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Title of the Entry: **Health services: migrant professionals (Mode 3)**

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text

Legal framework

According to the 2018 EU Labour Mobility report, there were 352 000 mobile health professionals, 20 per cent of which were doctors and 40 per cent of which were nurses working in another Member State.[1] Health professionals (doctors, nurses, dentists, pharmacists) have been working abroad for many years, either temporarily or permanently. Driving forces for health professionals to move to another MS to work include, for example, financial reasons, better training and career opportunities, working environment and conditions.

With the focus on 'Mode 3' mobility of services delivery, i.e. commercial presence abroad, the emphasis will be on the regulatory framework concerning health professionals who permanently stay in another MS after graduation with the purpose and effect of delivering health services.

The right to pursue a profession, either in a self-employed or employed capacity, in another Member State has been generally recognised as a key right under the Treaty on the Functioning of the European Union (TFEU), either under Article 49 (freedom of establishment) or Article 56 (services). In addition, 'the European Parliament and the Council shall issue directives for the mutual recognition of diplomas, certificates and other evidence of formal qualifications', allowing health professionals to pursue their professional activities in another MS, either as self-employed or a worker. The applicable directive is the Professional Qualifications Directive 2005/36/EU, replacing the so-called 'sectoral' directives[2] and setting out more detailed rules to regulate the mutual recognition of professional qualifications.[3] The Professional Qualifications (PQ) Directive modernises the sectoral directives (doctors, nurses, dentists, midwifes and pharmacists), in a way that it consolidates different several recognition regimes (professional qualifications and

[1] European Commission, 2017 annual report on intra-EU labour mobility, Final Report January 2018, p.114 <https://op.europa.eu/en/publication-detail/-/publication/cd298a3c-c06d-11e8-9893-01aa75ed71a1/language-en > accessed 20 July 2020.

[2] Including the following professions: doctors (Council Directive 75/362/EEC of 16 June 1975 OJ L 167/1); dentists (Council Directive 78/686/EEC of 25 July 1978 OJ L 233/1); veterinary surgeons (Council Directive 78/1026/EEC of 18 December 1978, OJ L 362/6); midwives (Council Directive 80/154/EEC of 21 January 1980 OJ L 33/1); pharmacists (Council Directive 85/432/EEC of 16 September 1985, OJ L 253/34); architects (Council Directive 85/384/EEC of 10 June 1985 OJ L 223/15)

[3] Directive 2005/36/EC of 7 September 2005 on the recognition of professional qualifications, OJ L 255/22.

professional experiences), for providing cross-border services or pursuing activities as a self-employed person or an employee. The Directive confirms several key principles regulated by the sectoral directives: equal treatment of qualifications; automatic recognition of regulated professions and minimum level training conditions, while incorporating new issues such as language requirements; mutual assistance; regulating so-called third-country diplomas by introducing compensatory measures; the exchange of information on 'problem doctors'; and excluding cross-border telemedicine, as it is based on the 'country of origin principle'. The Directive sets the rules for providing services on a temporary and occasional basis, and also for professionals who want to establish on a permanent basis. For health professionals, the automatic recognition (AR) system (Article 21) is applicable for regulated professions (doctors, nurses, dentists, midwifes, pharmacists, veterinarians, and architects), meaning that access to that profession is based on the possession of a given formal qualification ensuring that the person concerned has undergone training which meets the minimum conditions laid down (Article 3(1)(a)). This AR system also applies to (new) medical specialities recognised by at least two MSs. The professional recognition allows the health professional to pursue the profession in the territory of another MS – on a temporary or occasional basis – under the same conditions as its nationals (Article 4). This could mean registration at the Medical Professional Chamber as an administrative condition prior to pursuing the profession, as well as confirming the professional Code of Conduct applicable, and the rules of professional liability, as these rules are directly linked to the practice of medicine and thus the professional rules of the Directive (Article 5(3)). That would be different when the rules concerned are not directly related to the actual professional practice (Konstantinidis, Case C-475/11). In that case, national rules on calculation of fees and advertising fall outside the scope of the Directive's professional rules, but must be examined under the principle of free movement of services (Article 56 TFEU), taking into account the public health and consumer protection exemption (Konstantinidis, Case C-475/11, para 58).

Each MS shall recognise the evidence provided of such regulation of professions, which satisfy the minimum training conditions. For instance, in the case of medicine basic medical training shall comprise a total of at least six years of study or 5500 training hours of both theory and practice at university level (Article 24(2)). Similar conditions apply to other regulated medical professions. Still, the Directive does not harmonise or coordinate the conditions for continuous professional development *after* completing the education programme. As a consequence, these permanent development and education standards differ by country and health professions (both in content and duration), with mandatory and voluntary systems. To some extent that omission has been recognised by the revised Directive (Directive 2013/55/EU), amending Directive 2005/36/EC as it encourages continuous professional development, so that health professionals are able to update their knowledge 'to maintain a safe and effective practice' (Article 22). But apart from encouraging the exchange of best practices of permanent education, the revised Directive does not solve that issue.
For other health professions that do not qualify for automatic recognition (e.g. physiotherapists, health assistants) the general regime of diplomas is applicable.
Although the system has recognition as its starting point, MSs are allowed to impose compensatory measures (adaptation period, or an aptitude test) under certain conditions (Article 14).

The PQ Directive is applicable to MS diplomas and qualifications. In the case of third-country diplomas, MSs may employ these qualified health professionals – nurses and physicians – but must ensure compliance of professional qualifications with the minimum training requirements at EU level (and if necessary, apply compensation measures). This practice is based on the CJEU jurisprudence on third-country diplomas (Tawil-Albertini C-154/93, Haim C-319/92, Hocsman C-238/98).

The revised Directive also confirms the Court's case law on partial access to a profession where the activities covered by a regulated profession differ from one country to another (Colegio de Ingenieros de Caminos, Canales y Puertos, C-330/03; Nasiopoulos, C-575/11). It can benefit professionals who engage in a genuine economic activity in their home Member State which does not exist, in its own right, in the Member State where they wish to work. The competent authority (CA) may grant partial access when: (i) the professional is fully qualified in the home MS; (ii) the application of compensation measures would amount to requiring the applicant to complete the full programme of education in the host MS; (iii) the professional activities can be split in separable parts falling under the regulated profession in the host Member State (Article 4f). Still, the refusal of partial access can be objectively justified for reasons of general interest (e.g. consumer and health protection). But in *Nasiopoulos*, the total exclusion from even partial access to the profession of physiotherapist goes beyond what is necessary since a less restrictive measure was more likely. Consequently, the host MS has to accept and organise partial access to pursue the paramedic profession. But that does not mean that MSs have to lower the relevant qualification standards (Malta Dental Technologists Association and Reynaud, C-125/16, paras 47-49).

In order to pursue the profession in the host MS, knowledge of the language is essential. The PQ Directive does not specify the level of knowledge, just declaring that the level must be 'necessary for practising the profession', which means that the professional can communicate effectively in the host MS (Article 53). In addition, the revised Directive allows standard language controls applied for professionals with patient safety implications (Article 53(3)). But the language requirement should be separated from the professional requirements and will be tested by the MS CAs, and limited to the knowledge of one official language of the host MS. In general, the assessment of the language skills should be proportionate to the activity to be pursued, which gives State authorities some flexibility. Still, the Court's case law on mandatory language tests has proved rather problematic to solve (Commission/Belgium, C-317/14, paras 27-31).

In order to simplify the recognition procedure, the revised Directive makes the electronic exchange of administrative information, the Internal Market Information (IMI) system, mandatory. In addition, new features such as the European Professional Card (EPC) and an alert system were introduced to facilitate the mobility of health professionals within the EU. The EPC is an online tool that supports the holder of a professional qualification in applying for the CA of the host MS, within the IMI system (Article 4a). The home MS will verify whether the applicant's professional diploma is valid and authentic, and provide the relevant data to the host MS, who will decide within a certain time limit to decide on issuing the EPC. In the case of justified doubts, the host MD may request additional information. Where the host country authority fails to take a decision within prescribed deadlines, the EPC is issued

automatically. The corresponding IMI file has become an important platform to notify changes in the professional qualifications. For instance, the file will be updated with information regarding criminal and disciplinary sanctions related to the prohibition or restriction of practising the profession. In line with the Data Protection Regulation (Reg. 2016/679) such updates shall include the deletion of information which is no longer required. Both the holder and CAs have access to the IMI file and will be informed immediately after any updates (Article 4e).
The EPC was introduced in 2016 and currently available for a limited number of professions (nurses, physiotherapists, pharmacists – Regulation 2015/983). It is expected that it will be extended to other health professions in the near future.

The second new element, the alert mechanism, was created to ensure patient safety by preventing 'rogue' health professionals, who have been prohibited or restricted from practice in one EU country, or who have used falsified diplomas, from continuing to practice across national borders. The alert mechanism is applicable to all health professions whose actions could affect patient safety (Article 56a). When a professional has been banned, even temporarily, from carrying out their professional activity, an IMI alert will be sent by a CA to all other relevant CAs in other Member States. These alerts will include key information relating to the professional such as: the identity; the profession concerned; the scope of the restriction or prohibition; and the period during which the restriction or prohibition applies (Article 56a (2)).
A Commission evaluation in 2018 concluded that both policy tools, the EPC and alert mechanism, functioned well and had added value.[4] Apart from the steadily increasing number of EPC applications by profession, it showed a significant rise in alerts sent by all MSs. The vast majority of the alerts were for cases where a professional was restricted or prohibited from practice (p. 18). It is emphasised that it is the national sanction that triggers the alert and not the alert mechanism itself, as national sanctions and disciplinary systems differ by country. For instance, what is included as 'professional misconduct' differs by country. This diversity may cause some difficulty in case the action is lawful under the home MS legislation. For instance, the practice of euthanasia has been prohibited in many MSs, and physicians will be sanctioned when being involved in such practices in the host country. An IMI notification of such a criminal or disciplinary ruling will be send to all MSs, including the home MS which has legalised euthanasia. Still, that decision (e.g. removal of the right to practice) has to be respected on the basis of the mutual recognition principle (of court decisions). Common understanding of the contextual differences is therefore important.

The revised Directive also introduced access to online information on all regulated health professions in each MS.[5] The information, including the contact details of the CA and other administrative formalities by country, is aimed to facilitate professional mobility and will be publicly accessible. In addition, 'assistance centres' will be established in each MS to support citizens with the recognition procedures of professional qualification, and inform them about the applicable national legislation and the rules of ethics (Article 57b).

[4] European Commission, Assessment of stakeholders' experience with the European Professional Card and the Alert Mechanism procedures, Brussels, 9.4.2018 SWD(2018) 90 final.
[5] European database on regulated professions: https://ec.europa.eu/growth/tools-databases/regprof/

In the context of the fight against the coronavirus pandemic, the Commission issued a communication to help MSs in addressing the shortages of certain health professions in emergency situations.[6] The communication clarifies how to speed up mutual recognition procedures of temporary migrating health professionals in line with the flexibilities allowed by the PQ Directive 2005/36/EC. It also clarifies how EU countries can ensure that the Directive's rules on minimum requirements on doctors and nurses training can be respected in cases where students are not able to complete their training because of disruptions due to the coronavirus crisis, including by requesting a derogation from these rules.

Not covered by the PQ Directive are the licensing conditions for opening a private practice in the host MS. As a general rule, the freedom of establishment can be duly restricted for reasons of general interest (public health protection) but national measures must apply an objective and consistent standard when assessing the 'need' for newly established private clinics as part of the proportionality test (Hartlauer mbH v. Wiener Landesregierung and Oberösterreichischer Landesregierung, C-169/07, paras 63-64).
Since Hartlauer, the Court has confirmed the marginal testing of the restrictive measure in Blanco Pérez, where a licensing system for new pharmacies was aimed to ensure pharmaceutical care of good quality and the measure appropriate to realise the public health objective, taking into account the geographical circumstances (Blanco Pérez and Chao Gómez, joined cases C-570/07 and C-571/07, paras 75-80).
Another justified restriction of both the freedom of establishment and freedom of workers, is a repay clause of the awarded bursary for training purposes abroad, in case the candidate fails to meet the bursary condition to practise the medical profession in the home MS after finalising their medical speciality in the host MS. Since the repay clause was intended to guarantee access to medical specialist care in the MS's region, and given the necessity and appropriateness to recruit a sufficient number of medical specialists, such a restriction was justified to protect public health (Simma Federspiel, C-419/16, paras 45-49).

Final comment. Without doubt, the PQ Directive and the freedom of movement and establishment have facilitated the mobility of health professionals in the EU. The consequent loss of high skills and/or competencies in one MS, means the gain of 'brains' for the receiving MS. In the long term, the imbalance of the health workforce among MSs and scarcity of – categories of – health professionals may undermine the continuity and sustainability of national health care systems. To fight this problem, the repay and licensing option as mentioned may contribute to solving that problem. But other 'retention' initiatives and European recruitment strategies to circulate and 'regain the brains' will be necessary to manage health workforce imbalances.[7]

Scholarly work

[6] European Commission, Communication from the Commission, Guidance on free movement of health professionals and minimum harmonisation of training in relation to COVID-19 emergency measures – recommendations regarding Directive 2005/36/EC Brussels, 7.5.2020 C(2020) 3072 final
[7] Kuhlmann, 131.

Tamara K Hervey, Jean V McHale, *European Union Health Law*: *Themes and Implications*, (CUP 2015) 127-155.
Ellen Kuhlmann and others, 'EU law, policy and health professional mobility' in: Tamara K Hervey, Calum A Young and Louise E Bishop (eds), *Research Handbook on EU Health Law and Policy* (Elgar 2017) 111-133.