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The impact of EU law and policy

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Introduction

The management of HRH in EU countries is increasingly influenced by decisions and legislation at EU level. Examples include the EU directives on professional qualifications and minimum training periods for health care professionals, as well as other EU policies and laws that restrict or support the scope of action by Member States. This chapter examines EU policies' impact on HRH in Member States. We begin by interpreting EU competencies in health care and the objectives of these policies. We then discuss the European legislation relevant to HRH by examining: (a) the legislation on professional qualifications; (b) the European Community (EC) Treaty provision on free movement of services and its applicability to health care provision as defined by the ECJ; (c) the WTD; and (d) some recent developments in EU policy. A cross-cutting section analyses this legislation's impact on each of the key dimensions of HRH, followed by a concluding section. The policy and legal initiatives in this domain are developing rapidly, so it is possible that some of the problems we discuss might have been addressed by the time this book is published. However, our main conclusions remain valid.

EU competencies versus Member State competencies

The organization and financing of health care within the EU is the responsibility of the Member States. The EU has no formal competency in this field (European Commission 1997b), unlike in education where it has some competency to define educational matters but any harmonization of the content of education or vocational training is excluded (European Commission 1997a). Furthermore, the treaties empower the Community to act only in instances where it can be

more effective than an individual Member State in achieving a particular objective. Thus, Article 3 (b) of the EC Treaty states that the EU may act: 'only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States and can therefore, by reason of the scale or effects of the proposed action, be better achieved by the Community'. This principle of subsidiarity has been invoked frequently in relation to initiatives on health care provision and financing.

Member States' responsibilities for the organization and financing of health care include: defining the conditions for access to a health care profession; the scope and nature of professional training; the scope of activities specific to a health profession; a framework for continuing education, monitoring the quality of clinical practice and ensuring the application of ethical standards; the scope and conditions of publicly financed care; the establishment of pricing systems; and the terms of contractual relationships between purchasers and providers of care.

Member States do have to comply with EU law when establishing national regulations. European integration aims to create a single market by removing trade barriers between Member States through the treaties guaranteeing free movement of persons, products, services and capital. These four fundamental freedoms apply to the health care sector as they do to any other. However, the implementation of the principles of the single market is the task of the authorities responsible for economic affairs and the internal market at both national and EU levels. As a consequence, health policy-makers have little influence on policies that affect the health sector.

There are essentially four ways in which the EU can impact on HRH in Member States, relating mostly, though not exclusively, to legislation.

Secondary legislation specific to the health care sector

The conditions for access to the health care professions have long been regulated by the Member States. They aim to protect both patients and licensed health care professionals (De Bijl and Nederveen-van de Kragt 1997). However, the variation in regulations across Member States has the potential to obstruct the free movement of professionals. Indeed, national regulations on structures and conditions for access to health care professions can create de facto barriers for migrant professionals coming from another Member State. The EU has therefore established a regulatory framework guaranteeing minimum qualifications to be met by health care professionals seeking to assert the right to practise their profession in other EU countries without discrimination. Thus, Article 47 (3) of the EC Treaty specifies that: 'in the case of the medical and allied and pharmaceutical professions, the progressive abolition of restrictions shall be dependent upon coordination of the conditions for their exercise in the various Member States' (European Commission 2002). These professions have been singled out for special treatment because of their role in protecting human health (Lonbay 2000).

Rulings of the ECJ

Treaty provisions can also apply directly to health services, sometimes in ways in which their applicability to the health care sector was not considered when they were drafted. This is seen in a series of recent rulings of the ECJ. The ECJ has declared the provisions on the free movement of services to be applicable to health care provision and to the relationship between health care providers and funders of public health care. Member States had always considered these aspects to be part of their national social protection systems and thus under their individual exclusive competence, exempt from single market rules. Since their applicability to the health care sector was not considered when the treaties were drafted they do not take account of its specific nature. This creates substantial uncertainty, in some cases creating concerns about the sustainability and social characteristics of the systems in Member States.

In the wake of these rulings, since the late 1990s the political bodies of the EU have sought to reclaim issues of health care from the ECJ. However, this has led to contradictory responses that reflect the diffuse responsibility for health within the Commission. On the one hand, the EC launched a proposal for a directive on services in the internal market that considers health care services as being like any other commercial service. On the other hand, there have been attempts to include safeguards in the European constitutional treaty to redress the balance between the internal market objectives and the social objectives of the EU. A so-called *social clause* was introduced in the draft to ensure that internal market legislation would take account of requirements guaranteeing a high level of social protection and protection of human health (European Commission 2004c).

Secondary legislation not specific to the health care sector

European secondary legislation that is not drafted specifically for the health care sector but applies none the less includes EU legislation on the employer–employee relationship, such as the WTD (see below).

Other EU policies

Finally, EU initiatives other than legislation have the potential to influence HRH. For example, during the process of acceding to the EU in 2004, the then candidate countries received support for restructuring their professional training programmes. Some of these initiatives were financed by European funds. Other Member States benefit from investment in skills development in regional programmes also funded by the EU. Recently, Member States have decided to cooperate on health care issues in a structured way, to define common objectives and create common databases and analyses.

Directives on the recognition of professional qualifications

European legislative efforts on the mutual recognition of professional qualifications proceeded in four phases: transitional, sectoral, general and legal. The last of these is being driven by the ECJ. European regulations on the mutual recognition of diplomas still have a number of important gaps, so substantive policies on education, training and professional experience have not yet been finalized. These gaps and shortcomings are being filled by case law. The rules on mutual recognition were introduced originally to facilitate the freedom of establishment, but have since been used progressively to ensure the free movement of services (Mossialos and McKee 2002).

The first phase resulted in 35 transitional directives, aimed at the recognition of professional experience rather than mutual recognition of diplomas. This was followed by the introduction of sectoral directives enabling mutual recognition. Medical and paramedical professions were first regulated by sectoral directives in the 1970s, mainly because the treaty regarded it as a *sine qua non* for liberalizing services in this sector. The subsequent general directives on the mutual recognition of diplomas are also highly relevant. The first set up a general system for the recognition of higher education diplomas and established a three-year minimum period for professional education and training. This is supplemented by a second general directive. The third and final directive coordinates the previously mentioned 35 transitional directives on the recognition of professional training.

Sectoral directives

Sectoral directives establish minimum periods for educational and training programmes and comprise lists of diplomas that meet those standards in the various Member States. A diploma listed in the directive is automatically recognized in another EU Member State. This enables the competent authority to confine its efforts to determining whether a diploma is included in the sectoral directive without the need to assess the competence or knowledge of the holder of the diploma.

Many of the 14 sectoral directives concern the health care professions, i.e. medical doctor, general care nurse, dentist, midwife, pharmacist and veterinary surgeon (EU 1977, 1978, 1993a). In theory the right diplomas will be recognized automatically. In practice, however, the procedures in place require the applicant to contact the competent authority in the host Member State and, in some countries, to pay administrative charges. The authority has three months to examine the request and, if rejected, the applicant is entitled to appeal against this decision in the national courts.

This system is rather rigid and it is difficult to keep it up to date. In addition, some Member States with high standards of training are concerned about the quality of training in others, particularly since recognition is granted without assessment of the migrant's knowledge and skills. Indeed, it is an explicit principle underpinning the directives that the coordination of legal and administrative provisions is not intended to lead to harmonization of content. However,

there remain considerable differences between Member States regarding the status of professions and length of training. Advisory bodies such as the Advisory Committee on Medical Training were set up to address this issue. Despite rather infrequent meetings and limited financial support, this body has provided influential reports on medical training.

The limited opportunities for updating sectoral directives create considerable concern among those seeking high standards of patient care. The medical profession, perhaps more than any other, requires continuous training to keep abreast of the latest technological innovations and scientific developments. Free movement of health care workers needs to take account of these developments and should adjust the minimum training periods for medical qualifications accordingly. Furthermore, these directives do not take account of changes in some of the medical professions. Thus, the directive for general care nurses ignores the current trend for specialized nurses (e.g. branch nurses). Specialized nurses from Member State A cannot work in Member State B because they do not meet the requirements for designation as a general care nurse set out in this sectoral directive. In addition, they cannot call upon the general directives on mutual recognition because these do not apply if there is a sectoral directive for the relevant profession. Increasingly, therefore, the ECJ has to fill the gaps in European legislation on the mutual recognition of qualifications.

A related concern refers to the minimum requirement for the length of training (in years or hours) as set out in the directives. This is emphasized at the expense of content and scope. Thus, while current procedures ensure that migrant health workers have undergone the minimum period of education and training, they fail to assess the skills and capacity of the person concerned or the continuous updating of their knowledge and skills, and therefore fail to address quality standards. Given current developments in health care, such as advances in technology or rising patient expectations, there is a need to develop further the process of mutual recognition at the European level.

There is also a need to improve the system of exchanging information on professional and personal references. Before granting permission to practise, the doctors' directive allows the host Member State to request a certificate from the state of origin attesting that the requirements of good character or good repute have been met. This also includes knowledge of all necessary information on previous or outstanding sanctions, disciplinary action of a professional or administrative nature against the person concerned, criminal penalties imposed when pursuing his or her profession in the Member State of origin and a certificate of physical and mental health (EU 1993a). However, these provisions are very ambiguous and leave Member States much scope to decide what they should disclose.

The main challenge is the lack of uniformity between the various national regulations regarding preventing and penalizing professional misconduct and the consequent failure to capture these differences in ways that ensure high-quality medical care (Roscam Abbing 1997). As a result, the provisions on the exchange of information between the host Member State and the state of origin were applied insufficiently, incorrectly or not at all. One blatant example concerns a doctor who was barred for life in the Netherlands but set up practice

again in Spain without any problems. In Luxembourg, a migrant doctor was authorized to practise because the authorities were unaware of proceedings that had led to his suspension in his original country (Sheldon 1997).

EU enlargement highlights this issue further, with the enhanced possibilities for attracting health care workers from the new Member States as a means to meet increased need (see Chapters 2 and 3). However, it is important to ensure that this increased mobility does not affect quality.

New Member States have to comply with the *acquis communautaire* and implement EU standards such as the minimum requirements for education and training outlined earlier. The Treaty of Accession also permits certain acquired rights, as set out in Annex II, 2.C. of the Accession Treaties. Thus, for nationals of new Member States whose formal medical qualifications do not satisfy the minimum training requirements laid down in the corresponding directive, each Member State shall recognize evidence of formal qualification in medicine awarded by those Member States in relation to training that commenced before the date of accession (1 May 2004). This is to be accompanied by a certificate stating that the individual concerned has effectively and lawfully been engaged in the activities in question for at least three consecutive years during the five years prior to the date of issue of the certificate.

Similar provisions apply to nurses. In order to allow nurses who were trained before accession to continue to practise, most new Member States established licensing procedures, including bridging courses and requirements for work experience, to ensure that they comply with minimum European standards (Padaiga et al. 2005; Strózik 2005). Specific provisions have also been developed for people with diplomas, certificates or other qualifications obtained on the territory of the Czech Republic, Slovakia, Estonia, Latvia, Lithuania and Slovenia when they were part of a different country.

In summary, the European regulations on mutual recognition of professional qualifications in the 15 countries belonging to the EU before 2004 failed to ensure uniformity of quality standards and approved medical practice. This is even truer of the enlarged Union. Further action is needed to develop European standards designed to ensure high-quality health care, including standards of care for practising medicine, monitoring doctors' skills and competence, cross-border accreditation and improved exchange of information between Member States.

General directives

The regulations on professional recognition evolved in a piecemeal fashion with numerous parallel provisions, variations and lack of flexibility. This has created a great need for a more flexible and general system of mutual recognition in the various Member States. This general system applies to 'regulated professions', expanded to include 'regulated professions, qualifications and training' by a second general directive. However, this system applies only to people who have the necessary qualifications to exercise a profession in their country of origin. It is not applicable to those who want to continue their studies in another Member State, or to those who want to exercise their

profession in another state but have not yet completed the required training in their state of origin.

Compared to the sectoral system, general directives require the systematic assessment of the qualifications and skills of the applicant and introduce compensation mechanisms (supervised training, adaptation period or aptitude test) if the requirements are not met. In accordance with ECJ case law, professional experience following training has to be taken into account before compensatory measures can be imposed. The general system is therefore flexible and ensures that Member States no longer have to agree on parallel professions, while providing a relatively rapid system of recognition with sound assessment procedures. However, it is clear that this system places a higher burden on the competent authorities assessing candidates prior to recognition or accreditation.

The general system is becoming increasingly important in the health care sector, particularly for paramedical professions, where there is still substantial variation in the regulation of titles, training duration and content and scope of activity across EU countries.

Proposal for a framework directive on the recognition of professional qualifications

In 2002, the European Commission proposed a new framework directive on the recognition of professional qualifications for regulated professions (Commission of the European Communities 2002). It seeks to promote a more flexible market for labour and services and to simplify and consolidate existing regulations, while improving control, clarity and flexibility. It clearly distinguishes between freedom of establishment and the freedom to provide services, which we examine in turn.

Freedom to provide services

The existing directives on professional qualifications require professionals who provide services on a temporary basis abroad to do so according to the same rights and obligations as host country nationals and, in particular, the rules of conduct of a professional or administrative nature. Member States may request only a pro forma registration with a professional organization or body rather than registration with a public social security body that funds health care. The host Member State may require the person concerned to make a prior declaration to the competent authorities concerning the provision of services.

In contrast, the new proposal allows for the temporary provision of services based on the legislation in the country of establishment. A service provider who is legally established in one country and moves to another Member State would thus be allowed to pursue a professional activity for a period of not more than 16 weeks per year under the professional regulation of the Member State where the provider is legally established. The service provider concerned must inform in advance the designated contact point in the country of establishment and is obliged to inform those receiving their services about these arrangements.

Freedom of establishment

The proposed new directive integrates the existing general system for recognition and the sectoral system for certain professions, imposing stricter requirements on the right of establishment.

As noted above, the general system assesses whether individual applicants satisfy the conditions for recognition and provides for compensatory measures. The directive also allows for exemption from compensatory measures on the basis of so-called common platforms; a set of criteria for professional qualification that testify to the holder's competence to practise a certain profession. These are developed by professional associations at European level and are designed to be used for official accreditation by competent authorities in the Member States. It also includes recognition of professional experience; relevant activity practised in another Member State is sometimes regarded as sufficient evidence of skill and competence.

For certain professions, the directive has adopted the sectoral system and the principle of automatic recognition. Thus each Member State shall recognize automatically evidence of diplomas or certificates of professional qualifications that satisfy the minimum training conditions referred to in the proposal. A Member State shall, for the purpose of access to, and pursuit of, professional activity give such evidence the same effect on its territory as the evidence provided by diplomas or certificates of professional qualifications that it itself issues. Specific provisions are established for each profession in relation to training, specific acquired rights and the pursuit of professional activities.

Administrative cooperation and competence to act on recognition of professional qualifications have been simplified and are expected to make the system more flexible. The competent bodies of the country of origin and the host country are required to cooperate closely and assist each other in applying the directive, facilitated by a designated coordinator in each Member State.

The Commission's initial proposal was subject to considerable debate. Professional bodies opposed the drastic reduction in the system of automatic recognition. In contrast to current legislation, which allows for automatic recognition of all medical specialty diplomas present in at least two countries, the new proposal foresees that only specialties common to all Member States will be recognized. The remainder would fall under the general system of recognition by individual assessment and (possible) compensation measures. This reduces the number of automatically recognized specialties from 52 to 17, with the list of those included and excluded appearing quite arbitrary. Furthermore, if one Member State decides to abolish a certain specialty, that specialty will lose its automatic recognition. It was contended that this will not simplify the system because the competent authorities will have to assume the difficult task of comparing medical specialties across countries, requiring strict separation between the general and sectoral system.

There is also concern about the inability to control health care providers who make use of the freedom to provide services without establishment, particularly since they will no longer be bound by the professional rules of the host Member State. To ensure patient safety there are calls for a distinction to be made between the freedom to provide services and establishment and that both be

subject to stricter regulations than those outlined in the current proposal on registration, codes of conduct and disciplinary procedures.

At the time of writing the proposal is still being discussed in the European Parliament and the Council. The proposed amendments following the first reading and the common position in the Council seem to suggest a rather less radical move, with future legislation more like that which is currently in place (Council of the European Union 2004; European Parliament 2004).

Health care providers subjected to the treaty provisions on the free movement of services

The ECJ ruled, in a series of judgements starting with the famous Kohll and Decker rulings in 1998, that health care provision is an economic activity in the sense of article 50 of the EC Treaty (ECJ 1998a, b, 2001, 2003a). This means that the treaty regulations relating to the freedom to provide services also apply to the delivery of health care and its financing by national social protection systems. It applies to systems where health care funding is based on cost reimbursement (as where a patient pays the provider and is reimbursed by a sickness fund), as well as those that provide care based on benefits in kind (where services are provided free at point of use). Consequently, systems for funding health care that are regulated by national governments may not discriminate against foreign care providers unless there are justifiable reasons. Obstacles to the free movement of services may be justified if they threaten the financial sustainability of the social security system or the maintenance of a broad range of health care services accessible to all. However, these restrictions must be based on objective criteria.

The ECJ did not find any justification to inhibit the free movement of ambulatory care services. The costs of non-hospital care provided abroad when the patient has not sought prior authorization must be reimbursed by the patient's home funding body, at the same rate and on the same conditions that apply to domestic care providers, provided these conditions do not discriminate against care provided abroad. In contrast, for hospital care the court ruled that there may be justifiable reasons to restrain free movement because of the importance of planning the distribution of facilities to enable maintenance of a rational, balanced, accessible, affordable and high-quality supply of hospital services.

According to these rulings, health care funding is now subordinated not to the conditions and criteria applicable in the country where the care is provided but to the conditions and criteria applying in the patient's country of origin; these criteria may not discriminate against foreign providers. This can have far-reaching consequences for national health care systems, for the relationship between health care providers and the funders of public health and consequently for Member States' capacity to manage their human resources. We discuss some of these potential consequences below.

Non-discrimination of providers established abroad

Member States and health care purchasers may not discriminate against either providers established in another Member State or care provided abroad; therefore national criteria for funding health care that are inconsistent with those employed in other countries might be considered discriminatory. Thus, the ECJ did not accept a funder's right to refuse to reimburse ambulatory care provided by non-contracted providers abroad even where domestic providers were first obliged to enter into a contractual relationship with health care purchasers. It also accepted that patients have free choice of provider abroad even though this may be limited in their home country.

On the other hand, contracts or collective agreements between public health care purchasers and health care providers define the price and content of care provided and so may establish rules to ensure cost-effective use of funds. Examples include budget ceilings or performance-related payment systems. If health care purchasers have to reimburse services provided by non-contracted ambulatory providers they risk losing these important mechanisms to control the provision of health care abroad.

Although the existing constraints focus primarily on hospital treatment, reimbursement of ambulatory treatment received abroad may also have important implications for planning. Examples include national regulations on access to health care, such as referral systems and patient registration systems. Even if public health care purchasers were allowed to impose some of these requirements on foreign providers, it would be very difficult to do so.

Quality standards

The ECJ stated that conditions for exercising the profession of medicine in Europe were established in a uniform way and should be sufficient to ensure an equivalent quality of health care in the different Member States. This assertion may be questionable (Jorens 2003). As discussed previously, health care providers established in another Member State do not necessarily meet the same quality requirements as providers in the home country. Certain professionals can exercise their profession perfectly legally in Member State A but be refused the right to do so in Member State B (Nickless 2001). Furthermore, health care professionals have to comply with quality requirements defined by the Member States and the funders of health care. These quality standards may include guarantees of continuity of care, record-keeping, regulations on prescription or referral and participation in peer review activities.

In theory, EU law cannot oblige purchasers of public health care to fund a treatment provided abroad that does not meet these conditions. However, according to the ECJ, the free movement of services may not be hindered for reasons of general interest if the objective of the intended requirement is met by comparable requirements in the country where the provider is established. Therefore, Member States will have to take account of existing requirements in the country of establishment and it will be very difficult to prove that the provisions to ensure quality abroad are insufficient to achieve the same objectives.

Risk of reverse discrimination

If rules imposed on domestic providers cannot be enforced on providers established abroad, the question is: to what extent are national regulations tenable when applied to home providers? National providers could feel discriminated against, placing national regulations under pressure. This may lead health care providers to question the justification for their cooperation with the domestic health authorities and refuse to engage in contractual negotiations concerning availability, quality, quantity, price and efficacy of care (Mossialos and Palm 2003).

In Luxembourg, the main result of the Kohll and Decker judgements was that the medical profession perceived the opening of borders and the reimbursement of care provided by non-contracted foreign providers as discrimination. Consequently, discussions concerning the introduction of profiles of medical activity to trace abuse of the system have been blocked. Furthermore, Luxembourg's physicians sought to withdraw from the compulsory system that requires doctors to comply with imposed tariffs. In response, the government was forced to increase reimbursement fees by an average of 6.5% (Kieffer 2003).

The WTD

As noted previously, European legislation that is not specific to the health care sector can also impact quite considerably on health care professionals, who generally are considered to be regular workers rather than a special category. One obvious example is working time.

Directive 93/104/EC concerning certain aspects of the organization of working time (the WTD) defines working time as 'any period during which the worker is working, at the employer's disposal and carrying out his activity or duties, in accordance with national laws and/or practice' (EU 1993b). The WTD establishes minimum requirements for the organization of working time, such as daily rest periods, breaks, weekly rest periods and annual vacations, all with the aim of improving the working conditions of employees in the EU. The original Directive 93/104/EC did not cover some sectors, such as doctors in training, but was amended in 2000 (EU 2000) to include doctors in training. This may lead to considerable problems in health care staffing because of the complexity of the concept of working time in this sector, such as the status of on-call work. Thus, cases brought before the ECJ have led to two important rulings regarding the definition of on-call service.

The first case, SIMAP, concerned Spanish legislation regarding the 'resident on-call' service, following regular working time, with specific reference to primary health care teams (ECJ 2000). The workers concerned were required to be either physically present or available to answer professional calls in the workplace. This additional time on call was not taken into account when determining the maximum amount of working time. The ECJ was asked to pronounce whether doctors' time spent on call, either at or away from the workplace, counts as full working time. More specifically, the question was

whether doctors on call who are on the premises but asleep may be considered to be working.

As noted above, the WTD defines working time as any period during which the worker is working, at the employer's disposal and carrying out his or her activity or duties, in accordance with national laws and/or practice. The ECJ requires that the three conditions must be met to qualify as full working time. It is argued that during periods on call the first two conditions under WTD regulations are fulfilled. Moreover, even if the activity performed varies according to the relevant circumstances, the fact that doctors resident on call are obliged to be present and available at the health centre to provide their services means that they are carrying out their duty in that instance. The ECJ stated that time spent resident on call in primary health care teams must be regarded in its entirety as working time, overtime if appropriate, if they are required to be at the health centre. The situation is somewhat different for doctors who are on call by being contactable at all times without having to be present at the health centre. Even if they are at the disposal of their employer, in that they must be contactable, they may manage their time with fewer constraints and pursue their own interests. Here, only the time spent actually providing primary health care services is regarded as working time.

The more recent Jaeger case also asked whether on-call service in hospitals (*Bereitschaftsdienst*) should be regarded as working time (ECJ 2003b). During on-call service the employee was obliged to be present at a place determined by the employer, at or away from the employer's premises, and to be contactable but at the same time authorized to rest or to spend time otherwise as long as his or her services are not required. The ECJ ruled that if the doctor is required to be physically present at the hospital, time spent on call must be regarded as working time even though the person concerned is permitted to rest at the workplace during periods when services are not required.

The decisive factor is whether those concerned can choose where they are during waiting periods. Those who must be in a designated location, such as a hospital, are subject to appreciably greater constraints. By virtue of their separation from family and the social environment they face constraints on their use of time when their professional services are not required. This interpretation is not altered by the fact that the employer makes a rest room available for use until the service is required. The argument is even stronger for doctors on call in health centres because periods during which their services are not required may be of short duration and/or subject to frequent interruptions or they may be required to monitor the condition of patients placed under their care or to perform tasks of an administrative nature.

The ECJ rulings in the SIMAP and Jaeger cases will have substantial (financial) consequences for national health care systems. They may be required to recruit more health care staff in order to avert exceeding the maximum daily and, especially, weekly working time and ensure sufficient breaks for personnel. WTD prescribes a daily break of at least 11 consecutive hours within 24 hours. A 'sleeping wake service' followed by a normal working day and vice versa may not respect this minimum daily break. The average working time per seven-day period, including overtime, may not exceed 48 hours. This limit can be reached easily. The normal length of work for night shift workers may not

exceed an average of eight hours in any 24-hour period. Problems may arise when 'sleeping wake services' last 12 hours or more.

Although the impact of the case law is not limited to the health sector, its impact is greatest here. In Germany it was calculated that applying the SIMAP and Jaeger cases to the health care sector would require a 24% increase in staff and 15 000–27 000 additional doctors, amounting to an extra cost of €1.75 billion (European Commission 2003). The Netherlands estimated it would need to recruit 10 000 additional workers at an extra cost of €400 million. The United Kingdom believed it would require about 1250 additional health care staff other than doctors and between 6250 and 12 550 additional doctors, at an estimated €550–1130 million. Malta would require double the number of specialists in the highest training grade and up to a third more doctors-in-training (Azzopardi Muscat and Grech 2005).

A transition period was agreed in order to allow Member States time to adapt but the impact of this case law is expected to be even greater with progressive application of the WTD. For the three years after 2004 the number of weekly working hours may not exceed an average of 58; 56 for the following two years; and 52 for any remaining period, which may be no more than three years. The challenge arises because, in many countries, much front-line care is provided by doctors-in-training; as their working patterns change to comply with the WTD the training authorities must find new ways of delivering the training (European Commission 2003).

It is important to note that, prior to the SIMAP ruling, working time was generally interpreted to mean that periods of inactivity during time on call were not defined as working time. Following the SIMAP case some Member States made use of the opt-out arrangement provided in the WTD as a means to alleviate some of the problems created by this case law. The opt-out provision allows individual workers voluntarily to opt out of the 48-hour average weekly working time limit (including on-call time). For the health sector alone, the opt-out clause was adopted in the legislation of several Member States, including Cyprus, France, Germany, Malta, the Netherlands, Slovenia and Spain. Only the United Kingdom implemented the opt-out provision in national legislation as a general possibility for all its workers (European Commission 2003).

Following the considerable problems caused by the interpretation of the ECJ's rulings on on-call service, the European Commission embarked on a consultation with the social partners at EU level (European Commission 2004e) and subsequently adopted a proposal to update key aspects of the WTD. At the time of writing this is being reviewed by Council and the European Parliament (Commission of the European Communities 2004a). The amended proposal suggests that time spent on call but where the individual is not actually working would not be considered working time, while compensatory rest would be provided after 72 hours. An individual opt-out would remain possible but subject to stricter conditions to prevent abuse.

Recent developments (2004)

Directive on services in the internal market

The ECJ rulings on the freedom of provision of health services described above relate to the *passive* provision of services, i.e. where the service recipient moves to the country where the service provider is established. However, as outlined in previous sections, the principle of the free movement of services also implies service providers' right to establish themselves in another Member State or to provide temporary services in a Member State other than the one in which they are established.

In January 2004, the EC submitted a proposal for a directive on services in the internal market that extensively liberalizes the services sector (Commission of the European Communities 2004b). It introduces a general legal framework for services provided for remuneration and explicitly includes health services and services provided by regulated professions, such as the medical profession. It applies in cases when:

- the patient moves to the country where the provider is established to receive care;
- the health care provider travels to the Member State of the patient to provide care;
- care is provided at a distance (e.g. telemedicine).

The proposed directive distinguishes clearly between freedom of establishment, relating to services provided through a fixed establishment for an indefinite period, and free movement of services, concerning services provided on a temporary basis in a Member State other than the Member State of establishment.

Concerning the *free movement of services*, the proposed directive introduces the principle of the country of origin. Thus, health service providers operating legally in one Member State may market their services in others but are not required to comply with corresponding regulations in the host country. Health service providers would no longer be subject to the national regulations of the host country when engaging in cross-border activities. The country of origin is responsible for supervising the provision of services abroad.

Member States may not impose on health service providers established in another Member State an obligation, for example, to inform the competent authorities or to engage in specific contractual arrangements between the provider and the recipient. The future directive on recognition of professional qualifications, described above, is partially exempt from these provisions.

This proposal, if it does become law, could lead to deregulation of the health care sector. Providers could choose to establish themselves in the Member State that imposes the least restrictive conditions on the provision of health care. Subject to the legislation of this Member State, they could then provide care in other Member States and so compete with health care providers who have to comply with more restrictive legal requirements. In turn this could put pressure on regulations in those Member States and cause a downward spiral of deregulation.

A related problem is the country of origin's responsibility for supervision of

health care provision. The corresponding authorities are not required to give an account of their conduct towards the citizens in the host country who receive care. There is thus a lack of motivation and legitimation to control health care provided abroad.

Finally, Member States must ensure that service recipients (i.e. patients) are informed appropriately. This includes information on the legislation applicable in other Member States related to the access to, and exercise of, the (health care) activity. Given the complexity of health care legislation, it will be difficult to explain the systems of 25 countries to patients in a comprehensible way, especially since patients may need this information when they are in vulnerable and dependent positions because they need immediate care.

The chapter on the freedom of establishment obliges Member States to simplify and remove a large number of authorization and licensing procedures and to limit the number of documents required. The proposed directive introduces a major screening exercise, requiring Member States and the European Commission to identify and assess conditions for establishment. Member States must verify that the requirements are non-discriminatory, necessary and proportional; if not, they must be abolished. These include: quantitative or territorial restrictions, particularly restrictions determined on the basis of population distribution or minimum geographical distance between service providers; requirements imposing an obligation for providers to take a specific legal form; requirements stipulating a minimum number of employees; and fixed minimum and/or maximum tariffs with which providers must comply. The conditions listed here thus include national legislation on planning, staff norms in health care institutions, price fixing mechanisms and others, all crucial instruments for the organization and funding of health care systems. When this comes into force, Member States can introduce any new requirements of this kind only if the need arises because of new circumstances. The Commission will examine any new requirements' compatibility with Community law and can oblige abolition.

The proposed directive also defines the conditions under which national social security systems are to reimburse the costs of health care received in other Member States, based on ECJ case law. It lifts bans on advertising for regulated professions, while stipulating that this must respect certain rules and limits.

Overall, the proposal fails to take account of: the specificity of the health care sector, characterized by information asymmetry between provider and patient; the involvement of third-party payers in the definition of prices, content and quality of care; and the complexity of the health care sector, with its complex interplay between so many different actors. The proposal could have a substantial impact on the health care sector, stimulating deregulation and thus restricting the stewardship capacity of Member States as it relates to human resources, regulating and controlling quality, planning, setting rules of conduct and payment and others.

Health care's inclusion in this directive has caused substantial concern. Europe's health ministers expressed their disquiet in a collective letter to the Council administration responsible for the internal market.

European cooperation in health care

Cooperation in health care between Member States is being formalized progressively. Once it was acknowledged that the single market impacted on national health care systems, public authorities responsible for health policy began to accept the need for some EU cooperation in this domain. The EC presented a communication on the application of the 'open method of coordination' to health care and long-term care (European Commission 2004d) and patient mobility (European Commission 2004a). Member States would cooperate to define common objectives and indicators with relevance for HRH, including the following topics:

- collecting information on the movement of health professionals;
- developing a concerted European strategy covering issues such as monitoring, training, recruitment and working conditions;
- addressing regional inequalities in the provision of care;
- earmarking financial and human resources to the regions, services and different types of care, according to need;
- decentralization involving the various actors and making them responsible for the management of resources and the provision of care;
- introducing incentives for providers and patients or measures to promote new treatments that reduce costs while providing the same service;
- reducing staff shortages by investing in basic and continuing training and an improvement of the quality of jobs.

To promote this process of cooperation, the Health and Consumer Protection Directorate General (DG SANCO) of the European Commission, responsible for public health, established the High Level Group on Health Services and Medical Care, bringing together Member State representatives and the Commission (European Commission 2004b). This committee works closely with the Social Protection Committee on these issues.

EU impact on key dimensions of human resources management

This section discusses the findings from the previous sections and analyses the extent to which they may impact on key dimensions of HRH.

European legislation defines the minimum *training* requirements for regulated health care professionals, defined as minimum length of training and, for some professionals, the substantive content. It also defines the regulations for the mutual recognition of health care professionals' diplomas and the conditions they may impose for the establishment of health care professionals in their territory. Member States' discussions defining those minimum standards within the sectoral directives have undoubtedly led to improvements in the quality of training and a certain level of convergence of training programmes across the EU. However, the legislation does not provide for a harmonization of training standards. Nor does it impose conditions for continuing education, which is becoming crucial for the exercise of effective health care in a quickly developing scientific and technological environment. The instruments

employed by the directives concerned are not flexible enough to adapt to new developments in the professionalization and specialization of health care professions. Moreover, the definition of the field of competence of most professions is left to the Member States, indicating that the content of training will differ according to the responsibilities of the professional in each Member State. National authorities are strictly limited in their capacity to impose additional training for the entry into practice of health care professionals from abroad, thus restricting their capacity to adjust for the differences in training.

We have discussed recent developments by which the rules on mutual recognition of diplomas, originally introduced to facilitate the freedom of establishment, are used progressively to ensure the free movement of services. Hence, the legislation is supposed not only to guarantee minimum standards for entry into practice but also to ensure the quality of health care provided. This trend reduces further the national authorities' capacity to guarantee the quality of care.

The impact on *workforce planning* is exemplified by the ECJ rulings that require purchasers of public health care to fund ambulatory care provided in another Member State. As a consequence, the supply of health care workers is de facto extended to provision of care abroad. If the proposed directives on professional qualifications and on the free movement of services are adopted as they stand, Member States may lose further control over the number of health care providers that are active in their territory, and there may be a limit on the ability of health care managers to define the need and supply of health services for their population.

On the other hand, EU law offers the opportunity better to adjust the supply and demand of the health care workforce internationally. The principles of freedom of movement will make it easier to recruit or contract health care professionals from other countries, resulting in a 'win-win' situation if there is oversupply in one Member State and shortage in another. However, where there is a substantial difference in salaries, tariffs or working conditions there is a risk of health care professionals responding to attractive conditions abroad, regardless of the needs in their country of origin. The ten Member States that joined the EU in May 2004 have much lower living and working standards, and therefore there is a genuine risk of such a brain drain (Chapter 3). This has the potential to threaten levels of remuneration in the countries of origin and the financial viability of their public health care systems.

The definition of working conditions at EU level can also impact on national health care workforce planning. We have discussed the impact of the WTD. Many health care workers, mostly junior medical doctors, are employed in hospitals on conditions that do not meet the provisions of the WTD and its interpretation by the ECJ. Its application requires hospitals to recruit more health care staff. This not only has budgetary consequences but also may provoke important supply problems in countries with shortages of health care staff. When balanced with training requirements this may require extensive reconfiguration of services, and some commentators in the United Kingdom have argued that many peripheral hospitals may have to be closed.

EU law can impact on *performance planning*, namely the instruments that ensure that resources are used to achieve optimal health outcome. We described

the lack of appropriate EU-level mechanisms to enforce and control disciplinary measures for health care providers moving within the EU. We also described how the Kohll and Decker rulings may lead to reverse discrimination and might induce pressure to change or abolish national regulations on evaluation and accountability, practice standards, performance monitoring, clawback mechanisms for inappropriate care, etc. The same applies to the recent proposals on services in the internal market and on the recognition of the professional qualifications outlined above. The application of the regulations on the free movement of services also leads to a fragmented approach to service delivery. Health care providers are considered not as part of an interconnected system but as single providers of a service.

Finally, European legislation can also have an impact on *working conditions*. The most obvious example is the WTD, which impacts on the working hours of medical staff, but potentially also on remuneration. We have discussed the possibility of health care professionals from the new Member States moving to countries with higher salaries and better working conditions. This may push the countries of origin to increase salaries and improve working conditions in order to retain their workforce. The increased possibilities of cross-border contracting of health care may also produce financial pressures. Health care providers can opt to enter into contracts with the purchasers that offer the most profitable level of remuneration. The Luxembourg doctors who refused to renew their agreement with the Luxembourg health insurance system until they agreed to considerable increases in compulsory tariffs further illustrates the EU legislation's potential impact on the health care workforce. Finally, the ECJ rulings may lead to the introduction of new methods of remuneration; for instance, countries with a benefit-in-kind system have to reimburse ambulatory care provided abroad on a fee-for-service basis.

Conclusions

This chapter has traced the development of EU legislation and policies that have a potential impact on HRH. We identified European law's important influence on the education and training of health care staff, workforce planning, performance planning and the working conditions of the health care workforce. Despite the fact that the EU has no formal competency in the health care sector, we can conclude that its impact is considerable and growing.

EU legislation elaborated specifically for the health care sector undoubtedly has had some positive impacts on, for example, the quality and standardization of training. However, the driving force behind EU regulations is the creation of the single European market and the removal of trade barriers. These policies are elaborated by those responsible for economic policy, competition and the internal market rather than the authorities responsible for public health. Consequently, public health concerns are not always considered sufficiently when developing these policies. This places the authorities responsible for health care organization and human resources in a defensive position and limits their scope of action. National policies for human resource planning are often bypassed, neutralized or overridden by EU law.

Thus, although EU policies aim to remove trade barriers between Member States, their impact on the internal national organization of the health care systems and human resources management is often more important than their impact on the cross-border movement of professionals and services. On the other hand, Member States are reluctant to hand over some of their responsibilities in order to incorporate the safeguards necessary to ensure effective human resources policies at EU level.

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