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FEPS
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STRENGTHENING THE EUROPEAN HEALTH UNION

MATCHING FREE MOVEMENT OF PERSONS AND EQUAL ACCESS TO HEALTH FOR ALL

ABSTRACT

Across the European Union, sizes of the healthcare workforce differ greatly – not only between member states, but also between regions within member states. The inequalities in healthcare workforce result in structural inequalities in access to healthcare.

So far, these inequalities are not addressed in the context of the European Health Union, nor in any other policy context at EU level. If the EU is serious about access to healthcare for all, a European Health Union should include measures to reduce inequalities in health workforce capacities while respecting the right of every healthcare worker to move freely within the EU.

The lack of EU competence in the field of healthcare does not stand in the way of a creative use of other existing competences to address inequalities in health workforce. A wide variety of measures is possible, including compulsory reporting and better monitoring of data, guaranteeing decent minimum wages and maximum working hours, harmonisation of training standards, facilitation of knowledge- and information-sharing, fiscal solidarity, and others.

But first and foremost, explicit recognition of the inequalities as a concern for the European Health Union is necessary.

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TABLE OF CONTENTS

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Since the endorsement by President of the European Union Commission Ursula von der Leyen, on 16 September 2020, of political calls for the creation of a European Health Union (EHU),[1] this has started to materialise. This is happening via the inclusion of the concept in explanatory memoranda of legislative proposals, and policy documents, including the final report from the Conference on the Future of Europe.[2] In general, the focus is on preparedness for and response to serious cross-border health threats – by agencies that coordinate and surveille (the European Centre for Disease Prevention and Control [ECDC], and the European Medicines Agency) or produce and procure medical countermeasures (the European Health Emergency Preparedness and Response Authority). More recently the European Health Data Space for the use of health data was launched, and both the Pharmaceutical Strategy for Europe and Europe's Beating Cancer Plan were announced. These are all laudable initiatives, and nobody would contest the importance for public health needs of ensuring security of supply of medicines and medical devices, nor the usefulness of monitoring, surveillance and coordinated action.

It is questionable, however, whether these initiatives will address the structural inequalities in healthcare capacities across the Union, including inequalities in the size of healthcare workforces.[3] Though exact figures are lacking, statistical data coverage is variable per year and member state, and some data are based on nationality and others on country of training, trends can be detected in OECD (Organisation for Economic Co-operation and Development) data. An OECD 2020 report indicates that the number of doctors per 1,000 population within the EU varies between 5.4 and 2.4.[4] For rural and remote areas the number might even be lower than 2.4. The number of practising nurses per 1,000 population varies from 15.4 in Finland to 4.4 in Latvia.[5] By way of illustration, the following data on doctors' mobility trends from Poland and Romania to Northwest Europe were taken from OECD statistics:[6]

- Data on annual inflow of foreign-trained doctors show how EU accession and removal of transitional provisions led to an increase in Romanian doctors in Belgium (from 126 in 2007 to 176 in 2011, and decreasing to an annual inflow of around 55 as of 2017).

- Comparable trends can be seen in France (from 439 in 2011, to 208 in 2020), Germany (from 54 in 2007, to 579 in 2012, to 225 in 2020), Ireland (from 83 in 2010, to 194 in 2015, to 62 in 2021), Sweden (from 52 in 2007, to 116 in 2014, to 90 in 2019) and the United Kingdom (from 175 in 2007, to 667 in 2010, to 279 in 2021).

- In 2020 there were 1,501 doctors with Romanian nationality in Belgium, 4,116 in Germany and 686 in Ireland. There were 994 doctors with Romanian nationality in Sweden in 2019, and 1,388 in the United Kingdom in 2020.

- Similar observations can be made for doctors with Polish nationality: in 2020 there were 109 doctors with Polish nationality in Belgium, 248 in France, 1,776 in Germany, 310 in Ireland, 1,143 in Sweden, and 1,029 in the United Kingdom.

The database does not include numbers of foreign-trained doctors in Romania. The data show that most foreign-trained doctors entering Poland in 2021 received their training in Belarus (277) or Ukraine (511).

The imbalance of healthcare workers within the EU is hardly addressed at EU level. The European Parliament's Resolution calling for a EHU does

not mention this, while the S&D (Socialists and Democrats) position paper addresses it implicitly in suggesting a directive on minimum standards for quality healthcare that would introduce common criteria to be reported to the European Commission 'using parameters such as hospital beds per head, critical care capacities, numbers of doctors and nurses per head, rate of health expenditure and access and affordability of healthcare for all, including for vulnerable populations.'[7] The Council Conclusions are silent on health workforce capacity. The Manifesto for a European Health Union, initiated by leading political figures and academics working in the field of health policy, does address the problem explicitly and postulates as a policy for the EHU: 'Recognising the importance of the health workforce, the European Union and the Member States will work together to address the unequal distribution of health workforce capacities in Europe, providing support to regions that have difficulties in attracting health workers as well as promoting the training and education of health professionals according to common standards, coupled with measures to safeguard the rights of health workers, including those from other parts of the world'.[8]

Free movement rights have been among the most positive achievements of European integration. Therefore, as Goldner-Lang has argued, a reflection on the downsides of free movement needs to focus on further European integration that would aim to reduce disparities between EU member states and between regions.[9] This follows also from the framework of the Free Movement Directive. It imposes severe restrictions on the regulatory possibilities to address the imbalance in healthcare professional capacity. The European Court of Justice has ruled that any national measure interfering with free movement in order to prevent the loss of qualified workers cannot go beyond what is necessary to protect the domestic labour market, and can never be so restrictive as to negate of free movement rights.[10]

Measures that encourage free movement are considered a less restrictive alternative to address shortages than measures that hinder free movement.[11] Furthermore, as Damjan Kukovec wrote in 2015, there has been no serious discussion in daily EU legal reasoning about the distribution between actors located in different countries and regions in the EU through free movement and competition law.[12] He demonstrates how EU legal discourse has distributional consequences between countries, between regions, and between centre and periphery, with 'periphery' understood as countries or regions with a much lower GDP per capita, less capital and less foreign direct investment, and whose actors, products and services have less prestige than countries or regions of the centre.[13] The argument exists that the concerns and needs of the periphery are not adequately taken into consideration in the EU legal system because the discourse on EU law prioritises market freedoms over social concerns. Furthermore, it is argued that only the free movement challenges which harm the centre are given real consideration. This might explain why shortages of healthcare workers in the periphery are not discussed in mainstream EU legal literature and why they are hardly covered in the EU documents calling for the creation of an EHU or for strengthening the EHU. If we agree with Kukovec that the EU should 'acknowledge and resist the negative externalities of universalized social and autonomy claims and decisions on workers and companies of the periphery',[14] and if the EU is serious about access to healthcare for all, including the need to address unequal distribution of healthcare, workforce capacities in Europe as part of a EHU would be a first step.

Any measure addressing the unequal distribution of the healthcare workforce should respect the (social) right of every healthcare worker in the EU to move to another member state for whatever reason, including to improve their livelihood. Therefore, measures should be directed at addressing the reasons why healthcare workers from the periphery move away. The literature mentions in general several factors related to the organisation of the healthcare system that inspire medical professionals to leave the country, regardless of whether the sending member state is Poland, Romania or Ireland. These are: low salaries (in relation to richer member states); tough working conditions (long working hours and excessive workload); and limited career-development prospects. Next to that, dissatisfaction with the social and political situation in the home state, a lack of high-quality public goods such as education, housing, availability of infrastructure, leisure activities and social provisions are relevant in the decision of health professionals to leave a country.[15] Though EU competence in the field of healthcare for now is limited,[16] there are no reasons to exclude health workforce matters from the EHU. A creative use of existing competences allows multiple measures and actions at EU level.[17] Below follow several suggestions distilled from academic literature.

First, it would be possible to enact a directive on EU standards for minimum healthcare throughout the EU via compulsory reporting to the Commission, common criteria including number of doctors and nurses per head based on Article 168(5) TFEU.[18] The obligation to report contributes to the visibility of health deserts at EU level and would (hopefully) render it more difficult to ignore the problem. The preamble of the EU4 Health programme Regulation based on Article 168(5) TFEU refers to support actions 'to reduce inequalities in the provision of healthcare, in particular in rural and remote areas',[19] but does not aim for more structural quality standards. The voluntary stress test included in the Regulation could be adjusted via binding methodologies and preparedness templates to ensure convergence of national plans on healthcare resilience without intruding on member states' domestic responsibilities.[20] Furthermore, instead of self-assessment, national healthcare systems included in the Regulation could be monitored at EU level by the ECDC, or for instance by the intergovernmental Health Security Committee that could also formulate recommendations. It could make coordination more binding and the substance of information more detailed, while also enhancing mutual trust.[21] Data on professional health capacity and better mobility data could be part of such coordination.

Second, legislative action could also be undertaken to address decent minimum wages, a maximum number of working hours and the same training standards, for the same certifications, for healthcare professionals across the European Union, as recommended by Citizens' Panel 3 of the Conference on the Future of Europe.[22] One could imagine a revision of the derogation for healthcare workers in the Working Time Directive,[23] and adjustment of the Directive on recognition of professional qualifications.[24] The recent provisional agreement between the Council and the European Parliament on the proposed Directive on minimum wages could help to tackle the imbalance in health workforce capacity.[25] According to the Citizens' panel, a lack of common healthcare standards, common wages and common training for healthcare workers could result in differences between the member states and lead to unbalanced situations across the European Union. Standardisation of healthcare could help in having a stronger, more efficient and more resilient system and would also facilitate knowledge- and information-sharing in the

healthcare professional sector.[26] The Citizens' Panels had an additional idea that can be realised with existing competences, notably setting up a separate Erasmus exchange programme for medical schools, which could contribute to skills development throughout the EU.[27] The Council's preliminary technical assessment of these proposals is not very responsive – merely defensive – to the Citizens' panels: it refers to the existing Working Time and Recognition of Professional Qualifications Directives and the existing Erasmus+ programme as if no further action would be necessary.[28] The technical assessment report also signals that taking up measures on minimum wage has to respect the limitations imposed by Article 153(5) TFEU that excludes pay from the EU competence under Article 153.

Next to legislative action, fiscal solidarity addressing equal distribution of healthcare workers in the EU could form part of the EHU. To my knowledge, there are no reliable data or detailed empirical studies on the relationship between remittances, the cost of training healthcare professionals and the positive and negative impacts of their migration.[29] Structural development of the periphery could help in the retention of healthcare workers. In the preamble of the 2021 Regulation on the European Regional Development Fund and the Cohesion Fund, the resilience of public health systems is addressed, without any mention of healthcare professionals.[30] National plans submitted under the Recovery and Resilience Facility can however address domestic economic and social cohesion in order to mitigate imbalance of healthcare professional capacity between urban regions and the periphery.[31] Recital 15 of the preamble highlights the importance of accessibility and capacity of healthcare systems. The scope of the Facility covers health, inter alia (so not only) in crisis situations.[32] Including retention of healthcare workers in the periphery as an objective of these funding instruments might help, though in itself is not enough to address the distributional consequences of EU free movement law in healthcare.[33]

There is not a single 'golden solution' to address the imbalance of healthcare workers in the EU. It requires an approach in which multiple measures and actions should co-exist, both at member state level and at EU level. First and foremost, explicit recognition of the problem and its wider discussion is necessary. Therefore, explicit inclusion in EU documents preparing and developing a European Health Union is an indispensable step.

Endnotes

1 Letter of the Socialists and Democrats to the presidents of the European Council, the Council and the European Commission, 7 May 2020; Socialists and Democrats position paper, A European Health Union – Increasing EU Competence In Health – Coping With Covid19 And Looking To The Future, 12 May 2020, https://www.socialistsanddemocrats.eu/sites/default/files/2020-05/european_health_union_sd_position_30512_3.pdf. European Parliament Resolution of 10 July 2020 on the EU's public health strategy post-COVID-19 (2020/2691/RSP).

2 Ursula von der Leyen, State of the Union address 2020, https://ec.europa.eu/commission/presscorner/detail/en/SPEECH_20_1655; among others, see the Explanatory memorandum of the Proposal for a Regulation of the European Parliament and of the Council amending Regulation (EC) No 851/2004 establishing a European Centre for Disease Prevention and Control, COM(2020)726 and the Explanatory memorandum of the Proposal for a Regulation of the European Parliament and of the Council on the European Health Data Space, COM(2022) 197 final; Council conclusions on strengthening the European Health Union, OJEU C/512 I2 of 20 December 2021; Conference on the Future of Europe, Report on the final outcome, May 2022, https://www.europarl.europa.eu/resources/library/media/20220509RES29121/20220509RES29121.pdf, p. 52.

3 See also A. Alemanno (2020), 'Towards a European Health Union: Time to Level Up', *European Journal of Risk Regulation* 11(4), p. 725.

4 OECD/European Union (2020), *Health at a Glance: Europe 2020: State of Health in the EU Cycle*, OECD Publishing, Paris, p. 213. Data refer to all doctors having a licence to practise, and is a large over-estimation of the number of practising doctors. For an overview of physician density across regions, see OECD, Health at a Glance 2021, OECD Publishing, Paris, p. 217.

5 *Health at a Glance* (2020), p. 219.

6 https://stats.oecd.org/Index.aspx?ThemeTreeId=9

7 S&D position paper, as cited n. 1 above, p. 2.

8 https://europeanhealthunion.eu/#manifest, policies and other measures, under (e).

9 Iris Goldner Lang and Maroje Lang (2020), 'The Dark Side of Free Movement: When Individual and Social Interests Clash'. In *EU Citizenship and Free Movement Rights* (Leiden, The Netherlands: Brill | Nijhoff), chapter 17, 382–409 at p. 382. For illustrations of these downsides see also Janne Rothman-Herrmann and Brigit Toebes (2011), 'The European Union and Health and Human Rights', Human Rights Law Review 2011(4), pp. 419-436; Tamara K. Hervey and Jean V. McHale (2015), European Union Health Law : Themes and Implications, Law in Context (Cambridge: Cambridge University Press,) describe this 'dark side' of free movement in chapter 6, 'Consumerism: the health care professional', notably on p. 130; Zoe Papassiopi-Passia, Eleni Pasia, and Dimitrios Varadinis (2014), 'Migration and Law. Greece', *Revue Hellenique de Droit Internationals* 2014, 1–68, p. 64; Niamh Humphries et al (2021), 'COVID-19 and doctor emigration: the case of Ireland', *Human Resources for Health* 19, 3 March 2021.

10 Case C-208/05, *ITC Innovative Technology Center*, para. 44, ECLI:EU:C:2007:16.

11 The Court of Justice in Case C-73/08, Bressol, para. 78, ECLI:EU:C:2010:181, with respect to Belgian restrictive measures to prevent an alleged risk of shortages of professionals in the medical and paramedical sector.

12 Damjan Kukovec (2015), 'Law and the Periphery', European Law Journal 21(3), 406-428, p. 406.

13 Ibid, p. 408.

14 Ibid, p. 426.

15 Lang and Lang (2020), 'The Dark Side of Free Movement: When Individual and Social Interests Clash' (fn. 6), pp. 387-389.

16 Citizens' panels in the Conference on the Future of Europe called for Treaty change in order to include health in the shared competence of the EU, see also the concrete proposal for such inclusion in the position paper *Treaty Change for European Health Union*. However, it is questionable whether the Treaty will be changed in the near future, see also European Council Conclusions of 23 and 24 June 2022 points 27-29 presenting a flawed response to the final report.

17 See also Tamara Hervey and Anniek de Ruijter, 'The Dynamic Potential of European Union Health Law', *European Journal of Risk Regulation* 11(4), 2020, pp. 297-306.

18 See A. Alemanno, 'Towards a European Health Union: Time to Level Up' (fn. 3), p. 725, and S&D position paper, 12 May 2020 (fn. 1). A contrario: General Secretariat of the Council, Preliminary technical assessment of the proposals and related specific measures contained in the report on the final outcome of the Conference on the Future of the Union, 10033/22 ADD 1en of 10 June 2022, p. 47, point 10.1.

19 Regulation (EU) 2021/522 of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, preamble recital 19.

20 Regulation (EU) 2021/522 of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, preamble recital 19.

21 Ibid, pp. 818-820.

22 Conference on the Future of Europe, Report on the final outcome, May 2022, Annex, p. 60.

23 Article 17(3) under c) of Directive 2003/88/EC of the European Parliament and the Council of 4 November 2003 concerning certain aspects of the organization of working time, OJ L299/9 of 17 November 2003.

24 Directive 2005/36 of the European Parliament and the Council of 7 September 2005 on the recognition of professional qualifications, as amended by Directive 2013/55/EU of the European Parliament and the Council of 20 November 2013. For an account of obstacles to recognition at national level among others in the healthcare sector see Lavinia S. J. Kortese, *The Recognition of Qualifications in the EU. Blurring the Lines of Competence between the Internal Market and Education*, PhD thesis, Maastricht, 2020.

25 See https://www.consilium.europa.eu/en/policies/adequate-minimum-wages/#:~:text=The%20Council%20reached%20a%20provisional,levels%20of%20statutory%20minimum%20wages and COM(2020) 682 final, proposal for a Directive of the European Parliament and of the Council on adequate minimum wages in the European Union, of 28 October 2020.

26 Ibid, fn. 17.

27 Conference on the Future of Europe, Report on the final outcome, May 2022, p. 50.

28 Preliminary technical assessment (fn. 23), pp. 40-41.

29 See also Obijiofor Aginam (2010), 'Predatory Globalization: The WTO Agreement on Trade in Services, Migration and Public Health in Africa', *American Society of International Law Proceedings* 104, 139-146, p. 145. For the view that remittances are not a remedy, see Cristina Ilie Goga, 'Is Romania in a Social and Economic Crisis Caused by Emigration? The New Policy of the Romanian State on Migration', *Sociology and Social Work Review* 4(1), 2020, 31–37, pp. 33-34.

30 Regulation (EU) 2021/1058 of 24 June 2021, preamble recital 23.

31 Regulation (EU) 2021/241 of 12 February 2021 establishing the Recovery and Resilience Facility.

Article 3

32 Article 3, under (e). Furthermore, point 92 of annex VI mentions 'health infrastructure'.

33 See also Lang and Lang (2020), 'The Dark Side of Free Movement: When Individual and Social Interests Clash' (fn. 6), p. 407; Damjan Kukover (fn. 7), p. 411.

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