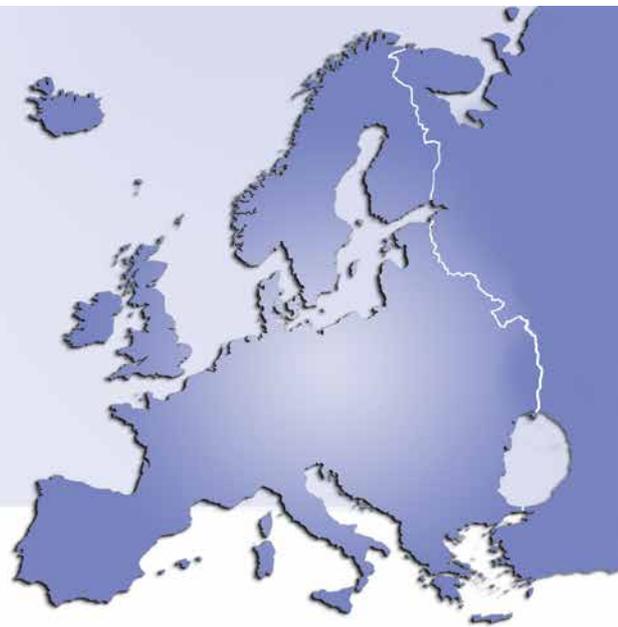


Crossing Borders Update



Welcome to the spring edition of the Healthcare Professionals Crossing Borders Update. In this edition we look at the results from our fitness to practise sanctions mapping exercise, the EC celebrate the first anniversary of the alert mechanism and European professional card, and we look at the proposed Proportionality Directive. We also look at the study on Big Data in public health, telemedicine and healthcare and the new patient sharing data initiative between Estonia and Finland. In addition, the European Patients' Forum discuss their proposed universal health coverage, CORU launches its five year strategy and the Nursing and Midwifery Council share their education programme for change.

Results of sanctions mapping survey

At the HPCB conference in October last year we launched the sanctions mapping survey that aimed to map the sanctions currently applied across Europe and to assess how these are reflected in the new alert mechanism. We thank all competent authorities from across Europe who submitted their responses. A full analysis of our results will be published on our website over the next few months.

For now, we have taken a general overview of the results and they have helped to shape our recommendations for the European Commission (EC) on the alert mechanism and European professional card (EPC). The recommendations can be found on page three of this update and have been shared with the EC.

Overview of results

We had a very positive response rate to the survey with respondents representing over 45 health care professions across Europe. Of the respondents, 88% were responsible for taking action when a complaint is made, and 80% were registered to use the IMI system and able to send alerts.

Fitness to practise sanctions across Europe

Figure 1 highlights respondent's ability to take action when receiving a complaint from another member state. A majority of respondents are able to intervene when falsified documents are found, however only 58% of respondents (figure 2) are able to take action on conduct outside of the professional's work.

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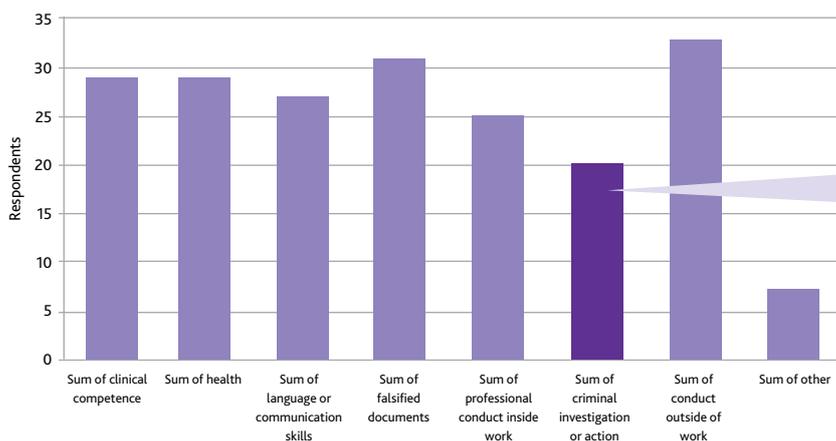
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Figure 1 - Do you take action if you receive a complaint about a registered healthcare professional?



While a high number of respondents are able to issue warnings, admonition, reprimand or equivalent (Figure 3), these wouldn't result in an alert as they are not restrictions on a professional's practice.

Use of IMI alert mechanism

The legal basis to enact sanctions varies considerably across member states and health professions – with 31% of member states able to send an alert after the ruling, but before the appeal compared to 59% of member states that only send an alert after the appeal period has expired.

Responses that fit into the *other* category include being confirmed by the High Court; legislation still being drafted; and a decision that is executable before the appeal period – but is considered of high risk.

The length of the appeal period which the professional can appeal the decision varies significantly across member states (the range includes 15 days to six weeks).

Certificate of good standing/current professional status

Of the respondents, 89% were responsible for issuing certificates for good standing/current professional status. The survey found there was little conformity in certificates of good standing, with:

- 61% issue a certificate of good standing when disciplinary action under an investigation is pending
- 66% issue a certificate of good standing when a restriction is on registration/practice
- 38% issue when the professional is in good standing.

Figure 5 opposite highlights if a restriction cannot be issued, whether the host member state can inform the requestor of the following circumstances

Figure 2 - Respondents that can take action on conduct outside of work

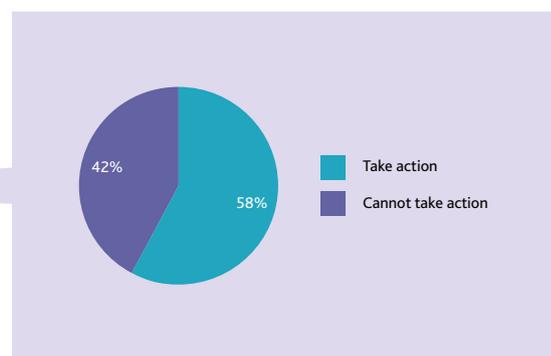


Figure 3 - What types of disciplinary sanctions are you able to issue?

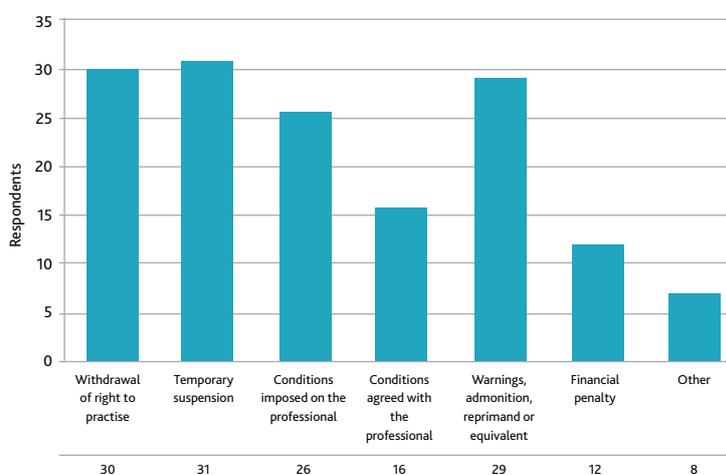
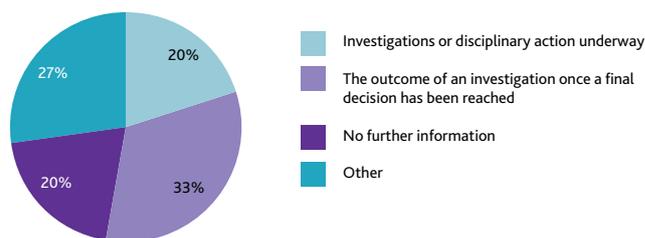


Figure 4 - If the certificate cannot be issued, do you inform the requestor of the following circumstances?



Key message

- Each member state issues alerts based on national norms and legislation – this issue has been highlighted in the recommendations to the EC as it results in a fragmented and often confusing system.

EU institutional developments: Proportionality Directive, alert mechanism and EPC, UK EU exit, working time Directive, off-label prescribing study, Big Data

HPCB issues recommendations on EPC and alert mechanism

Participants at the recent HPCB conference 'Promoting patient safety across borders' have agreed a series of recommendations to improve the functioning of the European professional card (EPC) and alert mechanism. The two new tools were introduced in January 2016 as part of the revised Directive on the recognition of professional qualifications.

After a year of operation, competent authorities have welcomed the alert mechanism and highlighted its importance in protecting patient safety. However, as with the introduction of any new system, users have identified a number of practical changes that could be made to improve the functionality of the system. One of the principle

suggestions is to introduce the ability to edit an alert once it is broadcast. It is suggested that this could reduce the number of alerts sent and reduce the burden on competent authorities.

In terms of the European professional card, authorities are concerned about the administrative burden on home member states and suggest a re-balancing of the responsibilities between home and host authorities.

The recommendations have been shared with the European Commission and are highlighted below. We hope that the recommendations will be considered alongside the results of the EPC and alert mechanism survey results.

Alert mechanism recommendations

- 1 Functionality to update an alert once broadcast**
 - Improve the functionality of the alert mechanism by introducing the ability to make updates to existing alerts. This will reduce the overall number of alerts being sent and help to address some of the concerns regarding resource burden associated with the high numbers of alerts received.
- 2 Functionality for requesting and providing additional information via IMI**
 - Develop guidance and standards to advise authorities in what circumstances authorities can ask for further information
 - Publish best practise guidance for responding to requests for further information about an alert
 - Review the set of questions in IMI and draft guidance to support the requesting of further information
 - Introduce a free text box for prohibitions.
- 3 Inconsistent use of the IMI system**
 - Convene a small group of competent authorities to draw up guidance for all competent authorities on the use of the alert mechanism
 - Consider amending the alert interface to make clear upfront whether the alert is being sent for a non-substantive reason including drop down options (i.e. non-payment of fees) so that a receiving country can quickly establish how to process each alert.
- 4 Linking IMI up with national systems**
 - Prioritise IT interoperability between national systems and IMI to ease the burden on competent authorities.
- 5 Pre-dating the alert mechanism**
 - Consider whether it would be operationally feasible to add sanctions issued prior to January 2016 to the IMI system.

European professional card (EPC) recommendations

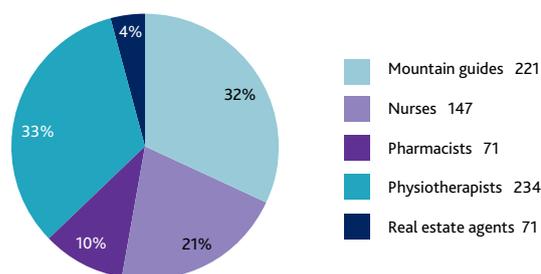
- 1 Administrative burden on home member state**
 - Revisit the responsibilities of the home and host member state to ensure that host countries are not overburdened by the need to verify large numbers of documents, and that host member states are able to assure themselves of the validity and content of documents.
- 2 Duplication of existing methods of recognition**
 - Improve the clarity of the EPC website to highlight that the EPC does not grant access to the profession and that the usual national registration rules must still be met.
- 3 High numbers of failure rates**
 - Improve the information available for applicants on the EPC interface
 - Consider whether it is appropriate for applicants to select their route to recognition when these are governed by strict legal rules and may not be easily understood.
- 4 Temporary & occasional registration applications**
 - Amend the EPC process so that in cases of temporary & occasional applications without prior check of qualifications (i.e. for sectoral professions), the host member state is able to view the full details of application as soon as it is made so as to enable it to assess whether the automatic route is appropriate and the application is genuinely temporary & occasional to allow it to revoke the EPC if necessary and in a timely manner.

One year with the European professional card and the alert mechanism

András Zsigmond, DG Internal Market, Industry, Entrepreneurship and SMEs, European Commission

The introduction of the European professional card (EPC), on 18th January 2016, was an important milestone in facilitating the recognition of professional qualifications for European citizens. The EPC, which is an electronic procedure rather than a 'physical' card, was made available from this date for general care nurses, physiotherapists, pharmacists, real estate agents and mountain guides. Over the first year of its use the interest of professionals exceeded expectations with more than 2,100 EPC applications being submitted. Amongst these, health professionals were the most active: 789 applications from physiotherapists, 589 from general care nurses and 238 from pharmacists.

It is important to recognise, and thank the national competent authorities who picked up very quickly this new procedure: within the first year more than 700 EPCs have been issued, and thus they have been instrumental in helping professionals follow their careers, temporarily or permanently, in another member state. The exact distribution of the issued EPCs is shown in the following chart.



While there was a general agreement that improving professional mobility is something positive, our stakeholders, you, also expressed legitimate concerns on the possible dangers of this mobility. These related especially to professionals who are subjected to

disciplinary sanctions in their home country and are trying to circumvent these by moving to a different country in the hope that their sanctions are not discovered, or those who may try to move around Europe with falsified qualifications. These are very serious concerns.

Accordingly, in parallel with the introduction of the EPC, from 18th January 2016 a proactive alert mechanism was introduced concerning health professionals; professionals working on the education of minors and; professionals attempting to gain recognition on the basis of false documentation. Since its introduction 11,212 alerts have been sent by European competent authorities. Amongst these alerts 6,212 concerned general care nurses and 2,509 doctors.

In order to continue to respond to stakeholders' requests and to ensure the most effective implementation of our shared objectives towards citizens and professionals, the European Commission will assess the experience of the past year in these initiatives. To aid the experience, the EC has been launched a survey which is open to professional organisations representing any of the five EPC professions as well as public authorities involved in the national implementation of the two initiatives. The survey is available at the [EC website](#) and will close on 3 May 2017. We thank you for any time you may give to sharing your views and experiences in this survey.

Workshop on EPC and the alert mechanism

On 16 May the EC will be holding a workshop to reflect on the results of the survey. The workshop will also look at the difficulties and advantages of the procedures. For more information please [follow this link](#).

EC publishes study into use of Big Data in health

The EC has published the results of a study into the [use of Big Data in public health](#), telemedicine and healthcare. The study looked at examples of Big Data use in healthcare and developed recommendations for its use across the EU and offers a number of solutions in key policy areas, including:

- Supporting the sustainability of health systems
- Improving the quality and effectiveness of treatment
- Combating chronic disease
- Supporting healthy lifestyles

One of the more well-known examples analysed by the researchers was the E-Estonia national identity scheme, which includes a digital patient record. The scheme allows the nation's various e-services databases, both in the public and private sector, to link up and operate in harmony.

Big Data refers to large routinely or automatically collected datasets, which are electronically captured and stored, and which can be especially useful when comparing health systems and improving performance.



JOINT PRESS RELEASE

PROPORTIONALITY TESTS FOR PROFESSIONAL REGULATION IGNORE PUBLIC INTEREST AND THREATEN QUALITY AND SAFETY OF PATIENT CARE



COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

European dentists, doctors and pharmacists conclude: proposed proportionality tests for professional regulation ignore public interest and threaten quality and safety of patient care.

The Council of European Dentists (CED), the Standing Committee of European Doctors (CPME) and the Pharmaceutical Group of the European Union (PGEU) have met the publication of the proposal for a Directive on a proportionality test for the adoption of a new or for amendments to the existing professional regulation with great concern.

The three health professions re-emphasise that purpose of the regulation of their professions is to assure the quality of healthcare services in public interest. Therefore, it has to remain clear and comprehensive and ensure safe and effective care. The regulation¹ of the health professions along with all the rules applying to their activities must remain in the full competence of Member States² and be based on local needs and national strategies. Such national strategies take into account demographical, geographical and cultural realities and reflect national preferences, such as the delegation of the regulatory task to the profession itself.

The three organisations are concerned by the lack of specificity in addressing the overall issue of health professional regulation. The CED, CPME and PGEU are convinced that health professions should be considered distinctly from other professions. Therefore, the three organisations call upon the EU institutions to exclude said professions from the scope of the harmonised EU proportionality test.

"We believe that the regulation of doctors' practice is essential for the safety of patients more than anything else. As health professions we are very supportive of the regulatory measures the new Professional Qualifications Directive introduced to improve patient safety, mainly the alert mechanism and controls on language knowledge. We therefore regret that the Commission's own efforts to make professional practice safer are now being threatened by the draft Directive. Case in point: does any small change to the national laws in place implementing the alert mechanism have to pass the proportionality test too?" asks **Dr Jacques de Haller, President of the Standing Committee of European Doctors.**

"It is a fundamental principle of EU and national law that public health must be protected by all possible means. That is why we highly question the intention of the draft Directive which reverses this fundamental principle: instead of protecting public health by regulation, the draft Directive challenges us to justify when regulation wants to protect public health. We are confident that the dentists and other health professions can pass this test, but at what price? The increase of bureaucracy and related costs will be immense," argued **Dr Marco Landi, President of the Council of European Dentists.**

"The draft Directive gives priority for implementation of the Internal Market for services and professionals at any costs. It appears to identify any professional regulation at national level as a potential 'barrier'. A sub-standard service provided by a pharmacist or a doctor or any other health professional will put patients at risk and in some cases, may lead to fatalities." added **Rajesh Patel MBE, President of the Pharmaceutical Group of the European Union.** "The new law will only increase costs and bureaucracy with no added value and may result in lower quality of healthcare services in the EU."

¹ The regulation of a healthcare profession involves the setting of standards of professional qualifications and practice, the professional ethics and supervision, the continuing professional development requirements, the rules relating to the organisation of the profession, quantitative and territorial restrictions etc.

² Article 168 of TFEU requires EU to respect the responsibilities of each Member State to define their own health policy and to organise, deliver and manage health services; as well as to allocate resources to their health systems.

EC publishes draft Proportionality Directive

In January the European Commission published its services package which aims to make it easier for companies and professionals to provide services across the EU. The package of measures includes a proposal for a Directive on a proportionality assessment of the rules of competent authorities. The EC has stated that regulation is often warranted for a number of professions, for example those linked with health and safety, but that there are many cases where unnecessarily burdensome rules can make it difficult for qualified candidates to access jobs. The EC has confirmed that it does not regulate or deregulate professions - this remains a national prerogative of member states. But unlike EU law, a member state needs to establish whether new national professional requirements are necessary and balanced.

The draft Directive would compel competent authorities to undertake a proportionality test before adopting or amending any legislation. There is no exemption for regulators in the field of health or patient safety. Member states would then have to assess the proportionality of the proposed measure and inform relevant stakeholders before the new legislation could be adopted.

The draft Directive will now be discussed with MEPs and member states.

European dentists, doctors and pharmacists on proposed proportionality tests

In our [December edition](#), CED, PGEU and CPME reaffirmed the importance of professional regulation in light of plans for proportionality testing. Following the publication of the EC proposal for a proportionality test, European dentists, doctors and pharmacists have reacted in a joint press release, stressing that the purpose of regulation of health professions is to ensure safe and effective care to patients, and calling on the EU to exclude health professions from harmonised EU proportionality tests.

The joint statement press statement can be read aside or [viewed online here.](#)

GMC and BMA release reports on EEA doctors

A [recent survey](#) conducted by the UK General Medical Council found that a majority of European doctors working in the UK are considering leaving because of the EU exit. Just over 2,100 doctors from the EEA (about 10% of the total who are currently working in the UK) responded to the survey and 60% said they were considering leaving the UK at some point in the future. Of those doctors 91% said the UK's decision to leave the EU was a factor in their considerations.

Chief Executive of the GMC, Charlie Massey told the UK parliament health select committee that while a survey was not "necessarily predictive of future behaviour" the results indicated a potential depletion in the UK workforce.

The UK GMC survey follows another study by the [British Medical Association \(BMA\)](#) poll that found 42% of respondents were considering leaving the UK because of the EU exit vote. Among NHS staff in England, over 59,000 are from the European Union, according to [NHS Digital](#), including 10,267 doctors – around 6.6% of the UK medical workforce.



UK triggers article 50 to begin EU exit negotiations

The UK government has triggered article 50 of the EU Treaty which confirms its intention to leave the EU and allows the commencement of exit negotiations. The exit negotiations are expected to take two years. The UK remains a full EU member state during this time.

The letter from Prime Minister Theresa May to President Donald Tusk notifying him of the UK's intention to leave the EU can [be found here](#).

Joint letter for EU exit negotiations from European medical organisations

A number of European medical organisations have called on 'Brexit' negotiators to safeguard patient safety, quality of care and high standard in medical education and training.

[The joint letter](#) to Michael Barnier, the EC Chief Negotiator, highlights that while the UK exit will fundamentally alter both the UK and the EU, it must not be permitted to threaten Europe's health. They noted that "Europe's medical workforces has become increasingly integrated and interdependent – over 30,000 registered doctors in the UK gained their primary qualifications in another EEA (European Economic Area) state – with such free movement playing a crucial role in both doctors' professional development and in meeting varying medical workforce requirements across Europe."

The letter from UEMS, CEOM, EJD, UEMO, FEMS and CPME acknowledges the importance of maintaining the alert mechanism and of ongoing efforts to ensure that minimum standards in medical education and training are met, with limited disruption to patients' health.

Brexit, trade and health event

Both British and European patients could pay a high price for the UK EU exit, concluded *Brexit, Trade and Health*, an event organised by the European Public Health Alliance (EPHA) in partnership with the University of Manchester and the Economic and Social Research Council (ESRC), in Brussels last month.

The event invited guests and subject matter experts to discuss the likely impacts of the negotiations on both patient health and the EU health workforce. The event has since [issued a statement which can be read here](#).

MEP Marin Harkin, who spoke at the event noted "we must focus on the public health implications of trade and

investment policies not just in terms of a future UK-EU trading relationship but also UK and EU trade policy following the UK departure. With the Brexit debate and deliberations strongly focused on economic and legal consequences, our public health concerns are in jeopardy of falling by the wayside, It is crucial that we don't relegate health care issues to some sort of second tier, behind the 'big picture'".

The UK Prime Minister Theresa May triggered Article 50 on 29 March, and the European Council President Donald Tusk has called a meeting of the remaining EU Heads of State on 29 April to consider the EU approach to negotiations with the UK.

Vicky Ford MEP re-elected chair of the internal market committee



Vicky Ford, a European Conservative and Reformist Group (ECR) MEP representing the UK, has been re-elected as Chair of the European parliament internal market committee (IMCO). This is the committee that leads on issues around the recognition of professional qualifications. Mrs Ford

first became Chair of the IMCO Committee in 2014 and will continue until May 2019.

Northern Ireland and EU exit - a unique set of challenges

Earlier this year healthcare employers, providers and Government officials from both Northern Ireland and the Republic of Ireland met to identify the main issues arising from Brexit. With the UK's only land border with an EU country, Northern Ireland's health and social care sector is facing specific and significant challenges from the vote to leave the European Union.

The roundtable discussed key issues including:

- Shared services and cooperation
- Existing staff
- Professional regulation and qualifications.

A more detailed [outline of the discussion can be found here](#). The [Cavendish Coalition](#) aims to ensure that the implications of the EU exit for health and care services are presented with a unity of voice and purpose.

International Patient Summary

In February 2017, the European Commission hosted a workshop on the International patient summary: policy, deployment and standards. Colleagues from the EC and those involved in [eStandards](#), [VALUeHEALTH](#), [EURACARE](#) and [EU-US eHealth at Work](#) met to discuss the *patient summary*, which is a digital dataset that includes the most important clinical facts required to ensure safe and secure care. When this summary is made available to the treating physician or the relevant health team, it becomes especially useful for the patient's safety in situations of unplanned or emergency care.

Several EU member states and regions have already implemented some form of patient summary in their

Study on the impact of liberalisation of professions

The EC is in the process of awarding [a tender for a study on the impact of liberalisation on access to certain professions](#). The research will contribute to improving economic evidence on the effects of regulation governing access to and the pursuit of certain regulated professions. It will focus on the quality of the services provided in specific professions and countries, and the way regulatory changes may have affected that quality.

EC communication on EWTD

At the end of 2016, the European Commission announced it would be launching an initiative relating to the Working Time Directive in its 2017 work programme.

Following a consultation of the EU social partners in early 2017, it is due to publish an interpretative communication on the implementation of the WTD, linked to the European Pillar of Social Rights which the Commission will present on Wednesday, 26 April.

The Commission asked for input from social partners on "which provisions of the WTD are to be clarified ...in view of the needs and challenges that the social partners may identify when the Directive is implemented on the ground."

The communication is not thought to include a proposal to re-launch the revision of the Directive, but rather will seek to clarify the implementation of the current law.

national healthcare system. Now the challenge is to have an International Patient Summary that can be readily accessible and understood at the point of care in any country around the world.

As part of the workshop the [European Committee for Standardisation \(CEN\)](#) launched [two new proposals](#) which are open for feedback until April 2017. The next discussion is planned for eHealth Week in Malta (10-12 May 2017) with a conference titled 'How to make the International Patient Summary a Reality?' For more information on the workshop, including papers and presentations [please follow this link](#).

Annual Growth survey

The European Commission has released the [Annual Growth Survey 2017](#). The survey outlines the most pressing economic and social priorities on which the European Union and its member states need to focus their attention on in the coming months.

In many member states, the working age population and the labour force continue to shrink, notably as a result

of low birth rates, ageing population, emigration and health-related exits from the labour market. For healthcare providers the survey highlights the importance to ensure access to quality services and in-kind benefits including healthcare and education and training.

The full [report can be read here](#).

European Reference Networks

On 1 March 2017 the first [24 European Reference Networks \(ERNs\)](#) officially started their activities. Within these ERNs, more than 900 medical teams in more than 300 hospitals from 25 EU countries (including Norway) have joined up to treat patients with rare or low prevalence complex diseases or conditions.

The ERNs are cross-border cooperation virtual networks involving healthcare providers across Europe. They are being set up under the [EU Directive on Patients' Rights in Healthcare \(2011/24/EU\)](#), which also makes it easier for patients to access information on healthcare and thus increase their treatment options. A two day conference was held in Lithuania in March to celebrate the start of the ERNs. A copy of the opening speech by the EC's Health Commissioner Vytenis Andriukaitis [can be found here](#).

Between 6,000 and 8,000 rare diseases affect an estimated 30 million people in the EU. An unfortunate feature of rare diseases and complex conditions is the scarcity and fragmentation of specialist knowledge, which is often not available in the patient's region or country. By consolidating knowledge and expertise scattered across countries, the ERNs will give healthcare providers access to a much larger pool of expertise.

The Commission created the [framework for the ERNs](#) and provides grants and technical networking facilities to support network coordinators. However, the driving forces behind the ERNs are healthcare providers and national health authorities.

EC publish study on off-label use of medicines



The European Commission has published its report ['Study on off-label use of medicinal products in the European Union'](#). The report aims to provide a description of off-label usage across EU member states, listing several drivers for off-label usage such as:

- Increasing the treatment options and the presence of health care professional guidelines
- Limited incentives to extend a marketing authorisation, especially for products out of patent
- Financial considerations, i.e. off-label prescribing, in case there is an 'off-label' product that is cheaper than the authorised product.

The report also outlines policy options for the regulatory system, healthcare system and healthcare professional/patient, including:

- Incentives for pharmaceutical companies to register new indications and modalities
- Providing EU guidance for national guidelines on off-label use
- Temporary recommendation for use
- Reimbursement measures.

The report will feed into any future EC policy recommendations or action on off-label prescribing.

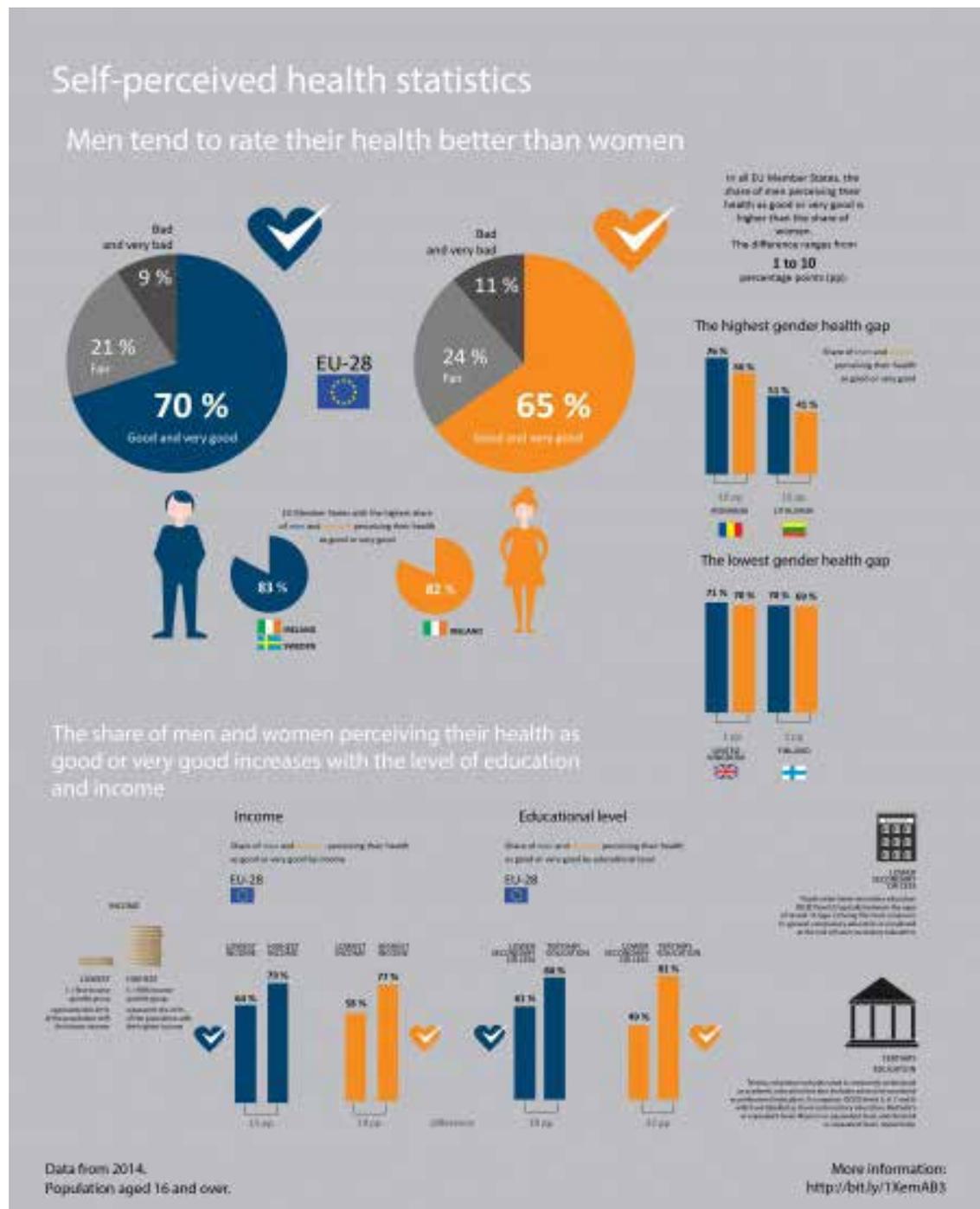
Updated statistics on healthcare professionals across Europe

In January 2017 the European Commission released data covering 2009 to 2014 on healthcare personnel statistics, as well as data pertaining to healthcare graduates. The updated information is part of an online publication by Eurostat Health in the European Union on health statistics that are related to healthcare resources throughout the EU.

As part of Healthcare Human and Physical Resources, Eurostat released the following data for:

- Physicians
- Nursing and caring professionals
- Dentists, pharmacists and physiotherapists
- Beds
- Technical resources and medical technology.

The data includes overviews of the number of practising personnel as well as graduating numbers in EU member states. It also provides ratio per inhabitant rates across the EU.



Physicians

There were approximately 1.8 million physicians working in the EU in 2014, with the highest overall number of practising physicians recorded in the largest EU member states; Germany (333,000); Italy (236,000); France (206,000); UK (181,000). Greece had the highest number of physicians per 100 000 inhabitants in 2014. For a full overview of the data on physicians please follow this link.

Nursing and caring professionals

In 2014 there were approximately 3.4 million practising nursing professionals (excluding Belgium, the Czech Republic and the Netherlands). There were 2.9 million practising healthcare assistants and almost 171, 000

practising midwives. Luxembourg had the highest average number of nursing professionals per inhabitant in the EU. For a full overview of the data on nursing and caring professionals [please follow this link](#).

Dentists, pharmacists and physiotherapists

In 2014 there were 345, 000 dentists working in the EU, where Greece had the highest number of dentists per 100, 000 inhabitants. There were over 440,000 pharmacists working in the EU in 2014 and close to 540, 000 physiotherapists. For a full overview of the data on dentists, pharmacists and physiotherapists [please follow this link](#).

Regulation of healthcare professions

David McAllister MEP has questioned the EC about its focus on the regulation of professions from an economic perspective and has asked whether certain professions should be exempt from efforts to de-regulate for reasons of patient or consumer protection. In response, the EC stated that it is up to each member state to decide whether there is a need to protect public interest objectives and to choose the most appropriate way to intervene and to impose rules and restrictions for the access to or exercise of a profession, as long as the principles of non-discrimination and proportionality are respected.

[Find out more here](#)

Health insurance networks in France

Alain Cadec MEP has raised concerns that the accredited networks of health insurance providers in France is in breach with EU law by posing an obstacle to free competition. This is because insured persons are required to consult healthcare practitioners and professionals who are part of the healthcare network accredited by their supplementary health insurance providers if they wish to secure maximum reimbursement. In response, the EC confirmed that the French competition authority has already issued an opinion on this subject which concluded that the networks are admissible under competition policy since it favours consumers' interest.

[Find out more here](#)

Spanish specialist doctors

Ramon Tremosa i Balcells MEP has highlighted the plight of a cohort of specialist doctors in Spain without official qualifications (known as 'MESTOs'). According to the MEP, these doctors were denied formal training as specialists because, as interns, they studied a specialty outside the residency system and without official recognition. He believes that this inhibits their freedom to provide services across the EU.

In response the EC stated that, while these doctors do not qualify for automatic recognition, their recognition could

be considered by the regulating host member states under the general system. During the last revision of the RPQ Directive, the concerns of the specific status of 'MESTOs' and the possible extension of existing acquired rights were not brought up by the co-legislators and so they are not given special recognition.

[Find out more here](#)

Swedish medical training

The EC has denied that the revised recognition of professional qualifications Directive prohibits Swedish trainee doctors from completing their medical internship in the Aaland Islands. In response to a question from Nils Torvalds MEP, the EC stated that the Directive allows trainee doctors to undertake their period of practical

training in another EU member state as long as the training meets the Directive's requirement on appropriate university supervision and the competent authority that issues the basic medical qualification is able to verify that the training met the harmonised minimum requirements.

[Find out more here](#)

Big Data and patient confidentiality

Barbara Kappel MEP has questioned the EC about the use of Big Data in healthcare in France and the risks for data protection and patient confidentiality that may entail from such use. In response the EC stated that the processing of personal data is subject to the Data Protection Directive and shall comply with the new [Data Protection Regulation as from 2018](#).

Both provide for specific rules on the processing of certain special categories of data– including health data – given

their sensitive nature. Processing of special categories of personal data is prohibited unless specific conditions are fulfilled. The most relevant for the health sector include the explicit consent of the data subject, the processing on the basis of EU or member state law for reasons of a substantial public interest and processing necessary to protect the vital interests of the data subject or of another person.

[Find out more here](#)

EPF gathers health stakeholders and patients to discuss access to healthcare and universal health coverage

European Patients' Forum (EPF)

On 27 February, the European Patients' Forum (EPF) held a policy meeting at the European Parliament to officially launch its one-year campaign on access to healthcare. The event brought together health stakeholders, patients, and decision makers to discuss what actions are needed to achieve universal health coverage and how each of the relevant parties can and will commit to this ambitious goal.

During the meeting, EPF presented the objectives and strategies of the campaign, and put forward its focus on five specific areas of actions where further improvement is needed.

While sustainable investment in health and affordability of healthcare products and services are more a question for decision makers, EPF believes that healthcare professionals have a role to play in the improvement of the three other areas of actions, which are:

- Quality of care
- Access to a holistic range of health and social services
- Non-discrimination

As drawn from the conclusions of the [EPF survey on access to healthcare](#) conducted in 2016, training healthcare professionals on chronic, long-term and rare conditions, on communication with patients, and on human rights will result in higher quality of care and will reduce stigma and discrimination.

The organisational changes in the health system will support access to specialist healthcare professionals and guarantee that the package of services is designed to meet the needs of patients. This holistic approach will promote better coordination and delivery of care.

EPF calls on healthcare professionals to engage in the campaign and help in improving access to healthcare. If we all work together, we can make universal health coverage a reality by 2030!

To know more about the campaign and how to get involved, [please visit EPF website](#) or use the #Access2030.

Developments in European regulation

GMC taking revalidation forward in 2017



In January 2017, the UK General Medical Council (GMC) published '[Taking Revalidation Forward](#)', an independent review of revalidation led by an independent reviewer. The review involved listening to a wide range of individuals and organisations involved in revalidation, as well as analysing the findings of recent research on the operation

and impact of the revalidation process. It made 15 recommendations to help improve revalidation in the UK.

The GMC have [responded to the review](#) which they have welcomed and strongly support. The findings suggest that revalidation is becoming embedded locally and beginning to impact positively on clinical practice, professional behaviour and patient safety.

They acknowledge that the process of revalidation is relatively new and recognise the difficulties and challenges that have been identified and they have committed to work collaboratively within five key priorities:

- 1 Making revalidation more accessible to patients and the public
- 2 Reducing unnecessary burdens and bureaucracy for doctors
- 3 Increasing oversight of, and support for, doctors in short-term locum positions
- 3 Extending the Responsible Officer model to all doctors who need a UK licence to practise
- 3 Measuring and evaluating the impact of revalidation.

For more information on the current UK revalidation process [please follow this link](#). More information on the review can be [found here](#).

Estonia and Finland to start sharing patient data



Estonia and Finland are set to start sharing patient data. In 2016 we reported that the Estonian and Finnish Prime Ministers had signed a joint declaration on an initial roadmap for launching data

exchange and eServices between Estonia and Finland. As part of this roadmap it was also agreed specific action plans would be completed for launching automatic data exchange in various fields including population registers, ePrescriptions and social benefit data.

Data sharing is a particularly relevant topic that has been highlighted by the EC, most recently in their Study on [Big Data in Public Health, Telemedicine and Healthcare](#). Connected health systems are becoming increasingly more pertinent as migration and global travel becomes more widespread.

The plan allows for the databases of both countries to be mutually available, thus supporting cross-border access to

digital prescriptions in the coming year, before progressing to full medical records by 2018-2019. The initiative is hoped to increase the quality of healthcare in both countries, as healthcare providers and patients will have access to all the data required, whenever necessary.

Deputy Secretary General for E-services and Innovation at the Ministry of Social Affairs, Ain Aaviksoo, stated "People move around more and more therefore data about their health should always be with them. This way they're able to use the best services from different countries, or live where they desire, without loss of important healthcare services." Mr Aaviksoo noted that cooperation needs to expand but infrastructure needs to be developed first, particularly around patient privacy.

The team behind the project are focusing heavily on security to ensure that the privacy of patients is not compromised, but they are committed that the first step of any privacy should be ensuring patients have control over their own data.

CORU launches five year strategy

CORU communications

In January, the Irish Minister for Health, Simon Harris, T.D. launched CORU's Five Year Statement of Strategy 2017 – 2021. CORU is the regulator for Ireland's designated health and social care professions and currently regulates over 9,000 professionals. This is expected to grow to over 25,000 professionals over the next five years when all 15 designated professions are regulated.

CORU's role is to protect the public by promoting high standards of professional conduct, education, training



Ms Ginny Hanrahan, Chief Executive, CORU and Professor Bernard McCartan, Chairperson of the Health and Social Care Professionals Council.



and competence through statutory registration of health and social care professionals. CORU is made up of the Health and Social Care Professionals Council and the Registration Boards, one for each profession named in the Act.

Health and social care professionals regulated by CORU include dietitians, occupational therapists, optometrists and dispensing opticians, physiotherapists, radiographers and radiation therapists, social workers and speech and language therapists. Work has commenced on opening registration for social care workers and for medical scientists while the registration and regulation of the remaining designated professions - psychologists, podiatrists, clinical biochemists and orthoptists - will begin when the Minister for Health appoints their Registration Boards.

Over the next five years CORU anticipates that the complexity of its registers will increase, reflecting both the increase in registrants and increased labour mobility resulting in more applications to CORU from professionals with international qualifications. It also expects the number of fitness to practise hearings to increase in line with the increase in professionals being regulated. To read the full publication, please [follow this link](#).

NMC modernising UK education standards

Nursing and Midwifery Council

Over the next five years the UK Nursing and Midwifery Council (NMC) has made a commitment to [undertake a strategic programme of change for the education](#) of nurses and midwives in the UK.

As the healthcare landscape continues to change, nurses and midwives are being asked to take on additional responsibilities, with many being required to undertake more complex roles across a range of health and care settings. Care provided by multi-disciplinary and multi-agency teams is increasing, and there is a growing focus on patient centred care delivered closer to home.

The NMC have a responsibility to make sure that nurses and midwives are prepared for the future. That is why we are undertaking a radical review of our education standards, thinking about what the public will need from nurses and midwives in 2030 and beyond, including:

- Standards for proficiency that all registrants must meet
- Emphasis on developing critical thinkers and leaders, who are able to work safely across a variety of settings
- Competency in caring for people with both mental and physical health needs

- Confident in relation to specific technical and procedural skills.

The standards will also look at how education is managed and delivered in theory and practice settings through examining how we set education standards to ensure a consistent student experience that supports and ensures that student nurses and midwives can achieve the proficiencies. Our aim is to have an education framework that promotes innovation and excellence with outcome focused standards. We are also undertaking an independent review of our quality assurance function to ensure that student nurses and midwives are meeting the proficiencies in a safe and effective learning environment.

[Our prescribing standards](#), our standards for medicines management, and [our return to practice standards](#) are all inextricably linked to standards for pre-registration education, and therefore we are reviewing these at the same time.

Further information on our education programme can be [found on our website](#).

Around the world

The economics of patient safety

The OECD has released a report on the *Economics of Patient safety - strengthening a value-based approach to reducing patient harm at a national level*. The report was developed by results from a health care snapshot survey involving 15 countries. The report looks at investment in the prevention of harm and whether it can create long term value through the reduction of costs, as well as maximising safety for patients.

Key messages from the report include;

- Patient safety is a critical policy issue
- The cost to patients, healthcare systems and societies is considerable
- Most of the burden is associated with a few common adverse events
- Greater investment in prevention is justified
- Solid foundations for patient safety need to be in place
- Active engagement for providers and patients is critical

- Innovation at the clinical level is enhanced through national leadership
- Practical approaches exist to identify national priorities for action.

The report estimates the cost of patient harm, and outlines a strategy for policy makers and healthcare leaders to improve patient safety with limited resources. It concludes that the financial and resource costs of patient harm are considerable and that a national patient safety strategy should be adopted by the countries involved in the survey. This includes investing in fundamental long-term programmes such as professional education, safety standards linked to accreditation and a sound information infrastructure.



OECD policy forum on the future of health



On 16 January, over 500 participants representing civil society, patients, providers, policy makers, academics and industry

came together in Paris to discuss harnessing digital technology and data to create proactive, people-centred systems; caring for older people with complex needs; and the importance of measuring what matters to people and to patients. The forum also featured a conversation among a small group of Health Ministers about their views on the future of health and healthcare.

The forum highlighted that while other industries had reinvented themselves around the customer, in healthcare a gap still exists between people who have one foot in the future and services that are stuck in the past. Participants agreed that the time is right to involve people and patients in their health and their care through:

- A more intelligent use of technology and electronic data
- Measuring more of what people want from their health systems

- Policies and regulation that promote team-based care designed around needs and preferences of individuals and communities

The outcomes and key messages from this event were discussed at the Ministerial meeting the following day. For more information on the forum please follow this link and links to videos from all sessions can be found here. The OECD and partners are keen to keep the conversation going, so feel to contribute to the debate by using #FutureOfHealth



IAMRA Symposium 2017

In October, the UK General Medical Council (GMC) will be hosting the IAMRA Symposium on Continued Competence 2017 in London, UK. The event will bring together experts from across the globe – including doctors, regulators, academics and educators – to discuss and evaluate systems designed to ensure the continued competence of medical professionals.

The Symposium will focus on measuring and evaluating the impact and value of continued competence systems

(such as revalidation, maintenance of licensure and continued professional development). This will be the fourth symposium on the subject of continued competence/revalidation, and the second such symposium held under the auspices of the International Association of Medical Regulatory Authorities (IAMRA).

More information about the event, and previous symposia, can be found on the [Symposium website](#).



INTERNATIONAL ASSOCIATION OF
MEDICAL REGULATORY AUTHORITIES

General
Medical
Council

IAMRA Symposium 2017

Continued competence systems - measuring their impact and value
5 – 6 October, London, UK

Submissions published on revalidation consultation



In 2016 the Medical Board of Australia (the Board) appointed an expert advisory group (EAG)

to provide technical expert advice on the introduction of revalidation for Australian doctors. The Board asked the EAG to develop one or more models for revalidation in Australia and to provide advice on how to pilot the models.

The EAG [developed an interim report](#) that identified a two part approach that proposed:

- Maintaining and enhancing the performance of all doctors practicing in Australia through efficient, effective, contemporary, evidence-based continuing professional development (CPD) relevant to their scope of practice

- Proactively identifying doctors at risk of poor performance and those who are already performing poorly, assessing their performance and when appropriate supporting the remediation of their practice

The full EAG report [can be found here](#).

Following a consultation, the Board [released the final submissions and comments online](#). The consultation received over a hundred written submissions and comments. The EAG and the Board are currently considering all feedback with a final report scheduled to be released in mid-2017.

Study finds lower mortality in patients treated by IMGs

A study published in the [British Medical Journal \(BMJ\)](#) has revealed that patients in the United States treated by international medical graduates had lower mortality than patients cared for by US graduates, despite international graduates caring for patients with higher rates of chronic conditions.

The study *Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study* looked at a 20% national sample of data for Medicare fee-for-service beneficiaries aged 65

years or older. Typically in the US international graduates are mostly from India, the Philippines and Pakistan and the study did not include US citizens who have gone abroad for medical education and returned to the US to practice.

The results also showed that patients treated by international medical graduates had slightly higher costs of care per admission. Readmission rates did not differ between the two types of graduates. To read the [full publication please follow this link](#).

Canadian healthcare organisations unite for better patient care



Thirteen national and provincial healthcare organisations have agreed to develop a common set of values and competencies under the newly united CanMEDs Consortium. CanMEDS is a framework for improving patient care by enhancing physician training.

- The Canadian Federation of Medical Students
- The Canadian Medical Association
- The Canadian Medical Protective Association
- The Canadian Patient Safety Institute
- The Collège des médecins du Québec
- The Fédération médicale étudiante du Québec
- The Federation of Medical Regulatory Authorities of Canada
- The Fédération des médecins résidents du Québec
- The Medical Council of Canada
- The Resident Doctors of Canada

The Consortium's mandate is simple – to improve patient care by using a consistent model to educate doctors in training and evaluate those in practice. The consortium is made up of:

- The Royal College of Physicians and Surgeons of Canada
- The College of Family Physicians of Canada
- The Association of Faculties of Medicine of Canada

The CansMEDS framework organises the many competencies of a doctor under seven different roles (see diagram). Numerous organisations in Canada already use aspects on the framework, but the consortium will enable a more systematic and coordinated adoption across the country. More information [can be found here](#).

Upcoming events

19–20 April

[FSMB 105th annual meeting](#)

Texas, US

26–27 April

Maltese Presidency – Healthy workplaces good practice awards ceremony in the frame of the tripartite conference on occupational safety and health

05 May

[17th ENMCA meeting](#)

Tallinn, Estonia

08–09 May

[ADEE/ADEA meeting](#)

London, UK

10–12 May

[eHealth Week](#)

Malta

16 May

[EC EPC/alert mechanism workshop](#)

Brussels, Belgium

23 June

[CEOM meeting](#)

Italy

14–16 June

[Joint 23rd Medicines for Europe and 20th IGBA Annual Conference](#)

Lisbon, Portugal

07 July

Consejo General de Colegios Oficiales de Médicos (CGOM) conference on challenges and future direction of healthcare and the medical profession in the EU

Madrid, Spain

04–06 October

[20th European Health Forum Gastein \(EHFG\)](#)

Bad Hofgastein, Austria

05–06 October

[IAMRA Continued Competency Symposium](#)

London, UK

16–17 November

[5th CLEAR International Congress](#)

Melbourne, Australia

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