hand in no sense represented a challenge to the public health system. Government rhetoric has denounced it as not being conducive to democracy. But at the same time it was given tacit support where it could alleviate the burdens on the public health service. This has induced public hospitals to feel free to produce preference of treatment lists, which has added more fuel to the democracy-in-health-care debate. Some of these provider competition schemes have inspired the idea of foundation hospitals in the UK, the most recent of controversial policies by the Blair government, who rather argue that democratic elements are enhanced since any across the board policy is always inherently unfair.

However, in an evaluation by British economists and medical experts in 1991, that is before the economic crisis hit at the infrastructure nerves of the system, it was pointed out that the evaluators were all struck by the absence of any articulated, let alone agreed, idea of equity in medical sector discourse. Furthermore the absence of much factual material on patterns of resource deployment, sickness experience by social class, and the matching or otherwise of needs to resources is as surprising as the absence of the idea of equity. But Sweden has shared this feature with other nations who have prided themselves in rhetoric of equality and equity. Whether health inequalities may be less in the UK or Sweden is a moot point. What causes inequalities in health care systems founded on egalitarian principles remains less clear, since these tend to have extremely wide variations in the rates of medical intervention, which cannot be explained by the underlying morbidity of communities.

Some of the mainstays of the proposed foundations hospitals figured in the debate already in the early 1990s. One was that it was considered useful to think in terms of horizontal and vertical equity, the essence of which was that the horizontal sort required that like resources should go to persons who were like situated, while the vertical sort required that appropriately unlike resources should go to unlikes. At the same time there are several candidates for the respects in which people might be regarded as “like” or “unlike”. With a definition of current health status implying that horizontal principles should correspond to each would be equal resources for equal need, equal resources for equal sickness, and equal resources for equal capacity to benefit there still lingered an ideal that contribution should be made by resource distribution to greater equality in health itself. This means also that there should not be any exaggeration of the innate conflict between equity and efficiency. In many cases efficiency (not to be equated with profit-maximising), in the sense of making the available resources have the greatest possible impact on the nation’s health, is very much consistent with equity, in the sense of ensuring the fairest distribution of effective and cost-effective medicine. Interestingly the difficulties of the 1990s have entailed much more of democracy aspects in health care and a serious treatment of equity as serious rather than a piece of rhetoric to rally troops with for the reassertion of traditional but vague
aspirations. Then with a serious treatment comes a demand for a clearer meaning of it and a devising of policy implementations as well as a monitoring of success and failure.

The discussion on ethics versus profits goes on in the Swedish context. It is has only just begun to reach a crucial stage. There is little scope for a belief in a rapid increase of a private sector share in Swedish health care. At the same time the National Action Plan stresses the important role currently played by the small enterprises, the cooperatives and other voluntary organisations as lubricants in the health care system. Through their competitive bids they can contribute to fulfil the explicit ambition on the part of the government to attain more of pluralism in health care, it is said in the NAP. However, the most recent state committee on health care questioned this statement by reiterating that rather than treating competition and pluralism as synonymous experience shows that increased elements of competition may well lead to uniformity and standardization as well as the vanishing of those suppliers of health care who have tried to profile themselves in accordance with the ideal pluralism.

Since non-profit institutions cannot employ risk capital to finance supply. Hence in most European nations with non-profit health care systems financial means are provided through borrowing against a tax-free interest rate for the capital suppliers, tax deductions for donations, and no tax when surplus is used for development investments. Non-profit health care has the advantage that when it is offered in a small-scale form the care may be performed in close development with the patients and the users. The prerequisite is often functioning networks or other close collaborative models such as cooperatives, for instance the health care branch organisation Medicoop, and institutionalised popular or social movements in the Swedish case. The ESF (European Structural Fund) council coordinates and supports such activities. So do other major interest organisations on both user and employer side.

To conclude this current discussion the decisive question is which scope justice can afford to give to pluralist freedom and how far the subsidiarity principle should be allowed to expand and encroach upon the solidarity principle, which has traditionally been a key feature in the Scandinavian political culture. Private forms of ownership may be allowed and promoted if the sustainable principle of freedom favours the principle of justice in the sense that the least favoured is most favoured. From an ethical point of view this must imply that the public sector with tax financed health and medical care must be wholly covering and within this model offer possibilities to attach and apply private health care.

The recommendations of the most recent state investigation commission suggest a broader common political approach in health care issues combined with a long term stable agreement on the scope and conditions for different forms of operation and ownership as well as a development towards more open forms of care and as close as possible to the location of patients. A strategy should emphasise preventive care and on the organisational side a better coordination of the highly specialised health care. At the same time entrepreneurs may develop forms of treatment for the sake of effectiveness. In all the ethical starting points on which the priorities and goals are based regarding care and municipal services in this field should also guide decisions that specify the frameworks and conditions at the point when this sector is opened up to new forms of ownership and operation.

Fundamental from an ethical as well as a democratic point of view is that care remains linked to the individual as a person and not in accordance with this person’s particular skills and
capacities as an actor in society. Considerations on priorities should then put to test everyone's empathy and ability to disregard self-interest in order to focus on people's different needs. Hence it is crucial to strike a fine balance between social justice and freedom as well as between solidarity and subsidiarity. It is as a consequence important that the public sphere will be able to promote and provide social justice and solidarity without hampering individual initiatives or responsibilities. Vice versa the development of new operating forms from individual responsibility and initiatives must not put solidarity out of action.

The basic frame of health care planning remains dependent on the Health and Medical Services Act that is based on three basic principles: 1) the value of the individual; 2) the needs principal; and 3) the principle of cost-effectiveness. Ideally resources should be distributed according to need, on equal terms and with an assessment of the result that can be achieved with a given treatment. At the other end and apace with increased knowledge in the community, health care encounters patients who clearly state their own wishes and needs. Hence citizen involvement in a public sphere debate on health care policies is crucial in order to safeguard the basic principles of care according to need and on equal terms even when the health care system is opened up to a greater diversity of care providers and a greater selectivity of medical specialist supplies.

The demographic challenge represents the greatest claim on care resources in practically every European nation. As the proportion of the elderly people in the population rises and as progress is made in terms of diagnosis and treatment thanks to advance in R&D and technology these added tasks increase organisational and financial burdens. The additional resource problems are not solved by higher taxes or extra charges for which margins are extremely limited in most tax financing nations. Nor can it be easily solved by nations applying compulsory insurance linked to employment for the financing of the health care system. In the latter case the charges are made on a smaller base and are directly linked to production and hence considerations must be taken to an international cutthroat competitive economy. Health care should ideally not be dependent on business cycles. Such a dependency would severely curtail the space each doctor needs for his/her patients.

At the same time the paradigmatic shift since the early 1980s brought about an internal overhaul of the public services in both Sweden and the UK and as it seems everywhere. Public service managers faced a plethora of government measures that required them inter alia to change their approaches to service delivery. Those measures were initiated through legislation that set out to reform all of the public services within an overarching policy framework. This form of modernisation of the public service sector not only affected the service delivery but also the organisation of the workforce delivering these services (Kessler & Purcell 1996; G. Bain 2002 on modernisation of services and its employment practices).

One important consequence to the public service workforce is that it has arguably become less skilled and knowledgeable with less job autonomy, more inequality and insecurity, higher workloads and less trade union representation at the workplace. The difference between public service concept during the period prior to 1980 and the one ensuing after the paradigmatic shift is a striking one. The conception of welfare statism, and health care as its most evident expression, was built on the idea that society was an organic whole where equality should reign in public services as an ethical foundation. Society within the confines of the nation-state was inherently dependent on trust and welfare state society must be able to offer an infrastructure of basic needs in order to be credible in its intents and thus acquire
complete loyalty among citizens. This also required coherence in the message of the political language, which should be understood in exactly the same way among citizens. There was no room for misunderstandings in political society just as there was no room for anything of the kind in an industrial corporation lest severe and unnecessary losses might arise.

As rational management acquired greater space in learning systems and the general learning curve of those responsible in public services acronyms such as PFI (private finance initiatives) and PPP (public-private partnership) became increasingly household. This was interestingly more a consequence of deliberate government policy. There are clearly public choice ideals underpinning NPM (new public management). And there are already many studies on the impact of NPM and the new agenda for a changed pay system in health care services, which are in line with governmental needs for a new pay structure to support the programme for a modernisation of public services in general. The Health Care sector is the most visible example of how modernisation and NPM strike.

In the British case UNISON sponsored research into the Dryburn Hospital PFI, which found that clinical staffing budgets were projected to decline by 22 percent during 1994-2001. These cuttings were achieved mainly by substituting health care assistants for qualified nurses, and shifting lower dependency care to community hospitals, primary health care settings and the home (Gaffney & Pollock 1999; R. Seifert 2003). With foundation hospitals, the aim of which is the creation of greater flexibility in health care supply, it was feared that qualified staff reduction would continue for the benefit of hiring from temporary work agencies. With greater activity on the part of the unions incidences of contracting out were reduced. Hence it was in the interest of trade union policy to keep services public rather than bow to flexibility experiments involving degrees of privatisation.

The NHS Agenda for Change in the UK, which is currently under consideration by union members, is based on increasing local elements of pay. During its first five years only some 37 employers and then mainly small district councils implemented it (UNISON 2002:6; IRS 710). Evidently there is some inertia regarding NPM in the Health Care sector. Even if there is an evident shift of concern from policy to management and emphasis is on quantifiable performance measurement and investment appraisals throughout public sector administration this shift may occur unevenly. The break-up of traditional bureaucratic structures into quasi-autonomous units, which are dealing with one another on a user pays basis and market-testing as well as competitive tendering (CCT or compulsory competitive tendering) instead of in-house provision, cost-cutting, output targets rather than input controls. This rationale also involves limited term contracts instead of career tenure, monetized incentives instead of fixed salaries, freedom to manage instead of central personal control, self-regulation instead of legislation and more of PR and advertising rather than an even distribution of high qualifications.

This logic broadly follows Niskanen (1967, 1971) who in critical reviews identified two main flawed characteristics of bureaus. One concerned the tendency that bureaucrats maximise the total budget of their bureau, given demand and cost conditions, subject to the constraint that the budget must be equal to or greater than the minimum total costs at equilibrium output. The other was the observation that bureaus exchange a specific output for a specific budget by putting themselves in a competitive environment, which according to Niskanen’s influential analysis would yield smaller government and hence better government. The Health Care sector has put up a brave resistance for a long time to an application of such a conclusion much because it has represented a highly specialised culture of its own making.
The time perspective is too limited to speak of any decisive change for the better or for the worse in the British system. A much bigger challenge would be the deliberate exchange of health care services between nations. As of now Swedes and Britons travel to either Germany or northern France for much quicker and hence mostly safer operations. This has triggered more of so called modernisations in both nations rather than an increase in the quality supplied. So far health care in Sweden is highly decentralised and national legislation provides considerable scope for county councils and municipalities to find appropriate administrative and organisational forms according to varying prerequisites. Rather than basing the system on national rules to be enforced, the fact that health care has mainly been operated in the public sector has provided a common political approach as a decisive force of cohesion. However these factors, which have held the system together are now showing clear signs of increasing weakness.

There are encouraging factors from a perspective of European cohesion in sensitive public services. There is for instance increasing scope for a convergence of health care systems both in terms of financing and organisation. As noted above countries with financing through compulsory insurance solutions also have equalisation systems to redistribute health care resources according to the needs of different groups. Countries with a great diversity of private health care providers also have, compared for instance with conditions in Sweden, a stronger central regulation to hold together the large number of health care providers. Nations that have tried more market-like organisational forms have in many cases toned down the competition perspective for the benefit of planning and collaboration.

The evident space for convergence is further promoted by the intense debates on comparative advantages in varying national health care policies. The relative absence of a troubled economy in health care financing used to distinguish the Swedish case. The endemic problem rather pertained to the too long waiting lists, which in the end involved a democratic as well as an obvious ethical dilemma. Swedish social policy that was built on the gospel according to Matthew or Robin Hood in reverse, that is the same generous allowances offered to the very rich as to the very poor, paid to the extent that the former were inclined to use the public health care system rather than ask for or use private care.

The main threat would obviously be the erratically long waiting lists since social equity also required that nobody irrespective of social status should be given priority. Only the severity of the medical cases decided. This circumstance gradually induced those, who could afford to seek other alternatives. The “roaring eighties” introduced changed attitudes. At the 1987 medical policy debate social democratic economists presented insurance schemes, which would economise health care and force the individual to put more at stake. The mandarins of the medical profession then retorted that no one from outside neither should nor could dictate anything concerning the realm of health care. Nor did the media have any right to meddle in goings on within the health care sector, which should be left to those who had any actual knowledge of it.

Come the new millennium and the economic crises of the health care sector was rapidly extended to a broader political spectrum. The idea to have the provinces footing the bill of health care not only implied decentralisation but also solved two other problems. One concerned the fact that municipalities could not afford finance patients who on occasion might be extremely expensive. The other dealt with the risks of having state run medical care with all the implied risks of politicking and top down decisions made by non-professionals. The provincial political class was not very influential but rather detached in its approach and
since medical care was the monolithic political issue at this level it provided for a degree of self-regulating organisations of huge dimensions for which there was little competence neither among provincial politicians nor among the medical profession itself. The state is shying away fromshouldering any direct responsibility. With regard to centralisation as a habit of the Swedish political culture some decentralisation in this respect is widely regarded as welcome.

Today the whole political spectrum demands the scrapping of the provincial health care systems. The provincial administration is seen as a superfluous mesolevel between individual health care units and the state. The provincial responsibility for this activity has become more of an end in itself than any rational policy. At the same time it is deemed important that apart from the university clinics there exist larger units of health care where courses can be held for an updating of knowledge and research. The present cost crunch is however causing panicky decisions to sack hospital physicians and leave primary care centres unmanned plus a number of other bureaucratic measures, which have become subject to major criticism in particular from inside the profession. This proves, according to the critics, that the provincial polity is unable to handle the health care sector.

Some critics compare the Swedish system with the British one. They invariably find that the NHS with all its shortcomings is vastly superior to the Swedish one. The NHS is put forth as a model both in terms of organisation and the services it offers. One of those services is that it is much cheaper to clients. The other is its much more preferable form of organisation compared to the wrecked Swedish model. In the UK the state has the ultimate responsibility. This puts the burden to correct evils and inconveniences in the system on the shoulders of the Health Care Ministry. The Minister in charge, Alan Milburn at the present, is always held accountable to the House of Commons.

75% of the workload and the budget has been placed on PCTs (Primary Care Trusts) that is local units, which with a minimum of administration shoulder the total responsibility for the health care within a limited geographical area that is corresponding to a small municipality. These PCTs must provide everybody with access to general practitioners (GPs), treatment by specialists in hospitals, dentists, opticians, psychiatry clinics, acute consultations, ambulances, chemistry shops. Every PCT is held accountable to the Ministry and the Health Care Secretary. The line is straight without any intermediaries. The GP has a key role in both the old and the new NHS. The GP has the authority to send the patient to a specialist that the GP trusts rather than, as is the cumbersome case in Sweden, providing the patient with a remittance to an anonymous clinic within an undetermined future.

A primary care system has indeed rooted itself in many municipalities in Sweden since more than a decade. This system is dependent the will of enough GPs to give up a specialist career and opt for a holistic treatment of the patients. But there is no incentive with regard to payment according to number of patients. In the UK on the other hand the GP who prefers to work half time and specialize for the rest is paid accordingly. Those who are pulling more of their weights are duly rewarded. Furthermore hospitals and GP receptions are undergoing national quality evaluations where the grades are zero to three stars in order to indicate quality standards to patients. Star rating is made on the basis of shorter waiting lists, professional performance, organisation and work environment, and the experience of the individual patient. The NHS model has the leitmotif of caring about the individual patient. In the Swedish province ruled half-house system such an approach has been reduced to lip service even though there exist glorious examples of an individualized care of pre-eminence
at the university clinics, which for obvious reasons give more complicated cases special attention for the purposes of research (cf in particular an article in SvD called learn from British health care published on the 10th of January 2004 written by a leading pathologist at Uppsala university clinic).

Other Swedish critics from within the profession insist that much more of resources should be allocated to the specialist clinics at the cost of the GPs and primary care (cf for instance some leading pediatricians who have published radically critical articles in the broadsheet press with this implication). Others still are praising the GP system to the skies referring to the work by Barbara Starfield on the potentials of GP work (see B. Starfield (1998) Primary Care: Balancing Health Needs, Services and Technology. Oxford UP). For the convenience of more direct comparisons a highly influential critical study called “The sick care” (Stockholm October 2003, Ekerlid publishers) scrutinized the state of health care systems in OECD nations. The weight of legitimacy accorded to this study appeared in the fact that one of the co-authors is the economist in chief of private sector industry and a grandson of Gunnar Myrdal and thus above questioning in every political camp.

The startling results of this comparison shows that Sweden has far more people than any other nation employed within the health care system as a percentage of the total number of people active in employment. Finland and Norway come closest but are still by far outdistanced by Sweden. France, the US and the UK are next in line but still far behind Norway and Finland. In fact Sweden has increased its health care staffs during the past three decades by quite astounding figures. Paradoxically enough however waiting lists are much higher in Sweden than elsewhere when the number of physicians increased by 185% during 1975-2001 or from 851 to 24,233, the number of nurses by 130% from 30,785 to 70,89 and the number of assistant nurses from 9,343 to 33,998 while the lesser degree of care assistants was scrapped to the extent that overall the less qualified personnel actual decreased while there was a sharp increase at the top.

At the same time the figures for hospital beds show an 80% decrease or an availability of now clearly less than 30,000 whereas a quarter century ago there were 136,000 beds available. Reforms making the system more efficient including daytime surgery reduced costs to an extent that the number of employees should have decreased accordingly. The contrary is the case with sharply increased numbers of doctors and nurses and as a result the number of visits by patients have fallen to 2.7 a day from 7.33 a day in 1975. Primary care maintains a figure of 13 patients a day. The reduced number of patient visits is neither a result of laxity nor of a lower degree of ambition. Rather it may be a question of wrong priorities. Incentive structures are weak and the treatment of patients too cumbersome. This does not mean that patients on the average receive more of administrative than medical attention. Since hospital cases require specialists most treatments tend to be more complicated and thus more time consuming.

Corresponding nations in western Europe should have experienced a similar development but rather the opposite is the truth. The number of hospital visits per doctor and year shows that the OECD average in 1998 was 2167 visits, the Swedish one 903, Germany 1857, Denmark 2069, France 2167, the US 2222, Canada 3143, the UK 3176, and Japan 8421. To put things into proportions some other Scandinavian nations Finland with 1400 and Norway with 1583 were also on the lower rung even though the Swedish figure remained abnormally low. Swedish doctors have a tendency to take out overtime work in the form of leisure time, which is more profitable. Also Swedish doctors have preferred to become specialists rather
than GPs even though there is no natural law saying that 80% of all physicians in a nation must work in hospital clinics.

Of the time at the disposal of the hospital physicians only 18% are devoted to direct patient care whereas 30% is set off for administration and documentation, 15% to meetings and communications, 14% to indirect patient care that involves a lot of paper work plus mixed rounds at the ward, 11% to further studies and research and 12% to moments of leisure. In primary care the GP spends 47% of the time at disposal to direct patient care, 25% to administration and documentation, 9% to meetings and communication, 6% to further studies and research, and 13% to moments of leisure. Also in Sweden hospitals are comparatively very large in part for the reasons given above, i.e. that specialists must stay in contact with peak research and knowledge in their own field and preferably also in adjacent ones. Remarkably enough, however, the same does not apply to central fields of technological application such as the use of IT. Its application in the Swedish health care sector is relatively much lower than in other sectors of society. This is endemic at every level where for instance the primary care system in only 4% of all cases has direct electronic communications with the IT system of other clinics, let alone those in other nations. In spite of this peak technology in other areas of the sector is up front. After all Sweden allocated 7.6% of GNP according to Swedish Statistical Central Bureau (SCB) to health care expenditures or 8.4% according to the OECD and 9.2% according to measures made by the WHO. Also by far bigger a proportion of the professionally active population are to be found in Swedish health care or 11.9% than in the US (7.4%), France 7.7%, the UK 6.4%, the US 7.4%, Italy 5.3%, and other Nordic countries.

How are resources used? This question is primarily related to individual as well as collective satisfaction experienced by patients. The paradoxical reduction of patient visits per day in spite of the far more than doubling of hospital physicians in a relatively short span of time entailed a number of irritations instead. Less accessibility and much worse behaviour towards the patients are among noteworthy effects. Patients have expressed dismay in the media where they rage against long waiting lists that affect morale and indifference on the part of physicians. The regular blame on lack of resources cannot be applied any more. There are for instance five times more cancer specialists than in the UK and twice as many as in the insurance-based Kaiser system in California. According to one poll in 2001 49 % of the patients consider that the quality of health care has worsened palpably since 1996. So do 38 to 59 percent of Swedish physicians themselves think in the same year, according to an international study made by Blendon et al and the same physicians expect quality to be aggravated and waiting lists to grow in the future.

A European study, called Europep, measured the rate of satisfaction among GPs in different European nations. In Sweden 35 per cent turned out to be dissatisfied with the lack of access to them. The share of content citizens had also fallen from 67 percent to 58 per cent only in the years between 1996 and 1998 whereupon Sweden fell from 6th to 10th place in Europe. Private care was given slightly higher ratings than public care. Overall satisfaction is greatest in Denmark and Finland. But none attains the degree of satisfaction as the insurance based, non-profit, Kaiser system of California. The bulk of those insured in this system come from working class and middle class backgrounds. The gist of this system is about selecting the right kind of insurance company and only secondarily about the form of care, which is reckoned to be of good quality anyhow.
The French health care system, which is regarded to be the best in the world, has met with a current crisis. Costs have mounted to the unpredicted heights of 11 billion euros. In early 2004 a reform package proposing radical reductions caused medical workers' unions to go out in strike. In the French system patients have had the opportunity to reach a specialist directly without any palpable waiting lists. The question of the role of des caisses d’assurances-maladie is clearly positioned. Both the agent of protection and the chairperson of CNAMTS (Caisse nationale d’assurances-maladie des travailleurs salariés) have publicly expressed their disagreement on the extension of their respective competences. The government tends to limit the little autonomy that the law has left to the caisses.

The universal coverage of medical care, which has been the last leg in an extended evolutionary process, implied a half-century long progressive offer to all residents in France of free health care. Two aspects have played a significant part regarding the role of the insurance system. One is the generalised social contribution (CSG) in the financing of health expenditures and the other has to do with the progressive weakening of the role of the caisses in the running of the health care system. The étatisme factor or state control of the health system becomes twice as reinforced. The CSG, which is largely financed by taxes on tobacco and alcohol, has successively increased its share in the financing of sickness insurance from 4.2% in 1989 and barely 8% in 1994 to between 40 to 50% in early 21st century estimates. Much of the health insurance used to be drawn from salaries and is now to a rapidly growing extent taken from item taxation instead. In political rhetoric the CSG is called a contribution rather than a form of taxation at the same time as the system is presented as more equitable. However, the potential consequences of an étatisation of the trusteeship of the health system have become much heavier.

The state also shoulders the responsibility to set the relative price on surgical or other treatments. The insurance funds only take partial responsibility for medical expenditures representing little more than one fifth of those relating to sickness insurance. As a neocorporatist agency par préférence the CNAMTS proposed a strategic plan for the government to realise savings of more than 60 billion French francs in three years provided that the caisses position themselves as buyers of health care (acheteurs de soin). Those, i.e. the caisses are the ones who regularly negotiate with producers of care such as physicians, hospitals and clinics, the pharmaceutical industry, etc. The government did only protractedly respond to the proposal by CNAMTS and then a year later only indirectly when it presented to parliament a Social Security Finance Act for the year 2000.

The contents of this Act ended up in the reverse of the original proposal in the sense that the state henceforth should shoulder all expenditures of private clinics to the same extent as the sickness insurance funds. However the interest organisations –le Medef, la CFDT, la CGC, la CFTC and la Mutualité française – which constituted the majority interests on the administrative council of the CNAMTS had no wish to appear responsible for a deficit that was out of their control. This system was considered likely to survive unto 2008-2010, when the baby-boomers of the 1940s would put inordinate pressure on the social security system with dire consequences for the sickness insurance system.

If the Jospin government had been in coherence with what appeared to be its wish to bring the French health care system under full state control then it should have suppressed the sickness insurance funds for the benefit of direct financing of health care products and a regional health care system either through partial decentralisation as in Sweden or Canada (that put the financing of its health care system under state control in 1980), or through de-
concentration as in the UK. Such a measure would have its implied consequences of system coherence and saved 20 billion francs plus the inconvenience of up to a number of a hundred thousand redundancies. These reform propositions were not supported enough during the Jospin administration and has now in early 2004 become subject to fundamental controversies that will decide much of the credibility of French public policy.

The alternative solution would be to copy the German and Dutch way and hand back power to the sickness-insurance funds. For such a retraction it could then be argued that these non-profit insurance funds are charged with a public service mission while guarding private rights. The state would then still be reimbursing sick people not only for treatments but also for outlays with regard to medicines and drugs. The state could reimburse up to 100% in more needy cases and then to 60% or 30% in other cases. The insurance funds on their part are free to negotiate with health care producers and the bio-medical industry. Hospitals are meanwhile assured of public service elements to be financed by the state. Competition is thus provided by each of the insurance funds and their capacity to negotiate with care providers on tariffs but also for the general well being of their members. The state in turn finds its role again as controller of the funds, guarantor of the quality of health institutions, provider of equitable repartition of health care supply but not any more the simultaneous roles of concept maker, producer and controller.

French analysts find a number of weak features in French medicine. The contaminated blood affaire, which implicated leading government figures, signified blatant incompetence or more delicately put illegitimacy on the part of the state in handling practical medical issues. A large part of the medical corps does not accept the legitimacy of the sickness insurance fund. Medical training is subject to review and there is an explosion of medical scientists, which is vouching for high quality in health care as well as possible over supply of physicians. Hence certain categories of French physicians are notoriously under-paid. Prescriptions of medicine and drugs are considered unreasonable and have made the French into the foremost of consumers of medical drugs in the world. Germans consume 70% and Britons 40% of what the French do. French health care presupposes that all doctors are well updated regarding all novelties in science journals. There is a constant discussion whether it is the sickness insurance funds or the regional medical associations that control medicine in practice.

GPs continue to be educated by default since French health care is famous for its direct access to specialists. The main features of the French system in practice have been retained since the 1920s. The state rules the sector and only more so after the statutes of April 1996, where the government pretended to embrace economic liberalism. In fact ever since 1970 all planning and mechanisms relating to it has involved the state and its implied sanctioning of any new acquisition whether in the form of a bed or an innovative practice. However, the health programme has not attained a more even distribution of hospitals and medical establishments across the nation. The same considerable inter and intra regional inequalities as 30 years ago manifest themselves. When in 1970 the amount of hospital beds were considered sufficient their number have since been reduced 17 times. The closing down of regional hospitals means an organised division of the market between large cities rather than a national provision of competition. A minimum of economic culture is required on the part of the health authorities, which is lacking in the current situation.

Arguments against state regulations, which end up in over-administration of hospitals, are as common in the French debate as elsewhere. The Minister of Health nominates hospital positions in accordance with a specific statute conceived by the Ministry. However, hardly
anything is done to address the asymmetrical relations in terms of resources and equipment between provincial hospitals and university clinics. The former may be small but are still often enough as expensive to run as the latter. Another comparable nation, Japan, which consumes as much medical drugs as France per capita and thus holds a world record, still pays two percent less than France in financial costs for its health care system. A rapid spread of progressive medical systems is thus not necessarily synonymous with elevated costs. On the other hand one of the reasons for the high costs of the American system derives from the bureaucracy imposed by the insurance companies on the actors of the system. The most viable measure according to French observers would be to institute as much autonomy as possible to the roles and procedures of the respective company, which should remain state companies but be submitted to a private legal justice system.

The French biomedical industry that used to be a prestigious SME industrial branch of the colbertist state has lost plenty of ground. The colbertist state and its relevant ministries (industry, health etc.) have not lived up to its doctrine and understood properly to support it adequately since it is not part of the criteria of trans-national and global markets. Being still predominately SMEs their series of production are too small to be competitive on such a scale. However several crucial innovations have recently been conceived in France and acquired a global spread through trans-national apparatuses and equipments. This sector remains under the tutelage and control of at least six state ministries, which may encourage them to evade colbertism for the agencies of the EU instead. This has awakened the state into a renewed interest to support innovations in this domain.

The pharmaceutical industry has managed to maintain the same price level for the past half century. In all likelihood that will be difficult to retain in the future. There is the highest dependency on pharmaceuticals and drugs in the world together with Japan due to the low price level but in terms of pharmaceutical business opportunities this has contributed to reduce the French share of the global market. The physicians, who are largely devoid of critical minds, have found themselves disarmed and believe their continued learning being dependent on financing by pharmaceutical laboratories. Hence, it is inferred, the French have become the foremost consumers of tranquillisers and anti-depressives, which annually lead to 140 000 hospitalisations due to accidents with medicines of which 9 % are fatal (See C. Béraud (2002) *Petite encyclopédie critique du medicament*. L’Atelier, Paris). The drugs industry have assumed a half house solution in the sense that price control of drugs has largely come to dictate health care policy and state incentives are there to boost innovations for stronger market positions. Once the euro-market begins to work full out the étatist health care policy with all its ramifications will be up against the general quest for not only an adjustment but also a convergence towards a European medical system.

Is the French system better than other national health care policies? The Canadians do definitely find their state control system superior to the overall American models, which vary to an extent (see above). The Americans are satisfied with the rate and efficiency of the care they receive even though there is vast ground for the absence of equality in their system as well as too much control of health by insurance companies, lawyers and the mighty drug peddlers. The Clintons’ failure to reform the medical-care system a decade ago was caused by a flawed strategy involving too complicated solutions and direct confrontation with the drug giants, whom no politician will force to concede a single inch of territory. Cajoling would have been a more viable tactic then carried out by medical professionals rather than by politicised lawyers.
Europeans have a much stronger tendency to be harshly self-critical. In the wake of a French reform in early 2004 there are scathing words of criticism for all the main actors in the sector by democracy analysts. The state, l’Assemblée Nationale and the parliamentarian debate there on medical care in November 1999, the unions and those behind the hospital strike in February 2000 were all depicted as detrimental to a democratic public sphere in this respect. The February 2000 strike and the parliamentary debate three months earlier managed together, according to one influential comment, to annul two years of serious efforts to reduce the inequalities in interregional allocations. The state is portrayed as a chaff blindly redistributing money beyond any parliamentary control or involvement of any political bodies or actors in l’Assemblée Nationale.

One issue, which has come to the fore at this juncture, concerns the education of medical students in EU member nations. This is decisive for the division of responsibility between General Practitioners and hospital bound specialists and eventually the politics of favouring GPs versus specialists. In Germany the specific education and training of GPs include participation of Balint groups so called after the Hungarian-British psychiatrist Michael Balint, who already in the 1940s formed groups of about ten medical students that would meet twice a month to approach relational stumbling blocks that arise in the medical profession. In order to handle such problems they talk about topics such as wish, repulsion, anguish, sorrow, wrath, aggressiveness, fright and doubt (Cf Michael Balint (2003) Le Médecin, le Malade et la Maladie. Payot, Paris). The fundamental idea is to probe and search for the essentially human aspect in relations between physicians and patients.

Apart from Germany this methodological approach is also applied in the UK, the Netherlands, Scandinavia and the US. In France on the other hand medical students are urged to suppress their sentiments. Balint’s practice appears to be despised and rejected in the majority of medical faculties and only about perhaps a hundred get in contact with it in the entirety of l’Hexagone. Medical faculties do not give anything for the relational dimension in health care. The old traditional forms of amphitheatrical teaching without ever questioning medical authorities are still alive just as the submissive role of the patient as training object to medical research and learning. On the other hand there does not exist any national consensus as to how to pursue medical courses, which tend to follow local and regional profiles. A leading mouthpiece of French GPs insists that the French medical corps seems to have this particularity of ignoring that scientific knowledge is subject to constant, perennial growth and change (see Martin Winckler (2004), Médecins sous influences. Les failles du système de santé français. LMD, Vol. 51, No 598., p. 3). French Sachverständige or field experts are as viciously critical of the own culture and system as everybody else is of theirs.

To the democratic aspect pertain obviously the rights of the patient and the potential to discuss frankly about sensitive issues regarding health care. Among relevant organisations and interest groups there is l’association d’aide aux victimes d’accidents médicaux on the side of the patients that noted almost 5000 medical accidents during 2003, while la Société hospitalière d’assurance mutuelle (Sham), which is the principal insurer of hospitals and clinics registered almost 4 500 corporal accidents during 2002. Annually, between four and ten thousands die unnecessarily from infections attributable to hospital conditions. This war of numbers takes place between patient associations, insurance companies and public authorities while 13,6 million individuals are hospitalised per annum for a total of 177 million days.
However, hospitals save perhaps tenfold more due to improved anaesthesia only since 1980. Confidence among French people in hospitals and the health care system is on the rise, which is indicated by increasingly more frequent consultations. Also the Sham reports that the sheer numbers and costs of reclamations have increased threefold in ten years. Hence in September 2003 a pool of specialists was created due to the judicialisation of problems linked to health care. The rights of the patients were confirmed in the legal act of March 4 2002 recognising that the patient from here on is a person and not a case of pathology. This was reported to have come as a crude shock to the corps of physicians, who were used to submissive silence on the part of the patients (G. Denis (2004) *Les hôpitaux sont-ils dangereux?* LFM Samedi Janvier 24, p. 53).

In connection with the debate on the law to secure safe transfusions and medical drugs, enacted on January 4 in 1993, an obligation to safeguard secure sanitation ensued. During the 1990s agencies of sanitary and security vigil acquired the role of alerting hospitals with regard to medicine and material. This was another lay intrusion into the medical bastion where regulations on sterilisation and hygiene remained the primary rules since Pasteur. However, the CSOs are gaining ground due to the now recognised battle against nosocomial infections. There is a growing advocacy for associating organised patients to decision-making on health care policies. Hospitals could be obligated to publish indicators informing users of the politics of prevention introduced in terms of staff training and the politics of antibiotics etc. and the results of this practice (see M. Betti-Cusso (2004) *Infections nosocomiales, les maladies honteuses de l'hôpital*. LFM op.cit., p. 57). At the same time the president of the Fédération hospitalière de France indicated that the organised medical profession would not accept any new rules and regulations without more financial means allocated to their cause.

Since 1976 the sickness insurance system has been exposed to a master plan of expenditures every 18th month engineered by rightist and leftist governments in equal measure in order to adjust medical drug prices and fixed hospital prices up-wards. Such measures are part of the law on financing of social security for 2004 that was enacted in October 2003. Reports on the health care system and the future of the sickness insurance funds were delivered to the French government in early 2004. The diagnostic of the health care system was shared under the chairmanship of a magistrate of the *Cour des Comptes*, who is also chairman of the *Haut Conseil pour l’avenir de l’assurance-maladie*. It engaged more than fifty people including representatives of labour and employer organisations, the medical profession, the national sickness-insurance funds, parliamentarians, patient associations, public authorities or qualified persons, who approved of it in unanimity. The report was accompanied by a synthesis of twenty notes, which called for the urgency of a recovery through quality.

A new phase of the reform is prepared by the government involving a meeting between all concerned actors in the beginning of February 2004. Lack of organisation is the main reason for the 11 billion euros deficit, which in case of no reform would amount to 66 billion euros in 2020. The *Haut Conseil* rejects any prospect of gross indebtedness. An improvement of the functioning of the system would then imply an enlargement of the basis of social contributions. Initially such measures would render 7.5 billion euros to the funds. Medef and Guillaume Sarkozy would be opposed to any increase of obligatory levying. In order to maintain the principles of equality and save the armature of the system the parameters but not the logic could be changed. There could be no durable reform without a reorganisation of the health care system, it was concluded in the report.
The SG of CGT Bertrand Thibault stated that if a status quo would not be an option then newly invented solutions would not necessarily be met by a consensus. On the cards is a stand to be taken by the government between a reinforcement of powers of the state and making the agencies and interests representing health care more responsible. In the *Haut Conseil* analysis several aspects have to be addressed. One matter concerns the geographical inequality in access to health care depending on territories. Another has to do with the insufficient attention to quality given to patients in the care-cum-reimbursement system. A third must deal with a more substantial and independent professional training to meet more flexible demands in the insurance system that ultimately will provide patients with a choice of care at the same time as surplus costs and two to four times greater dependencies on antidepressant and tranquillisers than neighbouring nations will melt away. Still in the view of the *Haut Conseil* the partitioning off between GPs and hospitals remains the greatest obstacle for an acceptable distribution of health care offerings.

The public debate has so far been limited to two strike manifestations as the way seven syndicates – CGT, FO, SUD, CFTC, INPH (l'Intersyndicat national des praticiens hospitaliers), CHG (la Confédération des hôpitaux généraux), CMH (la Coordination médicale hospitalière) – could voice a collective opinion. Moreover these seven who represent the vast majority of physicians, nurses and staff have risked their reputation in the public sphere. Public hospitals find themselves in a special spot since the reduction of working hours to 35 without any new job creation nor sufficient reorganisation of work coincided with the cost crisis. The unions expect to address both gross differences between regions and départements as well as different articulations on the part of those interests, who represent the exercise of clinical disciplines and who react more expressly and verbally, versus those, who exercise more technical ones such as radiology and surgery. Among leading physicians 53 reacted at first through the *Haut Conseil* and were later joined by 186 more. Together they vented their worries that the sensitivity of social links would be put to test by putting valuations on activities that might also lead to growing risks of growing competition between the public and private. In his article in the Rebons section of Liberation (21 January 2004, p. 35) Bernard Thibault of the CGT paid tribute to the French social security system as remaining one of remarkable solidarity and a powerful instrument to ensure the fundamental rights of humanity.

Thibault rejected however that wage earners were to be made culpable of the unsolved financial cost equation. To satisfy social needs, to define necessary measures, revalue in particular prevention, to take into account the extension of life expectancy as well as technological progress all count as basics. At the basis of these needs the most appropriate conditions for facilitating necessary financing should be defined. In other words, Thibault opined, the financing issue should be open to discussion just as the running of the health care system, in short their governance to use a concept in fashion. Solutions should be in conformity with medical and social needs. The financing of social protection is not a technical problem however complex but a principal one concerning the choice of social organisation as well as the responsibility of different actors such as enterprises, whose share in financing social protection has diminished by 10% in two decades - from 53.8% in 1981 to 44% in 1999 – whereas the expenditures of wage earners and society have increased correspondingly and sharply so for under employment and unemployment. Of the social costs fallen on enterprises the social security system was sapped of nearly 20 billion euros. At the same time universalising social coverage and transforming its financing, 88% of which are paid by wage earners, call for new ideas regarding governance.
So far Thibault was the most articulate single voice in the debate. On the other hand he represented the most distinct of opinions with the most clear political strategy. The French system lacks transparency, according to an administrative director of hospital services, in that any effort to improve the quality of health or the working organisation has no clear financing prospect. However with the cost cutting reforms of the government it is no longer certain that the quality of service is maintained as a primary objective. As long as researchers and interests of rationalisation, often representing new forms of governance, find a potential in palpable productivity improvements and a staff ready to act for it the debate will be stuck with technical prerogatives. The debate should rather focus on innovative initiatives from the GP’s district level and regional levels. In focus for such innovations are more or less constantly access to pertinent treatment and the sense that costs are universally shared according to ability and adequate participation by patients in the process of completing a full circle in order to receive quality treatment (cf *La Santé ingérable?* Revue francaise de gestion, no 146, septembre-octobre 2003; *Santé: quelles réformes?* Revue Sociétal, no 36, 2002; *Site du Centre de recherches en économie de la santé: www.credes.fr*).

The health care and social protection system of the Netherlands is by contrast quite original in comparison to the French one. The relevant Ministry is for Health, Well-Being and Sport, which indicates a preventive prophylactic approach. Two thirds of the population are covered by the social protection system as their only security element while the remaining third sign private insurance contracts. On top of this there is a law for exceptional expenses regarding long term and costly illnesses. In the moment that it is in the interest of the public health the insurance funds are authorized to propose complementary allowances for the obligatory covering system. The Dutch system foresees compensations for the sheer width of risks concerning insurance companies. The total of Dutch plans encompass 10% of GNP. France by comparison spends twice as much on medication whereas the Dutch invest much more in psychological assistance. However the financing of social protection meets as great difficulties relatively speaking in the Dutch system as anywhere else due to the ageing gentrification of the population, which is encouraged not to seek hospital care to quite the extent now occurring. The prototypical Dutch advice at hospitals is for the patients to in the first place stay in touch with their *huisarts* and to shun antibiotics at all costs unless a responsible physician, who is aware of all current risks, prescribes not just any but a very particular kind.

The Dutch medical care budget can be kept as low as two billion euros due to several health care items being labelled under private label: physiotherapy after nine sessions, transports to clinics, medicine bought without prescription, dental treatment after 18, contraceptive pills after 21, psychotherapeutic sessions after 30, and initial fertilization programmes. In 2005 a new measure will be introduced: the first 250 euros insurance deposits will not be reimbursed. The 2005 reform will be pursued in 2006 with the fusion of the two systems, public and private. This will not modify the solidarity principle on which the Dutch social protection system is founded. The new security plan cannot refuse the covering of patients and cannot be selective with regard to kinds of insurance payments. Incentives will be stepped up to increased competition between insurers, who may establish contracts with hospitals and pharmaceutical laboratories. The importance of the reform resides in the creation of protective, compensatory mechanisms in a semi-public system.

The big difference between French and Dutch medical systems is the resort to prescriptions in the former and the opposite in the latter. The Dutch GP or *huisart* functions
as a gatekeeper in that respect. But prescriptions tend to expand also in the Dutch system since there is a new alarm that as many as 800,000 people (of 16.2 million inhabitants) are dependent on some form of psycho-pharmaceutical medication. The Dutch strategy will hence focus on preventive measures such as a policy on medication and stricter anti-tobacco and anti-obesity programmes in order to contain the more obvious evils in ordinary living. A strict policy against antibiotics has brought the level of MRSA to lower levels than in the worst hit nations of Europe such as the UK, Austria and France.

However, the future is about some real issues which affect people directly and which ought to be up front in public sphere rhetoric. The populations of EU member nations have become used to the perspective of society bearing the costs of medical care since health should not be a question of the purse. Moreover they are expecting quality treatment as a result of peak research at medical faculties. They are tired of long waiting lists for essential treatment since anybody handicapped by an ailment wants to be rid of it and be back with all faculties in tact. They want to be met not by distant and too often high-handed superiors but by real experts who understand not only the medical subtleties but also the whole situation and can use the word empathy in a correct way.

They want a responsible relation between physicians and the pharmaceutical companies, today too often referred to as the drug peddlers since too many people are on permanent medication that debilitates and aggravates the symptoms while creating new illusory dependencies, which are hard to get out of for the average victim without a great amount of support from societal institutions. They want every measure to be taken to prevent the new risks from developing and flourishing. Even in a low frequency nation of MRSA such as Sweden 20 to 40 new MRSA victims are reported every day. It took only five years for the UK to go from two to three percent of MRSA to a fifty percent risk frequency of this hospital generated near fatal infection. Due to excessive carelessness with antibiotics widespread and variegated germ resistance has reached dangerous levels and is increasingly costly to cope with. Some hospitals became high-risk territories.

The university clinic in Gothenburg, which has enjoyed a high reputation for most of its existence, met with the MRSA problem at the very end of the 1990s. The situation became alarming to the extent that extraordinary resources were set in to stave it off. After some time this mobilisation of proper resources began to yield beneficial results. Delegations came from everywhere to find out how they had managed to get the problem under control. Currently the university clinics in the Stockholm region are the high-risk areas with mounting laboratory work and expenses as a result. In France the presence and scare caused by MRSA have become an acute reality.

Hence primary care institutions with GPs, who get proper opportunities to get updated on the research front, emerge as new attractions. Enter the crucial issue of ethics and its corollary democracy into the public sphere fray since the proper balance between primary care GPs and hospital specialists should involve the patient as a subject and not as an object. Primary care absorbs 75% of allocations and the primary care GP devotes considerable time to listen and become attuned to the whole picture of the patient’s situation. However there is a serious element of discrimination involved here in the fact that in multicultural and hence also more deprived suburban districts GPs, who take their time with their patients are considered to have broken with productivity regulations. Their primary care practices are inevitably merged into larger units in these districts, which is sharply aggravating conditions for
The hypothesis may be tested that the more comfortable and part of democratic decision-making the average citizen-patient the more trust will be invested into not only the health care sector but into society as a whole. This may automatically reduce the high levels of sick leave in all EU nations. But there are more than twice as many on long-term sick leave or sick absence in Sweden. This remains a riddle for which at least it is hard to find any solid explanation. In comparison with other nations sickness absence is in general higher in Sweden, Norway and the Netherlands than in Denmark, Finland, Germany, France and the UK. Structural factors can account for some of these differences.

However, there appear to be just as many intangible cultural factors to explain the excessive symptoms in Sweden. For one, sick absence became just as frequent in absolute terms among women as among men during the 1980s in spite of the fact that men in employment were still considerably more. The gender factor has also tended to become even more pointed since then. Burnt out cases and depression from exhaustion are by far the most increasing causes of absence from the labour market among both sexes but far more common among women between 18-34 years of age. Since 1997 an explosion has occurred in this direction. 23% more early retirements have added to the extraordinary picture of population imbalances.

Ellen Hyttsten of Landstingsförbundet points out that much is on paper in health care law but reality is not always there. Sees low correlation between health care system and governing bodies. Low correlation between insurance system and democracy. Medication a problem since there are clearly cases of overmedication such as 13 different medicines per patient and in odd cases over 25 per patient where one take out the other etc. and there are cases of under medication such as the case with depressed elderly; general calculation saying that due to insufficient follow up the health care system and thus the system as a whole will make an annual loss of 5 billion SEK

Patient influence and power on the rise from 3 to 4

Differences between the county councils where the position of patients also vary quite a bit and the health care barometer says something where the CCs are not informed enough.

There exists a notably good connection between highly specialised care and general care units, which is an exception rather than a rule perhaps.

The impact of state committee investigations and reports on policy making is much lower than it ought to be

Ministry of Health and Social Affairs has a surprisingly large number of external contacts with ordinary people and CSOs who approach the department directly with complaints, comments, suggestions and simple questions and the dept holds itself approachable and accessible to all sorts of these kind of external communications

Med representativ demokrati skall den basala inflytande frågan vara löst, that is in a representative democracy all basic questions of democratic influence ought to be solved via electoral opportunities

The level of information on the part of the citizenry is comparatively high and ought to be much higher but there clearly is a potential
There does so far not exist any acceptable or sufficient method to judge the workings and performance of medical systems by the public, 50 items in quality register but not opened up yet

Good experience of coverage in Jämtlands läns landsting by the media Commitment to medical research & research through periodicals more than enough rather difficult to sift through, but still no access to quality register

Immigrants do not experience it to be egalitarian in ethical norms

Objective commitment on the part of authorities and service personnel, staff, to cope in a progressive manner with ethnic/cultural divides

Ansvarsnämnden could always be approached for complaints

Pharmaceuticals where the medical company is not officially registered there but only there is there a lack of welfare coverage