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PROCEEDINGS REPORT

Strengthening Cross-Border Emergency Medical Services Seminar: Strategic Cooperation for a Resilient Europe

Policy proposition: Emergency Medical Capability should be able to cross a European border with the same predictability, speed and administrative clarity as a mobile telephone signal.

2 October 2026
Order of Malta Conference Centre
Clyde Road, Dublin 4

Hosted by Order of Malta Ireland

Executive summary

Europe has created seamless arrangements for communications, travel and commerce, yet emergency medical teams can still encounter material legal and administrative barriers when crossing a national border.

In a major incident, the difference between physical proximity and legal permission can determine whether trained personnel and equipment are used when they are most needed.

This report develops the seminar proposition of “No Roaming” for civil protection.

The concept does not seek to remove national sovereignty, replace domestic licensing systems or establish a single European ambulance service. It proposes a pre-agreed framework through which verified emergency medical capabilities can be recognised, requested, deployed and integrated rapidly during defined emergencies.

The central recommendation is the development of a European EMS Capability Framework supported by four forms of interoperability: clinical, command, communications and human.

It should be tested progressively at planned mass gatherings, predictable regional emergencies and major cross-border crises.

Current position	Proposed direction
Qualifications assessed after a crisis begins	Pre-verified capability and qualification mapping
Multiple ad hoc permissions	A defined emergency recognition pathway
Uncertain command relationships	Pre-agreed integration into host command
Incompatible communications and data practices	Minimum operational and information standards
Trust built during deployment	Trust built through routine joint exercises

Principal conclusion

Europe does not lack emergency medical expertise.

It lacks a sufficiently predictable mechanism for moving verified expertise across borders at operational speed.

The policy task is therefore to make assistance legally usable, not merely physically available.

With thanks to all conference participants and attendees who gave so generously of their time.

1. The Border Paradox

A traveller can cross much of Europe while a mobile telephone transfers automatically between networks.

That outcome was not inevitable: it followed deliberate political, regulatory and commercial decisions to remove friction. Emergency medical assistance has not yet achieved an equivalent level of administrative interoperability.

An ambulance, clinical team or field medical unit may be geographically close to a disaster but still face uncertainty concerning professional recognition, authority to practise, insurance, medicines, medical devices, data transfer, customs, command arrangements and legal liability.

These controls serve legitimate purposes in normal circumstances. The failure lies in allowing them to be negotiated for the first time during an emergency.

> *A text message should not have greater practical freedom to cross a European border than a trauma surgeon responding to a major emergency.*

The "No Roaming" analogy therefore identifies a governance problem. Borders remain, but the necessary interfaces are agreed in advance. National authorities retain control over activation and command, while recognised external capability can be admitted and used without avoidable delay.

2. What "No Roaming" should mean

A No Roaming framework would eliminate avoidable regulatory friction while preserving national competence, clinical governance and accountability. It would apply only where specified activation criteria are met and where the host authority requests or accepts assistance.

- Pre-identification of participating organisations, assets and clinical grades.
- A common description of capability, readiness, equipment and limitations.
- A rapid route for temporary professional recognition during declared emergencies.
- Clear host-state command, reporting, clinical governance and accountability arrangements.
- Minimum standards for communications, patient information, medicines, insurance and logistics.
- Post-deployment review, incident reporting and continuous improvement.

The approach is best understood as mutual operational assurance. It is not blanket licence portability, automatic self-deployment or freedom from local law.

3. The Diploma Dilemma: The right to practise

Seminar discussion identified professional recognition, often described through the concept of jus practicandi, as a principal obstacle to transborder clinical deployment.

A qualification that is valid in one jurisdiction may not provide immediate authority to treat patients in another, even where the practitioner is experienced and the receiving community faces acute need.

The practical answer is not to wait for complete harmonisation of every national profession and grade.

A more achievable first step is a **European EMS Capability Register** supported by a **Qualification Mapping Matrix**. This would allow competent authorities to understand what a team can safely deliver and under whose clinical governance it would operate.

Register field	Purpose	Assurance
Personnel and clinical grade	Maps national titles to defined competencies	Verified by the competent sending authority
Deployable clinical capability	States the treatments and procedures the team can provide	Standard capability descriptor
Equipment and medicines	Records deployable assets and controlled items	Pre-cleared inventory and custody rules
Clinical governance	Identifies the responsible medical authority	Named accountability and escalation route
Readiness and logistics	Confirms mobilisation time and sustainment period	Regular validation and exercise

4. Four Pillars of Interoperability

1. Clinical interoperability

A common understanding of qualifications, clinical grades, scope of practice, medicines and clinical governance. The objective is safe temporary recognition, not dilution of standards.

2. Command interoperability

A pre-agreed operating model defining who requests assistance, who exercises command, how voluntary organisations integrate with statutory services, and how decisions are recorded and escalated.

3. Communications interoperability

Compatible radio, digital and incident-management arrangements, supported by common terminology and resilient fallback systems. All deployed units require the same operational picture and instructions.

4. Human interoperability

Established relationships, mutual confidence and familiarity with different organisational cultures. Trust cannot be improvised during a disaster; it is built through joint planning, training and exercises.

5. From Concept to Predictable Capability

Government and statutory responders must be able to distinguish a dependable deployable capability from an unknown offer of assistance.

The framework should convert goodwill into predictable capability: verified, visible, requestable and capable of integration into the host system.

Tier 1 — planned mass gatherings: Validate credentials, command structures, communications and patient pathways in controlled settings such as major sporting, religious or civic events.

Tier 2 — foreseeable regional shocks: Apply the framework to flooding, extreme weather, wildfire, transport disruption and other emergencies where neighbouring capacity may be mobilised rapidly.

Tier 3 — catastrophic emergencies and conflict: Use validated modules in large-scale disasters and, where conditions allow, complex humanitarian emergencies requiring sustained support

6. Lessons from Complex Humanitarian Settings

The seminar considered experience from conflict-affected and disaster settings. These examples demonstrate that access is shaped by law, security, logistics, local acceptance and the availability of essential infrastructure.

They also show why cross-border response cannot be reduced to the movement of foreign clinical teams.

The scale of that operating environment is substantial. Malteser International reports that more than eight million people in 33 countries relied on its support in 2025. Its reported outputs included health support for 529,417 people and psychosocial support for 476,440 people. These figures demonstrate why interoperability must be designed as a repeatable system rather than an exceptional arrangement.

1. Local Capability First

In high-risk settings, the safest and most sustainable response may be to support qualified local personnel. Local clinicians understand language, referral routes, community dynamics and the operating environment. International partners can add value through finance, supplies, specialist advice, remote clinical exchange, training and institutional protection.

2. Neutrality as operational access

The Order of Malta's humanitarian mission is grounded in assistance without distinction. In fragmented conflicts, a recognised neutral and impartial posture can support access and cooperation across communities. Neutrality is not passive: it requires disciplined conduct, consistent decision-making and credible safeguards.

3. The Material Bottleneck

Medical delivery can be delayed by restrictions on goods classified as capable of dual use, customs requirements, transport permissions and security screening. Seminar contributors described protracted clearance processes affecting medical and construction supplies. The policy implication is clear: emergency arrangements must cover equipment, medicines, energy and logistics as well as personnel.

Malteser International emergency relief response following a major earthquake.

7. Data as a Clinical Lifeline

Cross-border clinical response also depends on lawful, secure and timely information exchange. Data protection is essential, but uncertainty about its application should not become a preventable operational barrier.

Participating authorities require agreed data sets, lawful bases, access controls, retention rules, cyber safeguards and procedures for periods when normal connectivity fails.

The seminar highlighted remote clinician-to-clinician exchange developed during the COVID-19 pandemic as a practical model. Such networks can transmit treatment protocols, specialist advice and situational knowledge without requiring every expert to travel.

A No Roaming framework should therefore address the movement of knowledge as deliberately as the movement of people and equipment.

8. Human Recovery: Restoring Normality

Emergency response must extend beyond acute physical treatment. Conflict and displacement produce prolonged anxiety, isolation, interrupted education and loss of community identity. Seminar evidence from Ukraine emphasised the importance of community centres and mental health and psychosocial support as part of an integrated health response.

The operational lesson is that civil protection capability should include psychosocial support, referral, community engagement and continuity of care. Restoring routine and safe social contact is not peripheral to recovery; it is part of recovery.

The 2025 Malteser International report records that 20,958 people in Ukraine attended individual or group mental health and psychosocial support sessions, while 103,869 internally displaced people received health measures. It also reports support for 12,172 children and adolescents through four mobile play units. These are practical examples of health, protection and community resilience operating as an integrated response.

Emergency care systems

The same report describes a long-term partnership with Uganda's Ministry of Health to strengthen emergency care systems through national policies, standards, training and equipment. In 2025, the programme supported 50 health facilities with training and equipment and upgraded eight ambulances to EMS standard. This reinforces a central seminar conclusion: resilient emergency response depends on systems, recognised standards and local capability, not equipment alone.

9. Policy recommendations

1. Establish an EU-level working group on emergency medical mobility, involving Member States, civil protection authorities, competent health regulators and recognised voluntary and humanitarian providers.
2. Develop a European EMS Capability Register and Qualification Mapping Matrix, beginning with a limited number of clearly defined clinical and support roles.
3. Create a model emergency recognition protocol covering scope of practice, liability, insurance, medicines, medical devices and clinical governance.
4. Agree a standard host-state activation and command template so that external teams never self-deploy and remain accountable within the national response structure.
5. Define minimum communications and patient-information standards, including secure fallback arrangements and a proportionate data-sharing protocol.
6. Pre-clear common equipment and supply categories, with expedited customs and security processes for verified emergency consignments.
7. Test the framework through recurring cross-border exercises and selected planned mass gatherings during 2027–2028.

10. Proposed implementation roadmap

Phase	Priority actions	Indicative output
0–6 months	Policy mandate; stakeholder group; map legal barriers and existing bilateral arrangements	Agreed scope and baseline assessment
6–12 months	Draft capability taxonomy, qualification matrix and activation protocol	Pilot framework and participating cohort
12–24 months	Exercises at planned events and regional emergency scenarios	Validated procedures and lessons report
24–36 months	Expand membership; formalise mutual assistance arrangements; establish annual assurance	Operational No Roaming mechanism

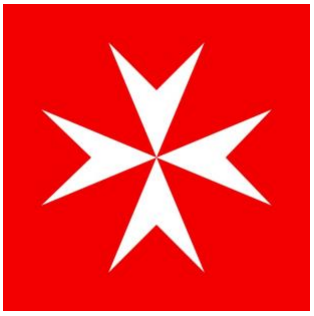
11. Conclusion

The future of emergency response cannot depend on ad hoc heroism or permissions negotiated after a crisis has begun. Europe requires a professional, lawful and predictable means of mobilising verified emergency medical capability across borders.

“No Roaming” provides a clear policy test: when assistance is requested, can the nearest suitable capability cross the border, enter the host command structure and begin safe operations without avoidable delay? If the answer is uncertain, the system is not yet ready.

Borders Define Jurisdiction.

They should not determine whether timely, qualified help reaches a person whose life is at risk.







2025 IN FIGURES

A snapshot of the Order of Malta's humanitarian work around the world.

10,189,606

PEOPLE ASSISTED WORLDWIDE

HEALTH & MEDICAL CARE

Hospitals	11
Hospital beds	2,249
Medical centres	153
Medical visits	3,423,800
Ambulance transports	1,298,000

REACHING THE MOST VULNERABLE

Migrants & refugees	93,439
Pilgrimages	247

THE PEOPLE BEHIND THE MISSION

Staff & employees	60,592
Volunteers	110,937
Trained in first aid	390,000

SOCIAL SUPPORT & EDUCATION

Social centres	301 run + 1,500 supported
Schools	49
Homeless assisted	1,049,000
Meals distributed	10,450,000

#WorldHumanitarianDay

DATA REFERS TO 2025