Council for Healthcare Regulatory Excellence, UK

Response to
European Commission consultation regarding 'Community action on health services'

Introduction

The regulation of healthcare professionals in the United Kingdom is conducted by nine regulatory bodies (competent authorities).The **Council for Healthcare Regulatory Excellence** (CHRE) is a UK government sponsored organisation which sits over these nine regulatory bodies with the purpose of ensuring best practice in regulation, facilitating a common approach to regulation across the bodies and for providing advise to the health ministers of the four countries of the UK. CHRE works closely and in partnership with the nine regulatory bodies and strongly supports the work of AURE.

CHRE recognises that the Commission does not have the competence, at present, to produce a formal legal directive for health services. As CHRE has the requirement to provide advice to government ministers we would not be recommending a transfer of power in this area from member states to the Commission. Although Treaty Articles 308 or 129 could be used for the development of a Directive in this field, CHRE, if asked to advise ministers, would not support this approach. Several directives already exist in various areas affecting health matters which could be amended to address some of the proposals in this consultation. Open Method Co-ordination with unqualified agreements would be preferable to CHRE than the transfer of power from member states for the management of their own health systems.

It is against this background that CHRE is providing a response to the Commission's consultation on '*Community action on health services'*. Although CHRE appreciates that the consultation paper largely concerns patient mobility it recognises that this does not exclude further consideration of professional (service provider) mobility in order to provide a safe, high quality and efficient service.

Consultation Questions

Question 2: ***What specific legal clarification and what practical information is required by whom (eg; authorities, purchasers, providers, patients) to enable safe, high quality and efficient cross-border healthcare?***

2.1 In relation to the mobility of healthcare professionals, although much is now covered in **Directive 2005/36 EC** some areas need further legal clarification to ensure safe, high quality and efficient services;

- In the case of temporary registration of a healthcare professional the registrant is not required to comply with the continuing professional development requirements of the host member state nor will they be subject to the same disciplinary processes. This is likely to create a two tier standard within each member state. In some cases the temporary registrants will not be required to achieve the same standard as that of the host state registrant. This may create a risk to patient safety and effect the achievement of high quality care. A way to address this would be to require all registrants to achieve the same standards of professional practice and to have disciplinary rules applied equally whether the registrant is temporary or established

- Although some Member States do not require continuous professional/educational development of their healthcare professionals this would present a positive opportunity to advise Member States of the value of such activity. Since the health and safety of European citizens (patients) is of concern to the Commission it should consider whether it is sustainable not to give such encouragement. Airline pilots, for example, are required to provide evidence of their regular professional development and competence to practice sufficiently to ensure air safety. Patient safety is, at least, of equal importance to that of airline passengers. Therefore, CHRE proposes that in Member States where there is a requirement to provide evidence of competence to practice through continuous professional development all registrants, temporary or permanent, should comply. Member States without this requirement should be encouraged to develop the same standard.

- Under the **Directive 2005/36 EC,** competent authorities are only required to check educational capability for entry onto a professional register. Unfortunately this leaves the matter of competence for registration (ie. capability in clinical practice) open to question. To be able to measure competence to practice, in the same manner that nationals are measured, would not provide a barrier to freedom of movement but would ensure the risk to patient safety from incompetent practitioners is reduced.

Question 3: ***Which issues (eg: clinical oversight, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different kinds of cross-border healthcare?***

3.1 In all types of cross-border care the regulatory competent authorities in the country in which the patient is receiving care should have full responsibilities for ensuring the appropriate clinical competence of the healthcare professional providing the care. Communication between the competent authorities will be paramount to ensure both high quality care and proper patient safety

Question 4: ***Who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?***

4.1 The role of the healthcare professional in ensuring the safety of the patient in their care should be paramount whichever member state is hosting the care. The regulatory competent authorities should be working to achieve common standards of patient safety through ensuring competence in practice and not simply agreeing a basic educational standard.

Question 6: ***Are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of healthcare providers not already addresses by community legislation?***

6.1 In accordance with the Treaty **Directive 2005/36EC** has been developed in order to remove barriers to free movement of professionals across Member States and to further develop the internal market. It has been based on an agreement to recognise the underpinning educational qualifications of the liberal professions across the EU. This has been a reasonably straightforward process for those groups previously under sectoral directives and there has been well aired debate about those under general systems, particularly for those groups that are not consistently regulated across member states.

6.2 However, the **'***Community action on health services'* document highlights the Commission's commitment to *'safe, high quality health services as a priority issue for European citizens'.* Such a commitment is to be both applauded and supported. Therefore, it is suggested that an amendment to **Directive 2005/36 EC** is

considered. This directive does not address matters of clinical competence as a pre-requisite for entry into another member state. Where such a requirement is relevant for nationals of that member state, other applicants to the register should be subject to the same requirements. Without this pre-requisite of competence the equal achievement of safe and high quality care across a single member state would be difficult and across all member states even more so.

6.3 Health care services globally are overstretched in no small part because of staff shortages. In seeking to address this within the EU the Commission should guard against the temptation of encouraging and enabling freedom of movement and unintentionally sacrificing patient safety. Although clinical competence could be considered to be a potential employers responsibility to assess, it may be fairer to the individual seeking to move, the employer seeking to employ and the patient expecting high quality and safe care, for the healthcare professional to be assessed for clinical as well as educational competence as a standard for entry into another member state whether temporary or established.

6.4 Each member state manages their services differently and lack of assessment to work within that service puts patients at risk. This is not to suggest that one member state provides a service 'better or worse' than another simply that ethical and clinical practice differs across the different cultural environments of the member states and if misunderstood, places patients at unnecessary risk.

6.5 The five pillars of Better Regulation include consistency and transparency. The application of directive 2005/36 EC without with competence assessment is inconsistent and obtuse in its reasoning when applied to patient safety.

Question 7: *Are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? In particular, what improvements do stakeholders directly involved in receiving patients for other member states suggest in order to facilitate cross-border healthcare?*

7.1 CHRE would wish to see the **Edinburgh Agreement** given legal status as a duty on competent authorities to share relevant information about professionals crossing borders. As failure to share this information potentially places patients at risk those who fail to share information, or to do so within the agreed timescale should be subject to action from the European Commission

Question 8: ***In what ways should European action help support the health systems of the member states and the different actors within the teams? Are there areas not identified above?***

8.1 Regulation of healthcare professionals is delivered in a different ways across the member states. In order to provide a more commonly understood system, cross-EU benchmarking of regulatory standards could prove to be a valuable tool for all, especially for those countries who are changing or developing their systems of regulation of healthcare professionals.

Question 9: What tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

9.1 The Information Management Initiative (IMI) project is a good example of a non-legislative process which will encourage member states to share information regarding healthcare professionals. Although there is an advantage in its being non-legislative there are concerns, however about non-compliance and what action can be taken in order to insist on compliance.