1. The Alliance of UK Health Regulators on Europe (AURE) brings together 9 of the health and social care regulators (competent authorities) in the United Kingdom to work collaboratively on European issues affecting patient and client safety. As regulators, our purpose is to protect and promote patient safety through effective regulation and ensuring proper standards in the practice of health and social care.

Introduction
2. We welcome the opportunity to respond to the Department of Health’s call for evidence on the Review of the Balance of competences between the United Kingdom and the European Union (EU). Our response focuses primarily on those sections in the consultation paper that impact on our work as regulators.
3. We believe that public protection and high standards of care should be at the core of any European initiatives in health.
4. As highlighted by the call for evidence, EU action in health is of a supporting nature. However legislative and policy initiatives in other areas often have implications for health policy and patient safety across Europe. This is partly complicated by the fact that different European Commission Directorate Generals (DGs) may not always work jointly to consider the specific requirements of the health sector.

Section 13 – Implications of free movement of persons: healthcare professionals
5. As healthcare professional regulators in the UK, we are responsible for implementing the recognition of professional qualifications Directive (2005/36/EC).
6. According to the Regulated Professionals Database, the UK receives almost three times as many European trained professionals than it sends out. As a net importer of healthcare professionals, both from Europe and internationally, the UK has significant experience with both the benefits and challenges of high levels of professional mobility.
7. Migrant healthcare professionals make a positive contribution to the provision of healthcare in the UK. However, the Directive has raised a number of challenges to public protection in the UK. Whilst we recognise that the current review of the Directive is intended to address some of these concerns, our response to this consultation outlines the opportunities and challenges of the existing legislative framework.

Administrative cooperation
8. The Directive has helped to initiate a dialogue and joint action with other competent authorities in the UK (as AURE), but also with our counterparts across Europe. The introduction and use of the Internal Market Information System (IMI) has helped us improve our interactions with competent authorities in other EEA countries.
9. As AURE, we share information, agree shared positions and jointly respond to relevant European initiatives, particularly the recognition of professional qualifications and data protection Directives.
10. In addition, the Healthcare Professionals Crossing Borders project, a European informal partnership between professional healthcare regulators launched in 2005, has enabled us to share best practices and improve information exchange between regulators for different health professions across Europe.

*Fitness to practise information sharing*

11. At present, the extent to which regulators exchange information about healthcare professionals is variable and there is no requirement for EEA competent authorities to proactively inform their counterparts on disciplinary issues. This presents a risk to patient safety.

12. We consider that a European legal duty for competent authorities to share disciplinary information is necessary and essential as it would provide greater assurances to UK regulators that the professionals they register are safe and fit to practise.

13. We hope that the introduction of an alert mechanism in a revised recognition Directive and the review of the data protection Directive will go some way to address these challenges to the benefit of UK patients.

*Language skills*

14. We strongly believe that the ability to communicate effectively with UK patients and colleagues is integral to the safe practice of all healthcare professionals and as such should be a prerequisite for access to the profession. However, the language requirements in the existing Directive are not expressed clearly enough and have lead to different interpretations and implementation across the EEA to the detriment of patients in the UK.

15. We therefore welcome the European institutions’ intentions to clarify Article 53 to enable healthcare competent authorities to assess the language competency of EEA applicants. This would ensure that patients are fully protected while increasing trust and confidence in the recognition system.

*Minimum training requirements*

16. There are some inherent tensions between member states’ exclusive competence in education and the minimum training times set out in the Directive under automatic recognition. To ensure public protection, competent authorities, employers and patients must have better assurances that the qualifications included in the Directive are and remain genuinely comparable over time.

17. Furthermore, the minimum training requirements in the Directive are so broadly drawn and general that they provide little assurance about the standards of education and training of migrants. At the same time, their focus on duration of training rather than the outcomes of training has imposed constraints which have impeded the health sector from developing their education system in line with the UK’s needs.

18. To ensure public protection, regulators, employers and patients must have better assurances that the qualifications included in the Directive are genuinely comparable. We therefore believe that there should be a European level review of the criteria for automatic
recognition and the minimum training requirements to better reflect current practice in education and training.

*Competence assurance*

19. The Directive as it currently stands does not require professionals to provide evidence of recent practice or current competence as a condition for automatic recognition. We believe that automatic recognition must be linked with a requirement on professionals to demonstrate that they have been effectively maintaining and improving their knowledge and skills throughout their careers. This will address the unease competent authorities experience when they have to automatically recognise healthcare professionals that have not practised for many years.

20. Where professionals cannot provide this information, competent authorities should have the discretion to assess applicants under the general system and, if appropriate, apply compensation measures to ensure public protection. This process does not need to be burdensome and would increase trust in the mutual recognition system.

*Unintended bureaucracy*

21. European initiatives such as the recognition Directive sometimes have a dissonance between intent and outcome. The intention of the legislation is to facilitate mobility but often generates bureaucratic outcomes that create perceptions of barriers.

22. For example, competent authorities’ ability, under the general system, to compare an applicant’s knowledge and skills against the national standards required for registration and the option to ask for successful completion of compensation measures before granting registration, is beneficial to patient safety, provides migrating professionals an opportunity to demonstrate their skills and facilitates mobility.

23. However, compensation measures pose some practical challenges for competent authorities. They can turn into an additional appeals point in the registration process if the migrant disagrees with the need for compensation or with the outcome of the measure. Compensation measures can also require significant stakeholder engagement in the UK for their delivery. Adaptation periods often take place in approved educational institutions and aptitude tests may require levels of bought-in expertise. European competent authorities with links to state ministries may have different abilities and ease with this aspect of compensation measures than an UK competent authority/regulator.

24. These outcomes have the effect of potentially increasing the regulatory impact of the competent authority and run the risk of confronting a migrant’s expectations by appearing to be barriers to the recognition of their qualification.

25. Further examples of the discrepancy between intent and outcome include the inability to create a common training platform under the current Directive and the proposal to introduce a professional card under the revised framework.

*Sectoral and general system professions 21*
26. The division in the recognition Directive of health professions into sectoral and general systems professions has led to policy inconsistencies in the way we regulate different health professions. For example:
   a. The use of the European Commission’s Internal Market Information system has not yet been rolled out to all healthcare professions.
   b. For sectoral professions, the service is to be provided under the professional title of the host member state. For general systems professions, if a decision is made not to verify the qualifications of a would-be temporary service provider, the service is to be provided under the title used in the member state of establishment and in the language of that state.
27. These discrepancies continue in the current review of the Directive. For instance, the Commission did not propose an automatic alert system to share fitness to practise information for general system professions and there is no derogation for these professions from partial access.

Review of the Directive
28. Despite the public protection issues highlighted above, AURE welcomes the review of the Directive and the attempt by the EU Institutions to address some of the concerns we have brought to their attention.
29. However, the adoption of the revised Directive might create some challenges for competent authorities including the implementation of the proposed European professional card (which serves no purpose in jurisdictions like the UK where there are web-based searchable registers of healthcare professionals) and the application of partial access.
30. Moreover, it should be pointed out that any changes to the recognition procedures as part of the review of the Directive are likely to have financial implications for competent authorities which in turn may impact on the registration fees for healthcare professionals.

Section 15 – Implications of free movement of services: cross-border healthcare
31. AURE strongly believes that high-quality and efficient cross-border healthcare depends on accessible information. As well as having a right to receive healthcare anywhere in the EU, patients have a right to be confident that they will be treated by safe health professionals who are properly regulated.
32. In the context of regulation, patients need direct access to information about professional standards, assurance about the professional indemnity of those treating them, and information about complaints and redress if things should go wrong.
33. AURE members, for example, have publicly accessible and searchable web-based lists of registered practitioners. This makes an important contribution to making regulation transparent and provides an easy way for members of the public, patients and health service contractors to check the registration status of practitioners. Therefore, we believe that all health regulators in Europe should be required to make up-to-date information about their registrants available to the public in this or a similar way.
Section 19 – Further case law

ECJ case on temporary and occasional

34. AURE is following with interest the ECJ case (C-475/11) brought by an employment tribunal for healthcare professionals in Gießen (Germany) against a Greek doctor registered under temporary and occasional mobility. The outcome of this case might have significant implications for healthcare regulation in the member states and has the potential to undermine the confidence of the professionals and the public at large in the mutual recognition system, should professionals working on a temporary and occasional basis not to be bound by the medical code of conduct of the host member state.

Section 20 – Non legislative action

Patient safety and economic efficiency

35. We consider that there are both economic and public safety reasons for treating healthcare professions differently from other professions. Concerns about healthcare professionals do not relate only to their competency, but also to their fitness to practise and professional behaviours, which are critically important when dealing with vulnerable patients. There are clear economic implications of healthcare professionals’ misconduct for the NHS. Therefore, it is crucial to assure the fitness to practice of all healthcare professionals in the interest of both patient safety and economic efficiency. 23