



# Study on cross-border health services: potential obstacles for healthcare providers

Chafea/2014/Health/10 – Executive Summary

Written by the consortium of Ecorys, Erasmus University Rotterdam, and Spark Legal Network and Consultancy Ltd.  
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## SHORT SUMMARY

This study seeks to identify the different requirements placed on healthcare providers wishing to either establish themselves in another European Member State (MS), or provide cross-border services in one MS whilst being established in another. The focus of the study was on cross-border General Practitioners (GPs) (including provision of online consultations and ePrescriptions), physiotherapists, medical laboratories, and hospitals setting up subsidiaries across borders.

The study concludes that the requirements that *only apply to cross-border providers* (in this study referred to as “additional requirements”) mainly concern requirements relating to individual medical professionals:

- *Recognition of qualifications* (GPs, physiotherapists and professionals running a medical laboratory).
- *Language requirements* (GPs, physiotherapists and professionals running a medical laboratory).
- *Additional requirements upon registration with regulatory bodies* (e.g. additional supporting documents and certified translations).

Requirements relating to the place of work and public funding coverage typically apply equally to all providers. For example, legislation on setting up subsidiary hospitals hardly ever distinguishes between national or cross-border providers.

Cross-border healthcare providers may face obstacles, partially because of the additional requirements, when they want to provide cross-border services. The three main obstacles identified are:

- *Language requirements*.
- *High costs* associated with providing the required *supporting documents* – and particularly the *certified translations* of these documents – in the processes related to recognition of qualifications and/or registration with a regulatory body.
- *Unfamiliarity with the specifics of the healthcare system in a MS*.

Cross-border providers may experience more practical obstacles in finding the relevant information and navigating through the system compared to national providers. This potential obstacle is likely to be even bigger in MSs with a decentralised healthcare system.

## SUMMARY

Freedom of movement in the healthcare sector is fundamental for both healthcare providers and patients in the EU. The free movement rights are enshrined in the treaties and delegated legislation. The EU dimension to policy regarding the provision and management of health services has evolved in recent years. The European Court of Justice qualified healthcare services as a service to which the principles of free movement fully apply. In addition, the uptake of legislation from other policy areas that also cover health services has been increasing over the last years.<sup>1</sup> As a result, EU Institutions and MSs are increasingly faced with the question of how to apply the principles of free movement of health services in practice.

Health care professions are highly regulated at national level, which could create a barrier obstacle for professionals that would like to practice their services cross-border. EU legislation aims to facilitate the provision of cross-border health services, but nevertheless, in practice, healthcare professionals still face different (potential) obstacles. These are the result of dissimilarities of rules between MSs, various (cross-sectorial) administrative requirements, language barriers, and even challenges in the process of recognition of qualifications.

This study examines the free movement of healthcare providers in practice through specific examples in national contexts. It aims to identify the different requirements placed on healthcare providers wishing to either establish themselves in another MS, or provide cross-border services in one MS whilst being established in another. More specifically, this study has three objectives:

- To *identify specific and cross-sectorial national requirements* for healthcare providers, when providing cross-border health services;
- To *identify the main barriers* to delivering cross-border health services by considering how the requirements apply in practice;
- To provide an *estimation of the amount of resources* necessary to invest as a healthcare provider in order to comply with the different requirements.

In this study, requirements that only apply to cross-border providers are referred to as *additional requirements*. These requirements, and/or their associated resource demands, potentially create an *obstacle* for healthcare providers that want to offer their services cross-border. The fact that a requirement is referred to as an additional requirement or a potential obstacle does not mean that it is not proportional or without good reason (e.g. to protect patient safety).

The study investigates five scenarios of cross-border health services provision:

- Scenario 1: a General Practitioner (GP)/family doctor wishing to set up a practice in another MS to offer standard GP services to patients;
- Scenario 2: A GP wishing to offer online consultations and ePrescriptions to patients (both private patients, and also patients covered by or claiming reimbursement from the public healthcare system) in one MS whilst being established in another MS;
- Scenario 3: A physiotherapist wishing to establish themselves as an independent practitioner offering physiotherapy services in another MS;
- Scenario 4: A medical services laboratory in one MS offering diagnosis services (for example, standard blood sample analysis) in another MS;
- Scenario 5: A hospital wishing to open a subsidiary branch in another MS.

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<sup>1</sup> Such as the Working Time Directive (2003/88/EC) and the Professional Qualifications Directive (2005/36/EC).

Each of these scenarios have been analysed for ten different MS: France, Germany, Italy, Latvia, Malta, the Netherlands, Poland, Slovenia, Sweden, and the United Kingdom<sup>2</sup>. The analysis of the requirements that cross-border providers need to fulfil in the ten selected MSs provides a sound basis for the identification of likely barriers to offer health services in different types of healthcare systems and legislative environments within the EU.

### **Mobility of doctors and physiotherapists**

The Regulated Professions Database on the website of the European Commission provides statistics on, amongst other things, the number of decisions taken on recognition of professional qualifications for the purpose of permanent establishment. These statistics illustrate that in 2014 'doctor of medicine'<sup>3</sup> and 'physiotherapist' are respectively the number 1 and 4 in terms of the highest number of decisions regarding recognition of professional qualifications<sup>4</sup>. This indicates that out of all regulated professions, these professions are the first and fourth most mobile, regulated professions in that year. Looking back at previous years, doctors of medicine are always ranked the first or second most mobile profession (trading places with nurses) and physiotherapist are consistently the fourth most mobile profession (after secondary school teacher).

From 1999 until 2014, a total of 106,525 recognition of qualification decisions<sup>5</sup> were made for the profession 'doctor of medicine'<sup>6</sup> and 29,131 for the profession 'physiotherapist'. A further analysis of the data reveals that mobility of professionals is highest between MSs with the same official language as well as between origin and destination countries that are geographically close to one another.

The majority of the migrating doctors of medicine had their qualifications recognised (which includes both positive and negative decisions) in Switzerland, the United Kingdom, Germany and Norway. For physiotherapists this list of countries is essentially the same, with the addition of France and Austria.

The countries where the majority of migrating doctors of medicine and physiotherapists obtained their professional qualifications are Germany, Italy, and Romania. Most of the migrating German and Italian qualified doctors and physiotherapists applied for recognition in Switzerland. Romanian qualified doctors and physiotherapists mainly applied for recognition in Germany and the United Kingdom.

### **Approach and methodology of the study**

The study used a combination of analytical tools and (data collection) methods in order to (i) identify specific and cross-sectorial national requirements for cross-border healthcare providers; (ii) determine the main barriers to delivering cross-border healthcare services by considering how the requirements apply in practice; and (iii) arrive at an estimation of the amount of resources necessary to invest in order to comply with the different requirements.

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<sup>2</sup> Several criteria were taken into account in the selection of the ten MSs, such as: geographical location within Europe and the type of healthcare system (tax-based vs. insurance-based and centralised vs. decentralised).

<sup>3</sup> Important to note is that while scenario 1 in this study focusses on GPs, 'doctor of medicine' is broader as it refers to both doctors with basic medical training as well as specialist training (including GP training). Hence, the number of decisions on recognition of qualifications for GPs is a sub-selection of the total number of decisions presented in this section.

<sup>4</sup> Disclaimer: statistics are based on national notifications.

<sup>5</sup> This includes both positive and negative decisions taken on the request for recognition of qualification for professionals qualified in another EU MS. The competent authority can take a positive decision, as well as a positive decision without compensatory measures. Compensatory measures can take the form of an aptitude test or a traineeship.

<sup>6</sup> Please note that while scenario 1 in this study focusses on GPs, 'doctor of medicine' is broader as it refers to both doctors with basic medical training as well as specialist training (including GP training).

The research began with mapping and categorising the requirements (e.g. regulatory, legal, administrative, civil) that providers have to meet in order to offer healthcare services. The requirements mapped and categorised were those related to the five scenarios, in the ten selected MS. The mapping was conducted via desk research by a network of legal country experts.

The mapping distinguished between three broad categories of requirements:

- (i) requirements pertaining to the individual;
- (ii) requirements pertaining to the place of work; and
- (iii) requirements pertaining to public funding coverage.

In addition, each requirement was categorised on the following variables:

- Specific to the healthcare sector or cross-sectorial;
- Demanded by a centralised or decentralised body; and
- Applicable to all providers or only to cross-border providers.

The results of the mapping formed the basis for a categorisation tables (using the above mentioned categorisation) and country fiches, which were continuously updated throughout the course of the study. In addition, infographics that visualise and summarise all the requirements needed to provide cross-border health services were developed.

Upon finalising the mapping, further desk research was conducted and national stakeholders as well as healthcare providers that are, or want to be, providing their services cross-border (i.e. examined real-life examples, from now on referred to as “actual cases”) were consulted. These consultations were conducted in order to:

- Validate and complement the results of the initial mapping;
- Identify the additional requirements for cross-border providers; and
- Identify the potential obstacles and the associated resource demands.

The collected information was then synthesised and analysed, first by scenario, and second, by MS (for selected requirements).

The draft findings of this analysis were submitted to a stakeholder review, which was conducted with stakeholders both at the EU- and the MS-level in October-November 2016. Finally, a peer review was conducted December 2016.

The approach for data collection in these tasks consisted of a combination of desk research, written enquiries to national stakeholders, and telephone interviews with so-called actual cases. All collected data and information was subsequently analysed and synthesised. Upon finalising the analysis and drafting the report, a stakeholder review and peer review were conducted. Based on the feedback from these reviews, the report was revised and finalised.

## **Main findings and conclusions**

### ***Additional requirements for cross-border providers***

The results of the study indicate that the legislation on setting up subsidiary hospitals (scenario 5) almost never distinguishes between national or cross-border providers. For the scenarios 1 to 4, on the other hand, there are requirements that *only apply to cross-border providers* and not to national providers. The fact that a requirement is referred to as an additional requirement does not mean that it is not proportional or without good reason, for example (e.g. to protect patient safety). These requirements mainly concern:



- *The recognition of qualifications*

The results for scenarios 1 and 3 show that cross-border GPs and physiotherapists need to have their qualifications recognised in the MSs where they wish to establish themselves and set up their practice. The same holds in most MSs for the individual running the medical services laboratory in scenario 4. In those MSs that have legislation in place for scenario 2, the GPs wishing to offer ePrescriptions or online consultations typically also need to have their qualifications recognised. The main aim of this requirement is to verify whether the qualifications of the cross-border professional are in line with the required level of education and quality standards in that MS. Given that, unlike for GPs, there is no common training framework for physiotherapists nor for persons running a medical services laboratory (for which requirements in terms of qualifications differ across MSs), the requirement of recognition of qualifications is expected to be more challenging for professionals in scenario 3 and 4, compared to the GPs in scenarios 1 and 2. In the process of getting their qualifications recognised, cross-border professionals need to supply a variety of supporting documents, related to e.g. evidence of education, professional experience, and/or capacity to practice. The number and type of documents differs per MS. For some of these supporting documents, certified translations may be required. In some MSs, scenario 1 requires most documents and translations, whereas in other MSs it is the other way around. The variation in fees for the recognition of qualifications across MSs is rather high and typically higher in scenario 1 compared to scenario 3. This results from the fact that some MS require additional recognition of specialist qualifications. On top of the costs, the potential waiting time, which is typically over one month, is one of the most burdensome (potential) resource demands.

- *Language requirements*

In all selected MSs there exist language requirements for cross-border GPs, physiotherapists, and professionals running a medical services laboratory. Proof of language knowledge is not a formal requirement in all MSs – in some MSs it is rather a practical, de-facto requirement. This is typically due to rules on patient care which emphasise the importance of effective communication and the societal responsibility of a medical professional to be able to communicate with a patient in their native language. The analysis of the language requirements shows that there is variation in the required level of language knowledge both across MSs and across scenarios. Resource demands also vary because of differences in costs and the amount of time necessary to reach the required level.

- *Registration with regulatory bodies*

The registration process is crucial, since most regulatory bodies are in charge of delivering licences to practice. Although national providers also need to register with the regulatory body, often additional requirements are imposed on cross-border providers. Examples of these additional requirements include the need for providing certified translations and/or additional supporting documents, which may include certificates issued by the home MS or declarations/statements on the applicant's character/criminal record, etc. The fees for the registration with regulatory bodies is relatively uniform across MSs (approximately EUR 100 with Poland as an outlier) compared to the fees for recognition of qualifications. DE and FR require the provider to file a request for registration before actually being able to register. Arguably, the requirement for registration with the regulatory body is thus most extensive for these two MSs. In terms of the number of required documents and certified translations it differs between MSs for which scenario the resource demands are higher.

The specific requirements that apply only to cross-border providers are often requirements relating to the individual – i.e. a practising GP or physiotherapist - and their capacity to provide services (evidenced by their degree) or communicate with patients (evidenced by language ability). In addition, these requirements may, for the vast majority, also be described as 'sectorial requirements' in the sense that they are specific

to the health sector. This may be explained by the fact that the health sector, highly regulated in all EU MSs, is very specific and therefore entails detailed, tailored rules.

Requirements relating to the place of work and public funding coverage typically apply equally to both cross-border and national providers. While the requirements relating to the place of work are typically cross-sectorial requirements (such as those relating to: company law, tax law, accountancy, insurance, etcetera), the requirements regulating reimbursement or funding by the healthcare system are all sectorial requirements. These requirements are very specific and indicate the extreme complexity of the rules regulating coverage by the healthcare system.

While the cross-border provision of GP- and physiotherapists services (scenarios 1 and 3) are highly regulated, most MSs have not legislated for the possibility of ePrescriptions, online consultations, or cross-border medical laboratories (scenarios 2 and 4). In some MSs, these scenarios do not even appear to be realistic or under way at the time of writing this report. Because of this reason, as well as the fact that both desk research and stakeholder consultations provided limited results for these scenarios, it is difficult to say with certainty whether or not the requirements in these two scenarios differ between national and cross-border providers, and if so, to what extent. However, it is worth noting that those MSs that have regulated these scenarios typically do impose additional requirements on cross-border providers, such as the need for recognition of professional qualifications.

### ***Potential obstacles for cross-border healthcare providers***

The analysis showed that cross-border healthcare providers may face obstacles when they wish to provide cross-border services. To some extent these barriers directly relate to the earlier described additional requirements.

First, the results of the study indicate that *language requirements* as assessed by language tests are issues for consideration. Amongst the consulted national stakeholders, language requirements were the most often mentioned potential obstacles to providers wishing to practice abroad. In addition, the actual cases also highlighted language requirements as a potential obstacle, particularly when there were obligatory tests and/or when additional training costs need to be incurred. Both the training and (obligatory) tests can pose significant resource demands on cross-border providers in terms of costs and time.

#### **Box 1: language requirements – obstacles experienced by a selection of actual cases**

A Dutch GP, wishing to set up a practice in the UK, mentioned that the first obstacle she encountered was the English IETLS test that she had to pass at the academic level (i.e. with 7.5 points or more). Although she is fluent in speaking and reading, she had to repeat the exam three times to get a sufficient score for writing. Each attempt cost about £ 150.

Two Polish physiotherapists, wishing to practice in the Netherlands, mentioned that language requirements formed an obstacle for them. One of them mentioned that the municipality pays for her Dutch classes and she follows the classes twice a week for three hours. The other Polish physiotherapist has to pay for Dutch classes by herself and as a result, she is incurring substantial costs.

A second potential obstacle is the *high costs associated with providing the required supporting documents* – and particularly the *certified translations of these documents* – in the processes related to recognition of qualifications and/or registration with a regulatory body. Fees often apply for the latter. However, as illustrated by the analysis of resource demands and the consultation of actual cases, these fees are relatively low compared to the costs of providing certified translations. It is worth noting that the results of the analysis indicate that the number of supporting documents, and thereby the estimated resource demands, differs substantially among MS. This difference, as well as the number of requirements and resource demands, is likely to decrease in the (near) future for Physiotherapists (scenario 3) due to the introduction of the European Professional Card (EPC) for this profession.

**Box 2: costs of supporting documents and translations – obstacles experienced by a selection of actual cases**

A Polish physiotherapist wishing to practice in the Netherlands shared her experiences with regard to the high resource demands she faced when applying for recognition of qualifications and the mandatory registration in the physiotherapy register. To date, she spent 900 EUR on the translation of all the required documents. Hence, the number of supporting documents and translations are an obstacle for this physiotherapist. This potential obstacle was confirmed by another Polish physiotherapist wishing to practice in the Netherlands; she indicated that she spent already up to 630 EUR on documents and certified translations.

A physiotherapist who graduated in Italy and now practicing in Malta mentioned that for him the main obstacle in the process of recognition of qualifications and registration with the regulatory body was the high cost for the required certified translations; he estimates that this was more than 300 EUR, which is a multiple of times higher than the registration fee.

Thirdly, *unfamiliarity with the specifics of the healthcare system in a MS* may be an obstacle. For example, the requirements relating to the place of work and public funding coverage. Though formally many of these requirements equally apply to national and cross-border providers, it can be argued that cross-border providers may experience more practical obstacles in finding the relevant information and navigating through the system (e.g. because of language barriers or unfamiliarity with the competent authorities, institutions and organisations). This was confirmed by several of the actual cases examined through interviews as part of this study. It is expected that these potential barriers are highest for the requirements relating to the public funding coverage, because these are typically very detailed and specific to the health sector in general, as well as to the healthcare system of that MS.

**Box 3: requirements relating to public funding coverage – obstacle experienced by an actual case**

A Dutch GP, wishing to set up a practice in the UK, considered the contract procedure with the NHS to be long and costly and the most difficult obstacle to overcome. Requirements included an introductory test about the NHS and a test on patient treatment, which are only provided four times a year and at a cost of £ 200. After passing these tests, it is mandatory to complete the NHS full-time course. You are classified based on your test scores into a NHS full-time course of 2 weeks up to 6 months (depending on your classification), which costs around £ 2,000 a month. This process thus demands substantial resources, both in terms of monetary costs and time.

This last potential obstacle is likely to be even bigger in MSs with a *decentralised healthcare system* as procedures and terminology may vary between regional competent authorities. Providers have to get acquainted with two sets of rules: those originating from the centralised government and those set out by the decentralised governments.

## **Limitations and recommendations for further research**

### ***Scope of the research***

One of the limitations of this study is that it focuses on 10 MSs. Though these 10 MSs were selected in such a way as to ensure a representative picture, the research shows that there are substantial differences between MSs in terms of both additional requirements and resource demands. This indicates that the potential obstacles will most likely differ between MSs in both depth and scope, but also in nature (e.g. aptitude tests vs. knowledge-based tests). The results for this study may therefore not be necessarily transferable to the other 18 MS.

Another limitation related to the scope of the study is the focus on 5 specific scenarios. Though there are similarities across scenarios (such as links between scenario 1 and 3) large differences are also observed, indicating that each professional or provider faces specific requirements.

The study therefore recommends that further research is conducted to map the (additional) requirements and potential obstacles for the other 18 MSs as well as for a

wider variety of scenarios. The scenarios could for example include nurses and medical specialists moving across borders, as the Regulated Professions Database of DG GROW suggests that these are amongst the most mobile professions in healthcare.

### ***Methods for collection information on requirements***

The data collection for this study faced several difficulties related to limited data availability as well as limited access to national stakeholders. For some MSs and scenarios, it was more challenging to find information than for others, e.g. for scenario 2 both the sources for desk research as well as the actual response to the consultation were very limited. In addition, information on resource demands and requirements for public funding coverage - for all scenarios - proved rather challenging to obtain.

For some scenarios, limitations may be explained by the fact that the scenarios are not yet very common in practice and/or are not yet explicitly legislated for (e.g. scenarios 2 and 4). This makes both desk research and consultation of stakeholders more challenging. With respect to the limited response rate for the national stakeholder consultation, this may be partly related to using only written enquiries.

One of the reasons for choosing written enquiries was to ensure that a larger number of national stakeholders could be included, given the set timeframe and budget. For future research, the study would suggest to combine written enquiries with face-to-face interviews with national stakeholders. Including face-to-face interviews in the research methodology will have a substantial impact on the project budget. This may reduce the number of MSs that can be covered in the study, but it will most likely also lead to more (in-depth) information for the selected MS. Particularly for information regarding the public funding coverage, in-depth face-to-face interviews could prove useful, given the complexity of healthcare systems.

### ***Including real-life experiences in the research***

As part of this study, actual cases were interviewed by phone to discuss their experiences. For further research, it may be interesting to also consider focus groups/group interviews with these actual cases. Given the fact that it is rather difficult to identify these cases and that they are located in different MSs, face-to-face focus groups may be difficult. However, a group interview via a webinar may be an interesting way to explore their experiences in more detail. The study would recommend organising such webinars per scenario rather than per MS, such that comparisons across the EU are facilitated. If for privacy or other reasons people are not eager to participate in webinars, an alternative may be to facilitate discussions between providers on experienced obstacles by hosting an online platform/forum or by developing mobile applications allowing them to rate their experiences and input constructive feedback on the process itself.

Another method for gathering real-life experiences that could be interesting to explore in further research, particularly to identify resource demands, is the use of mystery shopping or pseudo-patient (or pseudo-provider in this case) investigations. Essentially, these methods create actual cases that experience the resource burden placed on them when going through the process. However, given the long waiting times for meeting some of the requirements, this may prove difficult to execute within a limited study timeframe.

### ***Impact of the European Professional Card***

At the time of undertaking the research for this study, the use of the EPC was still in the early stages of implementation. Given that the introduction of the EPC is expected to have an impact on the resource demands for scenario 3 – through the number of required documents and certified translations – the study recommends that the results of this study are revisited in a few years once the EPC is common practice. An evaluation of

the impacts of the adoption of EPC could also shed light on the potential for savings on resource demands in other scenarios, if the EPC were introduced for those professions.

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