EÖTVÖS LORÁND UNIVERSITY

DOCTORAL SCHOOL OF LAW

CHALLENGES OF THE FREE MOVEMENT OF PATIENTS AND PROFESSIONALS FOR HEALTHCARE SYSTEMS

POSSIBLE TOOLS TO MITIGATE ADVERSE EFFECTS

Theses of the PhD dissertation

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Introduction and aim of the research

The right to free movement of persons is a fundamental pillar of European integration. Over the past 60 years, it has evolved from a restrictive to a more liberal framework, aiming to ensure equal treatment for European Union (EU) citizens while advancing the Treaty's objectives. This evolution has focused on removing internal barriers to free movement and has also offered a more permissive common migration policy for third-country nationals (1).

The right to free movement of persons within the European Union affects health systems primarily through the mobility of both patients and professionals. The Treaty on the Functioning of the European Union (TFEU) enshrines these principles, further reinforced by secondary legislation, including Regulation 883/2004/EC on the coordination of social security systems, together with its implementing Regulation 987/2009/EC, which have long been providing the framework for patient mobility, and Directive 2005/36/EC on the mutual recognition of professional qualifications, which governs the movement of healthcare professionals. These legal instruments, along with evolving European Court of Justice case law, have shaped the regulatory framework for cross-border movements, presenting continuous implementation challenges for Member States. Recent legislative developments include Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, which codifies key case law on patient mobility, and Directive 2013/55/EU revising Directive 2005/36/EC on the mutual recognition of professional qualifications, introducing new mechanisms to further facilitate professional mobility.

Healthcare remains a politically sensitive issue across all EU Member States, often shaping election outcomes (2). Consequently, national governments are reluctant to transfer authority to the EU in this domain (3). Under Article 168(7) TFEU, Member States retain primary responsibility for planning, financing, and operating their healthcare systems. However, as the European integration progresses, the expansion of the internal market's legal framework increasingly influences national healthcare policies, limiting Member States' room for manoeuvre in certain areas in managing their healthcare systems (4,5,6,7).

While upholding the right to free movement, ensuring equal access to quality care is the clear endeavour of EU health ministers as reflected in the 2006 Council Conclusions on Common values and principles in European Union Health Systems. However, these core values – the free movement of people and services alongside the maintenance of high-quality, accessible healthcare – sometimes come into conflict. While the benefits of the internal market are widely acknowledged, cross-border healthcare services are often perceived as favouring well-informed, wealthier patients, potentially disadvantaging those who remain in their home countries as healthcare resources become more constrained (8,9,10,11). Furthermore, access to healthcare is further challenged when highly skilled health professionals move to other Member States in pursuit of better living conditions and higher salaries, leaving their home healthcare systems struggling with workforce shortages – particularly in certain professions and geographic areas. This issue is especially pressing in the context of aging populations and the

rising prevalence of chronic diseases, necessitating more strategic health workforce planning (12, 13).

So, both patient and professional mobility significantly impact national healthcare systems, necessitating a comprehensive approach to analysing these processes and the policy responses they require. While these two aspects are often examined separately, this dissertation uniquely considers them together, providing a holistic perspective on the challenges and opportunities arising from cross-border healthcare dynamics.

The issues explored in this dissertation lie at the intersection of EU law and health policy, reflecting the complex and often delicate balance between supranational legal frameworks and national healthcare governance. Understanding these interactions is essential for assessing how Member States can navigate the tensions between EU integration and the need to maintain sustainable, accessible, and high-quality healthcare services. By examining both legal and policy dimensions of free movement in the healthcare sector, this research aims to contribute to ongoing academic and policy discussions, offering insights into the broader implications for both national and EU-level decision-making.

The systemic research is focusing on how the continuous evolution of EU law in the context of the internal market affects healthcare governance and what – primarily legal – reactions are and can be given at Member State and EU level to mitigate their potential negative effects. By identifying and analysing good practices and legal mechanisms available to Member States to address these issues, this research aims to provide recommendations for balancing the EU's free movement principle with the imperative to maintain sustainable, accessible, and high-quality healthcare systems.

The research questions and methodology

The research questions

This PhD thesis explores the legal, policy, and practical implications of patient and professional mobility within the EU, with a specific emphasis on Hungary's experience.

The overarching research question is:

How does the development of EU's legal framework on free movement impact national healthcare systems, and what – primarily legal – responses can Member States – particularly Hungary – adopt to manage its effects, including potential mechanisms at the European Union level?

To answer this, the thesis is seeking answer to the following key sub-questions:

Patient Mobility

1. How have legal developments by the European Court of Justice and EU co-legislators shaped the patient mobility acquis, and what recent trends and challenges have emerged?

2. How have Member States – with a special focus on Hungary – implemented Directive 2011/24/EU, especially with regard to managing patient inflows and outflows?

3. How have patient mobility trends evolved in response to legal developments, and to what extent has cross-border patient movements affected healthcare access across the EU?

4. What legal tools can be recommended for Member States to effectively manage patient flows while ensuring equal access to healthcare, in compliance with the EU legal framework on the free movement of persons and services, with a special focus on Hungary?

Professional Mobility

5. How have legal developments at the EU and international levels shaped the regulatory environment for professional mobility, and what framework have emerged for national legislations to justify restrictions?

6. How have broader structural factors, major political events, and legal developments shaped health professional mobility in the EU, what trends can be observed and what are the consequences for national healthcare systems – especially in source countries like Hungary?

7. What legal tools can be recommended at the Member State level to effectively manage professional mobility in a way that mitigates its negative impacts on sending countries, while preserving the benefits of mobility and remaining compliant with the EU legal framework on the free movement of persons?

8. How can the WHO Global Code of Practice on the International Recruitment of Health Personnel and the European Health Union contribute to managing intra-EU health professional mobility, and what role can they play in reconciling free movement with sustainable national healthcare workforces?

By addressing these questions, this thesis aims to provide a comprehensive legal and policy-oriented analysis of how patient and professional mobility in the healthcare sector can be managed within the boundaries of EU law, offering practical recommendations for national-level strategies – particularly in Hungary – as well as for supportive measures that could be developed at the EU level.

Research Methodology

The thesis employs a qualitative research methodology – combining doctrinal legal analysis and secondary desk research through the review of relevant academic literature and policy documents, as well as primary research through case studies that include original data analysis and comparison with general trends identified in the literature.

The two topics – patient and professional mobility – are not usually addressed together. This approach represents, on the one hand, a novelty, and on the other hand, a limitation – as each

topic could independently offer sufficient material and questions to explore within the scope of a doctoral thesis. Therefore, alongside the legal analysis of relevant EU and national legislation and the review of academic literature, the research strategy has been twofold: firstly, to collect information on Member States' legal solutions and policies from horizontal studies that compile and analyse data and measures from all EU Member States; and secondly, to conduct a few deep dives – case studies – to better understand specific phenomena.

The primary sources for the legal doctrinal analysis include European Union legislation – such as the relevant provisions of the TFEU; secondary legislation, including Directive 2011/24/EU on the application of patients' rights in cross-border healthcare; the social security regulations – Regulation 883/2004 and its implementing Regulation 987/2009 – and Directive 2005/36/EC on the mutual recognition of professional qualifications; as well as landmark rulings of the ECJ that have shaped the current EU acquis on patient and professional mobility. Through this analysis, the thesis explores how EU legal frameworks have evolved over time and how they interact with national healthcare policies.

To broaden the study's perspective, the research also incorporates desk research on global healthcare workforce governance – examining the WHO Global Code of Practice on the International Recruitment of Health Personnel and its relevance within the European Union, where health professionals are entitled to move freely across borders. Additionally, bilateral agreements of EU Member States at national or lower levels are examined to assess their potential for jointly managing mobility flows.

In addition to legal analysis, the thesis employs a comparative policy approach to evaluate the implementation of patient mobility rules across EU Member States. By analysing EU-wide Commission reports – including national legislative adaptations – the research aims to identify challenges and variations in the application of Directive 2011/24/EU, with special attention to the mechanisms used by Member States to regulate access to cross-border healthcare services. Regarding professional mobility, the research focuses on comparative studies on retention strategies and includes case studies from Hungary – examining available data and solutions to better understand the effects of global trends, political events, or legal adaptations on health workforce mobility. These also serve to highlight good practices in legal tools for workforce retention.

This multifaceted methodology enables a comprehensive assessment of legal developments, implementation challenges, and sustainable policy solutions for managing both patient and professional mobility within the European Union.

The Format of the PhD

Following the introduction, which outlines the central tension between the EU's principle of free movement and the objective of equitable access to healthcare, the thesis presents the research questions, the methodological approach, and the structure of the PhD, followed by an overview of the main provisions of primary EU law relating to both topics of the thesis.

The core of the work is divided into two main parts: the first addressing cross-border patient mobility and consisting of four chapters, and the second addressing cross-border health professional mobility, consisting of six chapters.

Part One begins with an analysis of the development of the EU legislative framework in Chapter I. It covers secondary legislation on the coordination of social security systems and the case law of the European Court of Justice, which paved the way for Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. The discussion continues with an in-depth examination of the Directive itself, followed by an analysis of key judgments that have further shaped the interpretation of prior authorisation. Chapter II focuses on how Member States have implemented the patient mobility rules, based on the analysis of Commission reports and studies mapping administrative procedures. Special attention is given to the Hungarian example as a national case. Chapter III follows with an assessment of the impact of Directive 2011/24/EU on national healthcare systems, drawing on EU-level data and reports based on both the Directive and social security regulations. The experiences of Hungary are again discussed in this context. The first part concludes in Chapter IV with a synthesis of research findings from the whole of Part One, organised under the research questions, including the presentation of good practices of a legal nature applied across Member States for managing patient flows.

The second part of the thesis turns to the issue of health professional mobility, starting in Chapter I with an introduction to key concepts and definitions, as well as the health workforce situation across the EU, which raises growing concerns regarding the sustainability of health systems. Chapter II outlines the relevant EU and international legal frameworks, including Directive 2005/36/EC on the mutual recognition of professional qualifications and the related jurisprudence of the European Court of Justice concerning free movement and the right to establishment. This is followed by a broader analysis of case law on equal treatment and non-discrimination, identifying the legal elements that national legislation must observe when aiming to manage mobility. The chapter concludes by introducing an element of global health governance: the WHO Global Code of Practice on the International Recruitment of Health Personnel. Chapter III continues with an analysis of how recent legislative developments and major political events have affected professional mobility trends, placing special focus on Hungary. After an introduction to mobility measurement indicators, two detailed case studies are presented: the European Professional Card and Brexit, serving as examples of the influence of legal and political change on mobility patterns. Chapter IV examines good practices to address mobility challenges by thoroughly analysing studies on Member States' broader retention strategies, with the aim of identifying legal solutions. Chapter V further extends the analysis to the European level, discussing the relevance of the WHO Code in the EU context and evaluating the potential role of the European Health Union as a possible framework to better address workforce challenges. This part concludes in Chapter VI by summarising the findings from the whole of Part Two, organised under the research questions, including the presentation of good practices of a legal and policy nature applied across Member States for managing professional flows.

The thesis closes with a final chapter that brings together the key conclusions of both parts in a simple table format and formulates theses and, where applicable, recommendations connected to the research findings. These are aimed at supporting a sustainable and equitable framework for patient and professional mobility in Hungary, across Member States, and within the European Union.

Main findings of the research

Thesis 1 – The jurisprudence of the European Court of Justice, complemented by EU secondary legislation such as Directive 2011/24/EU, has progressively expanded patients' rights to cross-border healthcare, while recognising the need to maintain stable and well-functioning national healthcare systems. Recent case law however highlights an emerging tension between quality-of-care obligations and systemic resource limitations.

The current legal framework – including Directive 2011/24/EU, the social security coordination regulations and the connected case-law – is well-established, balanced and adequate for managing cross-border patient flows. Its central element is the system of prior authorisation, which enables Member States to control access to planned healthcare abroad while protecting the sustainability of their national health systems. Over time, the framework has clarified many aspects of how and when prior authorisation must be granted, while progressively expanding patients' rights to cross-border healthcare in balance with the need to maintain stable and effective healthcare systems. Despite the codification of patient rights in Directive 2011/24/EU, case-law developments continue to pose interpretative challenges.

The concept of "undue delay" remains the most complex element of prior authorisation; recent case-law – especially the *Petru* ruling – adds to this by introducing that care affected by systemic deficiencies and lack of resources can be considered equivalent to unavailable care, establishing a direct link between the quality of care and the obligation to authorise treatment abroad. Further clarification is necessary concerning these outcomes and the possible need for benchmarking, as allowing patients to access treatment abroad in cases of systemic deficiencies in a healthcare system would endanger the balance established by previous case-law between patient mobility, healthcare quality, and financial sustainability across all Member States.

A clear new trend is emerging in the jurisprudence treating Directive 2011/24/EU as a legally autonomous framework, distinct from the traditional social security coordination rules. This development reflects a shift in legal reasoning from the coordination of benefits based on the free movement of persons to a service-based logic grounded in the free provision of services. The *A v. Veselības Ministrija* case exemplifies this evolution, where the Court differentiated between the two legal frameworks by concluding that – while a medical approach to authorisation and financial stability considerations are acceptable under the Regulations – refusing authorisation for treatment abroad under the Directive is only possible where it is necessary and proportionate to legitimate objectives, such as preserving healthcare capacity or medical expertise.

These developments also highlight the demanding position of Member States, which must integrate a growing body of EU-level jurisprudence with their own healthcare regulations, administrative procedures and systemic limitations – all while ensuring the correct and

consistent application of national law in light of EU principles. A more unified interpretation mechanism (e.g. through updated guidance or periodic review of the Directive) could support Member States in aligning national implementation with ECJ jurisprudence and ensure balanced application across the EU.

The research has discovered that Hungary has not transposed key ECJ rulings of *Elchinov and WO* regarding reimbursement in urgent cases without prior authorisation. To overcome this, Hungary should revise its legislation and ensure that reimbursement is not denied in cases where authorisation was requested but could not be awaited due to urgency, and establish a clear procedure for the ex-post submission and assessment of authorisation requests where the patient was unable to apply in advance owing to the urgency or severity of his or her medical condition.

Thesis 2 – Although Directive 2011/24/EU grants Member States a degree of regulatory discretion, its implementation across the EU – as illustrated also by Hungary – has often taken the form of restrictive legal and administrative measures aimed at controlling patient outflows, potentially narrowing the exercise of patients' rights and highlighting the need for more proportionate, flexible and transparent frameworks.

The analysis of Member States' regulations confirmed that the implementation of Directive 2011/24/EU has posed a significant challenge for almost all Member States, many of which have subsequently faced formal notifications and infringement proceedings by the European Commission concerning the substance of their legislation. Most Member States have implemented the Directive cautiously, applying broad prior authorisation systems and administrative requirements that often act as barriers rather than facilitators of cross-border care. Compliance concerns arise from broadly applied prior authorisation with limited transparency, lower reimbursement rates for cross-border care compared to domestic treatment, and complex administrative procedures that can undermine patient access.

While most Member States introduced prior authorisation systems as a general tool for managing patient outflows, a few have deliberately opted for more flexible regulatory models. In these cases, prior authorisation is either not required at all or may be introduced selectively through secondary legislation for specific treatment categories if justified by overriding reasons of general interest. Such safeguards provide a more proportionate response to potential increases in patient flows while maintaining compliance with Directive 2011/24/EU. These safeguards have not yet reported to have been applied in practice. Although no official good practices on patient inflows have been identified, Hungary's institution-level restriction can nevertheless be considered a relevant example.

Hungary's implementation of the Directive is formally compliant but remains among the most restrictive in the EU. The national system relies heavily on prior authorisation, covering all hospital and to a great extent specialised treatments. Although certain amendments were introduced in 2016 – likely in response to Commission concerns – the regulatory approach has remained largely unchanged. While some interpretative questions remain – such as the classification of hospital care or the role of national or contracted doctors – the overall system remains legally sound. The choice of managing outflows in the strictest possible way likely reflects concerns about financial sustainability in the event of increased patient flows, which

however not have been materialised in the number of patients asking for authorisation or reimbursement.

Given that the number of requests for cross-border treatment under the Directive has remained extremely low in Hungary for more than a decade, simplification of the current authorisation system is justified. The removal of prior authorisation could be considered and replaced with a safeguard mechanism that would allow its reactivation only if reimbursement expenditure exceeds a predefined threshold – and only for those treatments where that threshold has been reached. Additionally, a safeguard clause could be introduced to temporarily limit reimbursement where necessary. Existing procedural rules could remain in place and be applied if the prior authorisation requirement is reintroduced.

Thesis 3 – Despite extensive legal developments on cross-border healthcare rights, patient mobility remains low and geographically limited, with negligible financial impact on national systems, indicating that earlier fears of mass outflows and systemic disruption have not materialised. Nevertheless, disparities in access and legal uncertainties continue to affect patients' ability to fully exercise their rights.

Cross-border patient mobility (planned care as used in this thesis) remains extremely limited across the European Union, accounting for approximately 0.01% of overall healthcare expenditure. Recent legal developments – including the adoption of Directive 2011/24/EU and continued evolution of case law – have not led to a significant increase in such movements. Concerns that legal entitlements would trigger substantial outflows from less affluent Member States have not materialised. No measurable negative impact on access to healthcare in countries of origin has been identified, and fears about exacerbating social inequalities or undermining solidarity have not been substantiated by the available data.

Patient mobility under both the Regulation and the Directive is driven primarily by proximity, language, and bilateral patterns. Most patient flows occur between neighbouring countries – particularly among France, Belgium, Luxembourg, Switzerland, Germany and Austria – and often involve returning to one's country of origin, seeking specialised care, or accessing treatment supported by family or linguistic ties.

Hungary shows among the lowest levels of use of Directive 2011/24/EU. According to data reported by the Hungarian National Health Insurance Fund, there have been only a few requests under the Directive – mostly concerning reimbursement for prescribed medication – while prior authorisation requests for planned care are practically absent. This low level of use can be explained by the general requirement of prior authorisation for all inpatient and high-cost outpatient treatments, low reimbursement levels, and a generally low willingness to seek care across borders due to travel, language, and organisational barriers. In most cases, planned care abroad is authorised through the "equity route", applied to treatments not included in Hungary's domestic healthcare coverage.

Given the persistently low use of Directive 2011/24/EU, Member States should reinforce the visibility and effectiveness of their National Contact Points to ensure that patients are better informed about their cross-border healthcare rights. Further efforts should also aim to reduce duplication in data provision and clarify procedural distinctions between the two legal

frameworks (regulations and directive) to improve overall coherence and administrative efficiency.

Thesis 4 – Comparative analysis of national implementation practices reveals that flexible regulatory models – characterised by optional or conditional prior authorisation, possible reimbursement safeguards, and institution-level inflow controls – offer a more balanced and sustainable approach to managing cross-border patient mobility, with significantly lower administrative burden than rigid authorisation systems, particularly in low-mobility contexts such as Hungary.

In mobility contexts where the use of Directive 2011/24/EU remains extremely limited, I consider that more flexible regulatory approaches may serve as better alternatives to rigid prior authorisation systems. Therefore, I looked for such balanced good practices, focusing my research on Member States that have not maintained general prior authorisation systems and identified solutions that include safeguards for potential changes in patient flows.

These less stringent but still efficient solutions include regulatory models where prior authorisation is not required by default but can be activated through regulation for specific treatment categories if justified. This model – applied, for example, in the Czech Republic and Estonia – allows the government or the minister, where appropriate upon the proposal of the competent authority, to activate the safeguard clause and introduce a prior authorisation requirement without the need to amend existing legislation. The procedure is established, and in the Czech case, a predefined list of treatments is also determined. Ireland offers another good practice through an optional but strongly encouraged prior authorisation system, which is not a precondition for reimbursement but supports patients in ensuring that all procedural conditions are met – such as obtaining a general practitioner referral and attending an in-person specialist consultation.

Safeguard clauses under Article 7(9) of the Directive, allowing national health authorities to impose temporary or targeted limits on reimbursement where justified, can also be considered good practice. These reimbursement safeguards offer a balanced alternative to blanket prior authorisation, providing proportionate responses to budgetary or planning challenges. The Irish system combines such a safeguard mechanism for reimbursement with the optional prior authorisation system, allowing the Health Service Executive to introduce temporary or targeted restrictions on reimbursement if justified by overriding reasons of general interest – such as cost control, planning, or the prevention of waste – and is explicitly subject to the principles of necessity and proportionality.

Concerning patient inflows, only the Hungarian institutional-level solution – which allows providers to refuse treatment to incoming EU patients if doing so would endanger their territorial care obligations – has been identified by this research. The provision is designed to address inflow pressures that may disproportionately affect a small number of high-demand institutions offering specific treatments or possessing superior infrastructure, and in such situations, can serve as a noteworthy example for other Member States. This refusal must be justified in writing and is grounded in the principle of subsidiarity, as it targets the specific institutions affected rather than applying national-level restrictions.

A balanced and effective regulatory approach to managing cross-border patient mobility – particularly in Member States where the social security regulations are significantly more beneficial – should aim to replace rigid prior authorisation systems with proportionate and flexible safeguards. Good practices exist, can be combined, and can effectively support a balanced approach that preserves access to cross-border healthcare, minimises administrative burden, and remains responsive to future changes in patient mobility.

Thesis 5 – EU primary and secondary law on professional mobility – anchored in the principles of free movement and mutual recognition principles – provides Member States with two complementary but limited avenues to justify restrictions: one under Directive 2005/36/EC, and the other under the broader equal treatment and free movement framework. In both cases, restrictions must meet strict tests of non-discrimination, objective justification, and proportionality, as established by ECJ jurisprudence.

The legal framework governing professional mobility within the EU is firmly established through Treaty provisions, secondary legislation – particularly Directive 2005/36/EC – and consistent case law of the Court of Justice, which together delineate two complementary layers of the permissible scope of national regulatory action aimed at managing mobility flows. These instruments are grounded in the core principles of free movement, equal treatment, and mutual recognition of professional qualifications, forming the legislative foundation of health professional mobility in the Union.

Directive 2005/36/EC provides a detailed procedural framework for the recognition of qualifications, consolidating earlier sectoral and general system directives and facilitating both establishment and the temporary provision of services. It includes provisions for the automatic recognition of five health professions based on harmonised minimum training requirements, with qualifications listed in Annex V. Host Member States are obliged to recognise these qualifications without further assessment. For professions outside Annex V, the Directive applies a general system requiring case-by-case comparison and, where substantial differences exist in the training content, allows for compensatory measures such as adaptation periods or aptitude tests. Host Member States are required to take full account of prior professional experience.

Measures by sending countries to restrict the effects of automatic recognition are legally possible but politically sensitive. These include not aligning certain training programmes with the Directive's minimum requirements or excluding qualifications from Annex V, thereby avoiding automatic recognition obligations. However, such measures are open to challenge and may undermine mobility rights under EU law.

Beyond the Directive, national measures affecting mobility must comply with the broader EU law framework on equal treatment and free movement, as established under Articles 18, 45, 49, and 56 TFEU, and further elaborated in the case law. Landmark rulings such as *Bosman*, *Bernard*, and *Bressol* confirmed that even formally neutral national rules can constitute unlawful restrictions if they deter mobility or disproportionately affect non-nationals. Based on the case law, any restriction must be objectively justified by an overriding reason of general

interest and must satisfy the *Gebhard* test: it must be applied in a non-discriminatory manner, be suitable for achieving the objective, necessary, and proportionate.

Given the existence of a well-defined EU legal framework allowing limited but meaningful national regulatory action, Member States should make more active use of underexplored legal tools as part of broader retention strategies. Legally restrictive measures should be embedded within an incentive-based strategic framework that combines financial, professional, organisational, and legal tools. Such a comprehensive approach is likely to be more effective in managing professional mobility than reliance on legal restrictions alone.

Thesis 6 – Health professional mobility in the EU is shaped less by recent legal changes than by broader political and economic developments and persistent structural imbalances. Sustained east–west flows have intensified shortages in source countries such as Hungary, highlighting the limits of national retention efforts and the need for coordinated EU-level responses to ensure equitable workforce distribution and long-term sustainability.

Health professional mobility continues to be a major structural factor influencing the capacity, performance and equity of national health systems across the European Union. While it facilitates labour market flexibility and supports individual career development, it also contributes to persistent workforce shortages and distributional imbalances – particularly through sustained east–west flows. These trends are most evident among medical doctors, where net annual losses exceed 1% in several Central and Eastern European (CEE) Member States, including Hungary. Such losses constrain the resilience of health systems despite significant national investments in expanding medical education and training capacities. The inability to retain graduates – including international students who frequently do not remain in the country after qualification – further undermines these efforts.

The European Professional Card (EPC), introduced to streamline the recognition of professional qualifications, has had limited impact on health professional mobility. Although designed to digitalise and simplify procedures, its use has remained low among health professions already subject to automatic recognition, such as pharmacists or general care nurses. In these professions, existing procedures are widely regarded as effective, limiting the practical value of the EPC. The EPC has demonstrated somewhat greater relevance in professions governed by the general system – such as physiotherapy – where recognition procedures tend to be more burdensome. Nevertheless, even in these cases, uptake remains modest and often limited to specific cohorts, such as foreign-trained professionals returning to their home countries.

Any proposed extension of the EPC to other health professions should therefore be approached with caution. In fields already covered by automatic recognition, such as doctors, it is unlikely to offer meaningful improvements. In contrast, for health professions subject to more complex recognition procedures, the EPC could provide modest facilitation – although the diversity of qualifications among these allied health professions would pose challenges to such extension. Further procedural simplification must be weighed carefully against the risk of exacerbating workforce shortages in Member States already facing structural deficits.

Broader political and economic developments can also swiftly reshape mobility patterns. Brexit, for instance, has had divergent effects – leading to increased inflows of doctors from CEE countries, including Hungary, to the United Kingdom, while simultaneously causing a marked decline in nurse emigration to the UK from across the EU. This divergence illustrates how legal, regulatory and perceptual changes in destination countries can affect professional groups differently.

These developments underscore the urgent need for a rebalanced approach to health professional mobility within the EU. While mobility supports individual opportunities and European integration, its uneven impact – particularly the sustained outflows from countries such as Hungary – threatens the long-term sustainability and equity of healthcare provision across Member States. Without coordinated and deliberate action to address these disparities, the principle of equal access to healthcare for all EU citizens risks being undermined.

Thesis 7 – Legally viable tools for managing professional mobility at the national level include conditional scholarship schemes and structured bilateral cooperation agreements, which – when designed in line with EU law – can support workforce retention and mitigate emigration without infringing free movement rights.

Legal instruments remain underdeveloped and underutilised within health workforce retention policies across the European Union, largely due to concerns regarding their compatibility with the right to free movement. While these legal constraints are real, they are not absolute. European Union law permits proportionate, non-discriminatory measures that serve legitimate public interest objectives. As such, legal tools can and should be considered as components of broader retention strategies, where designed in a manner consistent with fundamental rights.

One such example is the use of return-of-service obligations linked to publicly funded education. Hungary's student contract and resident scholarship programmes demonstrate that such measures can be legally feasible under EU law when participation is voluntary, conditions are proportionate, and repayment alternatives are provided. Though isolating their individual impact is difficult, available data suggest that, when embedded in comprehensive incentive frameworks – including salary increases and professional development opportunities – they contribute to improving retention outcomes, particularly among young doctors.

However, the universal application of such obligations, as seen in Hungary's current model, imposes a significant administrative burden and may dilute policy effectiveness. Therefore, Hungary should consider reforming its student contract scheme and introduce a more targeted approach – limited to strategically important fields such as medicine, where graduate emigration poses demonstrable risks to health system sustainability. This approach would reduce bureaucracy and would further strengthen alignment with EU law principles such as proportionality and objective justification.

Institutional-level bilateral cooperation has also shown potential as a legal retention instrument compatible with free movement rights. The Semmelweis–Karolinska model illustrates how ethically designed, short-term placements – underpinned by clear return conditions and mutual benefit – can support workforce sustainability without encouraging permanent emigration. Participants benefit from professional experience abroad and enhanced income, while retaining

ties to the home system. The programme's design, including non-recruitment clauses and financial support, has contributed to stabilising a critical medical specialty in Hungary with minimal long-term outflow.

In the intra-EU context, such institutional cooperation appears to be the most feasible and effective approach, although national or regional level bilateral agreements with special focus could also be explored. To support its wider uptake, Member States, including Hungary, should therefore support the replication of such models through national coordination mechanisms – including the development of legal templates, model agreements, financial incentives and administrative guidance. Targeted support could facilitate structured, ethically sound mobility, aligned with national workforce planning and EU free movement law.

Thesis 8 – The WHO Global Code of Practice and the European Health Union together constitute a complementary framework that, if underpinned by sustained political commitment, can help reconcile the EU's principle of free movement with the imperative of sustainable national healthcare workforces – by promoting retention-oriented policies, enabling ethical and circular mobility, fostering data-driven coordination, and exploring solidarity-based compensation approaches within existing legal boundaries.

The challenge of ensuring a sustainable health workforce is increasingly present at both national and EU levels. Supporting national retention efforts is essential to address persistent health workforce imbalances across the EU. While Member States retain primary responsibility for healthcare workforce planning, national measures alone are often insufficient – particularly in countries experiencing sustained outflows of trained professionals.

This research has examined two frameworks that help inform the emerging policy response to these challenges. The WHO Global Code of Practice on the International Recruitment of Health Personnel offers a valuable ethical and policy foundation that supports sustainable workforce governance beyond the regulation of recruitment. Within the EU, its relevance lies in addressing broader systemic issues – including retention, fair treatment, and data sharing – and in guiding equitable responses to cross-border workforce pressures. Meanwhile, the European Health Union (EHU) reflects a growing political ambition to strengthen EU-level coordination on health policy. Although its current engagement with health workforce issues remains limited, recent debates have increasingly called for a more strategic role for the EHU in reconciling free movement with workforce sustainability and in supporting Member States facing persistent shortages and imbalances.

Examining the applicability of the WHO Global Code's principles within the EU shows that a more proactive EU approach – focused on enabling retention, supporting ethical circular mobility, improving workforce data, and exploring solidarity mechanisms – could significantly strengthen healthcare systems across the Union and help ensure equitable access to care for all EU citizens.

Member State retention policies could be supported by the European Commission in multiple ways also within the framework of the EHU. The Commission could play a more active role in facilitating cooperation and promoting the exchange of best practices. It could also explore how to make better use of cohesion policy instruments to mitigate intra-EU disparities. EU-level co-

financing of scholarship-based return-of-service schemes or other targeted national retention initiatives could also be considered, provided they comply with EU law.

Institutional-level schemes represent one of the most feasible, ethically sound, and mutually beneficial forms of intra-EU circular mobility. EU funding programmes such as EU4Health and Interreg should prioritise such initiatives, supporting return incentives, dual-placement models, and institutional partnerships with clear reintegration pathways.

A coordinated EU-level health workforce monitoring mechanism is currently lacking. While various data sources exist – including international collections such as the Joint Questionnaire and the EU database on diploma recognition – they remain fragmented and underutilised. A robust, integrated monitoring system, building on existing data collections, would support early detection of structural imbalances, inform targeted policy responses, and enhance comparability across Member States. The European Labour Authority, with its existing mandate for cross-border labour issues, could be tasked with coordinating this function in collaboration with Eurostat, the European Commission, and national authorities. Mobility-relevant indicators should be further developed to track trends more effectively and support evidence-based planning.

Compensation for workforce losses remains a politically sensitive and legally complex issue. While binding compensation mechanisms are not currently feasible under EU law, solidarity-based alternatives could be explored within existing frameworks at EU level. Even as voluntary mechanisms, they should rely on aggregate-level data, avoid individual tracking, and be guided by principles of proportionality, administrative simplicity, and fairness. Nonetheless, the feasibility of such mechanisms remains limited.

Advancing EU-level action in health workforce governance will require both sustained political commitment and effective coordination. As health workforce sustainability cannot be ensured through national measures alone, it should be recognised as a key strategic priority at the EU level and addressed through coherent, coordinated solutions. The framework of the European Health Union provides a suitable platform to support such efforts.

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