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Building a European Health Union: Opening borders for intensive care specialists

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Intensive care medicine (ICM) has taken centre stage throughout the COVID-19 pandemic. Intensive care units (ICUs) across the EU were under immense stress, with the health crisis having an unprecedented impact on the number of patients admitted. The pandemic highlights the importance of a well-functioning ICM workforce and exposes staff shortages across Europe. It also places a spotlight on the barriers to the free movement of ICM specialists between EU member states due to a lack of mutual recognition under Directive 2005/36/EC on the recognition of professional qualifications.

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The urgent situation in ICUs across Europe exposes the need for the EU to tackle these barriers. Building a stronger European Health Union (EHU) with freely moving ICM specialists will help prevent the dire situations of the pandemic and improve the resilience of Europe's healthcare systems. This Policy Brief calls on the European Commission and member states to remove the roadblocks to the freedom of movement of ICM specialists and include the profession in Annex V of the Directive on the recognition of professional qualifications. This would better prepare the EU and its member states for future crises and ensure quality ICM for all citizens.

BACKGROUND: THE IMPACT OF COVID-19 ON EU INTENSIVE CARE

The pandemic highlights European healthcare systems' structural vulnerabilities, exposing their unpreparedness and weakness to respond and adapt effectively to shocks and challenges. Healthcare systems were unprepared to address the dramatic increase in the demand for care. The pandemic also reveals the pre-existing shortages of healthcare professionals, particularly in Eastern and Southern Europe.[1] Finally, the crisis places a spotlight on the diverging national capacities to cope with health threats.

Intensive care medicine on the frontline

While the pandemic's impact has undoubtedly been felt across all areas of healthcare, ICUs were placed under particular stress, especially at the onset of the crisis and during the early waves. ICUs across the EU were confronted with various challenges, including short supplies of critical goods (e.g. personal protective equipment, ventilators, laboratory equipment, medicine).

Member states' initial responses were concentrated at the national level. But as many European regions became overwhelmed, cross-border cooperation started to develop, with patients transferred from one member state to another. For example, patients from Denmark and Belgium were treated in ICUs in Germany, while Luxembourg provided ICU beds for Italian and French patients.[2] In some cases, cross-border solidarity went beyond patient transfers to funding, with some governments compensating domestic hospitals for the additional expenses incurred due to admitting COVID-19 cases from neighbouring countries.[3]

While transferring patients between members states helped alleviate some of the pressures placed on ICUs, it did not solve all the challenges associated with the exponential increase of patients. Staff shortages, already a challenge pre-pandemic, amplified across Europe. During the early stages of the crisis, some member states sent teams of doctors to their most severely impacted neighbours, providing critical countermeasures via the EU Civil Protection Mechanism.[4] However, it remained difficult to transfer ICM specialists between one member state and another. Indeed, the specialists report that it was much easier for hospitals to transfer patients than staff. While such cooperation is welcome and undoubtedly played an important role during the pandemic, it is not without risk. ICU patients are by definition high-risk, with mortality rates often ranging between 20% and 50%.[5] Transferring specialists rather than patients could help save more lives.

STATE OF PLAY

The European legislative dimension

To promote the free movement of professionals in Europe, the EU adopted measures in 2005 to foster the recognition of professional qualifications obtained in other countries, with provisions extending to countries in the European Economic Area and Switzerland.[6] For example, the Directive on the recognition of professional qualifications allows for the automatic recognition of qualifications awarded at the end of training programmes and are included in its Annex V. Six out of the seven professions covered are in the healthcare sector: general care nurses, dental practitioners, veterinary surgeons, midwives, pharmacists and doctors. To benefit from automatic recognition, professionals must obtain a diploma that complies with minimum training requirements under the Directive and is listed in Annex V, as well as any other certificates listed with regard to the profession in question.

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However, if common minimum training requirements do not exist at the EU level, as is the case with ICM, then automatic recognition does not apply. As such, the job market for ICM specialists remains national. This acts as a barrier to countries showing cross-border solidarity in times of crisis as it is difficult for ICM specialists to move to the member state or region in need.

Intensive care pathways in the EU

The pathway to becoming an intensivist varies across the EU. In some countries, ICM is recognised – either subsequent to or within the existing medical specialities – as a subsidiary speciality, while others recognise it as a base medical speciality. Much of the difficulty in transferring specialists arises not from a difference in competences, but rather a (lack of) recognition of said competences.

Parliamentarians call for action

In a letter sent to European Commission President Ursula von der Leyen in July 2021, Members of the European Parliament from across the political spectrum call to remove all bureaucratic obstacles under the existing frameworks and recognise national ICM qualifications in other EU member states. They also urge for more investment in the training and competences of European professionals working in ICUs. Finally, they highlight that granting free movement to ICM specialists would raise the standards of care for EU citizens and play an important role in the EU's preparedness for future pandemics.[7]

Building a European Health Union

In response to COVID-19, the European Commission is building a EHU to better protect its citizens' health, and equip the EU and its member states with the necessary tools to better prevent and address future pandemics and improve the resilience of its healthcare systems.[8] The restricted mobility of ICM specialists should be viewed as a roadblock to constructing such a health union. Removing obstacles to training would allow national systems to cope with cross-border health threats. It would also enable the Union to provide a common approach to deal with health challenges.

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The benefits of freely moving intensive care specialists

As previously mentioned, transferring ICM specialists rather than patients could help save lives. In addition to the mortality risk, patients are often deprived of family support when transferred to foreign ICU units. Family-centred care, including communication, collaboration and support, is a core element of ICUs. COVID-19 and its associated restrictions highlighted the importance

of family support. Although alternative remote family support was arranged during the pandemic, they are an inadequate replacement for physical visits.[9] If barriers to the free movement of ICU specialists were removed, they could move to regions in need of support instead of patients being relocated and potentially separated from their families.

To be better prepared for future shocks like pandemics, ICUs across Europe need access to a workforce trained to the highest standard of ICM. Should an acute disaster occur in a member state, swift action would be required. Currently, ICM specialists who would be willing to help would be unable to due to the lack of mutual recognition. Utilising and mobilising the EU's ICM workforce in times of crisis should be a priority when building a EHU.

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A specialised workforce is essential for the proper functioning of ICUs. During the pandemic, many European countries increased their ICM staff by setting up rapid training programmes to equip healthcare professionals specialised in other disciplines with the skills most needed to cater for the needs of critically ill COVID-19 patients. At the EU level, the Emergency Support Instrument funded the C19_SPACE (Skills PrepAration CoursE) programme, which also trained 17,000 European healthcare professionals in the basic skills necessary to work in ICUs during the pandemic.[10]

While these measures addressed staff shortages during the pandemic, they are not permanent solutions, as they only equipped the workers with the most basic skills to work under the supervision of specialised ICU teams. Increasing the number of people training to become ICU specialists in Europe is a must. Removing the barriers to free movement – both for training and work – could increase the profession's attractiveness.

A common EU training and competency framework would not only encourage the free movement of specialists but also promote all EU citizens' equal access to high-level care. Free movement between member states with varying healthcare systems could harness the exchange of best practices and knowledge between ICUs. This could enhance the quality of care for ICU patients across Europe, not just in times of crisis but permanently. In fact, research shows that the mobile healthcare workers across the EU creates stronger professional networks and encourages the circulation of medical knowledge beyond national borders.[11]

The inclusion of other healthcare professions in Annex V of the Directive on the recognition of professional qualifications has undoubtedly promoted such mobility. In the last decade, almost 85,000 doctors and more than 90,000 nurses obtained their qualifications in one country and work in another.[12] However, movement tends to occur from Eastern and Southern Europe to Western and Northern Europe. This skewed migration trend is attributed to different working conditions, including in earnings and work environments. As such, while eroding the barriers to the free movement of ICM specialists would have positive implications, member states must also ensure the provision of qualitative work standards and pay conditions to avoid a potential brain drain and attract ICM specialists from other parts of the EU.

The challenges of including intensive care medicine into Annex V

As things stand, the full automatic recognition of ICM between all member states under Annex V of the Directive on the recognition of professional qualifications is not possible due to an absence of a majority of member states recognising ICM as either a base medical speciality, or subsequent to or within the existing medical specialities. In order for a system of full automatic recognition to be created for a qualification type under Annex V, at least 11 member states must recognise said qualification. The system would then only apply to the recognising countries. But the diversity in pathways to becoming an intensivist are not in themselves a flaw. In fact, their multidisciplinary nature is an asset. As such, a single universal pathway to becoming an intensivist should not be the end goal.

PROSPECTS: ESTABLISHING EU TRAINING AND COMPETENCY FRAMEWORK

Instead, minimum EU training requirements and competences should be established and incorporated into the existing ICM training programmes across the member states – many of which already require at least two years. A common framework could establish minimum requirements for intensivists to practice in ICUs across the EU. A common minimum training period and the core competencies required as an ICM specialist should be defined.

A framework like the International Competency Based Training in Intensive Care Medicine for Europe (CoBaTrICE) could be the precursor for the framework. Partly funded by Leonardo da Vinci, the European Commission's programme for lifelong learning, CoBaTrICE provides a common curriculum for doctors acquiring ICM competencies that lasts two years. The competencies set out in the CoBaTrICE framework are already used in training programmes in many countries. Mutual recognition for these intensivist qualifications could be achieved with such training under a common EU framework. This recognition could be partial in nature, whereby member states in which ICM is a base speciality

would recognise the training and competences of the intensivist coming from a state where ICM is part of a dual speciality, and vice versa. The intensivists could practice in all member states as they would in the country where they received their qualification.

The European Commission should propose revising the EU acquis to include intensive care medecine in Annex V of the Directive on the recognition of professional qualifications via a common EU training and competency framework.

While this approach is not the norm under the Directive on the recognition of professional qualifications, it could include ICM into Annex V's list of professions. The Commission should propose revising the EU acquis to include ICM in Annex V via a common EU training and competency framework. Opening EU borders for the free movement of ICM specialists would have positive implications for all ICU patients. It would reduce the risks of transferring patients between member states and promote greater access to high-quality care. The Commission should also consider the negative impact of omitting ICM from Annex V and its consequent barriers to founding a EHU. If the Commission is truly committed to strengthening cross-border cooperation to be better prepared for future crises, then ensuring the free movement of ICM specialists is a priority.

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