

Ensuring quality of health care providers within the single market

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The Joint Committee is responsible for the supervision of all general practice training in the United Kingdom, and I am responsible for quality assurance and standard setting. My research interest is into performance assessment of GP registrars using simulated patients.

INTRODUCTION

EU Directive 93/16¹ was introduced as part of the free movement of labour provisions of the European Union under the Treaty of Rome. Currently all the directives on free movement of regulated professions are concerned with ensuring that there are no barriers to movement between member states. Directive 93/16 states the length and place of training, but it does not specify the content of training nor the competencies that are expected to have been acquired. Member states automatically accept the qualifications obtained in other member states, providing they meet the minimum requirements stated. The concept of ensuring quality in health care providers for the benefit of patients is not part of this legislation.

Competent authorities are appointed by each member state to supervise training -Article 31 of 93/16 states "it shall be supervised by the competent authorities". The level and process of this supervision are not specified and may only consist of ensuring that the minimum times are spent in the training programme. The present system of European regulation has not kept pace with changes within medicine, within the profession and with the expectations of the public. Citizens are entitled to expect that doctors and other health professionals are trained to a satisfactory level of competence, and that the training has been of a suitable quality.

It is important that free movement of workers becomes secondary to issues of patient safety and a satisfactory system of quality assured education that will provide safe doctors. This becomes even more of an issue with the current enlargement of agenda and free movement between more than twenty different types of healthcare systems.

CONTENT OF TRAINING

Many countries already exceed the minimum length of training for general practice, some having programmes lasting five years, but others have programmes of the minimum length. Even a simplistic examination such as this does not reveal the true extent of the differences. In one of the five year programmes four of the years are spent in a general practice setting, whereas in another four years are spent in hospital training. What is the difference in the competence of the doctors concerned? Should a doctor trained in one of these systems be able to work at a satisfactory level in the health care system of the other? How do we know? What is certain is that under the current regulations we are not entitled to ask the question.

The content of training is determined by both the content of the medical discipline (common core), which is common to all doctors in that discipline, and by the tasks required of the doctors in a given health care system (context). Some of these tasks will be common to all healthcare systems, but some will be unique. Work on this for the discipline of general practice has started this year in EURACT^{*} and is being continued through ESGPFM^{**2,3}.

In order to demonstrate that practitioners have reached the required level of competence and some form of assessment is usually applied before the period of training is completed. However the form of this assessment varies from country to country, uses different methodology, and may look at different areas of competence and skill acquisition. If there is to be our move towards competency based judgements to inform free movement then these processes will need to be harmonised at a European level.

* European Academy of Teachers in General Practice

** European Society of General Practice / Family Medicine – WONCA Region Europe

QUALITY ASSURANCE

What is meant by "shall supervise" as far as the Competent Authorities are concerned? In the United Kingdom the general practice Competent Authority, the JCPTGP carries out this quality assurance work by setting criteria for training posts and programmes^{4,5} and will only accept training in approved posts and programmes which meet these criteria towards its certificates of training. Having set national standards it devolves their application to a regional level, where they are applied by Postgraduate Deaneries. General practitioner teachers are subjected to a rigorous assessment of their teaching skills and have their practice at a Deanery level prior to being appointed, and are subject to three yearly by approval were made to demonstrate that they have maintained their skills. Teaching posts in hospital are also subject to selection and accreditation by the Deanery and education approval of these posts can be, and sometimes is, withdrawn.

The Joint Committee satisfies itself that its own national standards are met by its own monitoring visits to Deanery teaching organisations⁴. This it carries out on a three-yearly basis, with a visiting team of three or four assessors, who are appointed from the senior educationalists in the discipline. These visits last three days, and use one or two training schemes within a Deanery as a sample. All elements involved in the teaching process are interviewed, from the Dean and hospital Chief Executive to the newest trainees in post. Offices, libraries, hospitals and general practices are all visited, and extensive interviews take place. Reports are considered by the committee, and if satisfactory training accreditation is continued for a maximum of three years. The committee has powers to withdraw teaching recognition, or make it conditional on improvements to the education in any post, either in hospital or in general practice. This process has ensured that the education programme for general practice is of the highest quality.

COMPETENT AUTHORITIES

If this model can work successfully at national level is there any reason why it should not work at a European level? Could the Competent Authorities quality assure training? The answer is they could but unfortunately do not at present.

There is no agreement on the degree of supervision by the competent authority. Should they all be working to the same quality standards in education when they can only apply such quality assurance measures to those programmes that they supervise? If so what are these standards, and who should develop them? Should Competent Authorities be medical professional organisations, with skill and expertise in medical education?

Currently there is no harmonisation in the composition, function, or method of working of the Competent Authorities themselves. More importantly there is no European forum for them to meet and discuss these matters. As an officer of a competent authority I have to tell you that there is very little contact or common understanding on these matters, and we are in regular contact with very few of our colleagues in Europe. In the Report of the High Level Panel on the Free Movement of Persons, chaired by Simone Veil⁵, a number of barriers to the success of the directives on free movement were explored. They found that there was a failure of trust and co-operation between officials and official bodies in member states. Greater contact with and understanding of other competent authorities was recommended to individual governments.

There is no common pattern of quality assurance throughout the European Union. Each medical discipline concerned must, at a European level, be able to describe the content of its training, its assessment, and its quality assurance for this to occur. Work has been carried out in this area by a number of different disciplines, and is currently under way in my own discipline of general practice/family medicine. In the past this work on harmonisation would

feed-back to the Commission through the Advisory Committee structure, but these have now been suspended.

SECTORAL OR GENERAL SYSTEMS DIRECTIVE

There is a lot of discussion at present as to whether there should be changes to free movement directives. Directive 93/16 is a sectoral directive in which standards are agreed at a European level and are incorporated into the drafting of the regulations. Individual member states are expected to meet these standards, and provided this is the case, must automatically accept qualifications from other member states. The advantage of this type of directive is that it is relatively easy to administer at a national level. The disadvantage is that when originally drafted the standards were based on time spent in a training programme rather than on competence achieved. It appears from the way that the medical directive was drafted that there was intent to modify this over time, but this has proved impossible to achieve. Even minor changes have taken years to be implemented.

On the other hand the general system directive sets no agreed EU standard. It places the onus of investigation on the Competent Authority of the host member state, who can make enquiries about an individual applicant if the applicant's training programme in their home state differs significantly either in length or content from that in the host state. In practise there are significant restrictions on the powers of Competent Authority to make such enquiries, and even more restrictions on the actions that can be taken as a result. The administration of this type of directive places a large burden of administration on host Competent Authorities.

Both types of directive have major flaws as they are currently drafted and as part of any review of the regulation of the medical profession, whether by the sectoral, the general system, or a new consolidated directive, there must also be a move away from the use of time as the basis for the judgement of equivalence of training and the development of judgements based on competence. In the interests of patient safety any limitations placed on national competent authorities in making enquiries, assessments, or prescribing training for incoming professionals should be removed.

LOOPHOLES IN THE RECOGNITION OF QUALIFICATIONS

Many member states now exceed the minimum training requirements of Directive 93/16. Some have created a special class of doctors within their health care system for those who have trained to this higher standard and access to this employment is limited. They have also created an "underclass" of doctors who have only been trained to the European standard. Any incoming doctors wishing to make use of the free movement legislation to move to such member states find that they have to work at the lower level or agree to undergo further training, although their home state regards them as fully trained. This clearly contravenes the spirit if not the letter of the free movement of regulations. Although one has some sympathy with the reasons behind their move, which is to promote higher standards within their own health care system, this issue would be better addressed by getting agreement at a European level to improve the standards of training for all.

RE-ACCREDITATION

European legislation at present only deals with the requirements on completion of training, and does not address the issue of the maintenance of skills throughout the career of the doctor by periodic process of re-accreditation (currently called re-validation in the UK). This is being addressed in different ways by different member states and at present they are free to require re-accreditation for doctors in respect of their own health care systems. This has no

impact on free movement but, as an area of concern for the continuing quality of health care, should be addressed as part of any review of health care regulation in Europe.

ENLARGEMENT AGENDA

The difficulty in ensuring common standards across a diversity of health care systems will be increased with any increase in member states, bringing their own systems of health care and medical education. With the current sectoral directive most states are bringing their medical education systems into line with EU directive minimum requirements. However as these are time not competency based, they are not adequate to guarantee quality for patients.

CONCLUSIONS

A number of conclusions can be drawn.

1. Quality assured patient care must become the prime concern of health care directives, and free movement become a subordinate issue.
2. Any change to the directives must include a change to a competency base rather than a time base.
3. All elements of the training of doctors and other health care workers should be subjected to a rigorous quality assurance process by the national Competent Authorities.
4. At a European level the performance of Competent Authorities in carrying out their quality assurance should also be subject to scrutiny.
5. The medical disciplines should be supported in continuing work towards agreement on the content of each discipline and harmonisation of training and assessment methods.
6. A professional group at European Level is required to oversee these processes, utilising the work of European professional organisations already in existence.

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