This article was developed from a presentation at the 2009 FSBPT annual meeting in San Diego, California. It provides US regulators with a look at a very different approach to healthcare practice and regulation.

**Healthcare Regulations in the UK & European Union**

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**The United Kingdom**

In the United Kingdom, the Health Professions Council (HPC) is a complete departure from typical regulators. It’s a single, multi-profession regulator of one council with no boards underneath it. The council makes decisions in relation to all 14 professions. It is truly multi-professional; the standards of conduct and code of ethics is generic across all 14 professions and the standards of proficiency for each profession are about 85% generic in content. It has been quite an exciting launch, especially since many people were anticipating that it would fail.

Individual professions do not necessarily have a seat at the table. The 20-member council has 10 public members and 10 members drawn from the registrant population. The 10 are chosen based on the fact that they are registrants, so in theory it would be possible for the council to have, for example, two physical therapists or two paramedics. That hasn’t happened yet. The 10 people chosen are simply the best people for the job, and there is open competition to be part of the council.

While the concept is rather wild, it was supported by the professions. They drove for the change to a multi-profession regulator. We had the slightly odd situation where public members were appointed and professional members were elected. People would stand for election on a manifesto and say, “When I am elected, I am going to do this and when I am elected I am going do that,” but then got appointed and were...
told, “No, your job is to serve on this multi-professional board and you cannot run that kind of agenda as you would be in breach of your legal obligation.”

**A bit of history**
The UK is very complex. If you create a constitution bit-by-bit over 1,000 years, you tend not to write it down in one document. Instead, you keep amending old documents. When we introduced metric measurements in the 1970s, for instance, the Weights and Measures Act just amended the Magna Carta.

Scotland, England and Wales make up Great Britain. When you add Northern Ireland, it becomes the United Kingdom, or officially the United Kingdom of Great Britain and Northern Ireland. Each has a separate government, with about 84% of the people living in England. So in the UK, we have four governments and three-and-one-half legal systems. The legal system in Northern Island and the legal system in Scotland are completely different from those of England and Wales, which have one legal system. If you reside in Wales, though, you can speak Welsh, so that is why it is 3 ½ systems.

HPC is not a federal system, because we do not get to impose the model across the four countries. Instead, we apply the relevant law in the jurisdiction in which we appear. So, I have to send Scottish lawyers out to do cases in Scotland with the Scottish rules and civil procedures applying in those proceedings. On top of that, we have a National Health Service, which does not exist. It is really four health services - in Northern Ireland, it is not even called the National Health Service. These services are each completely different.

Contrary to popular belief and recent debate in the U.S., this is not a state-run, state-employed healthcare system. No family doctor in the United Kingdom is an employee of the state. All are independent practitioners that contract with the government. There are also significant differences among the four health services. For example, in Scotland and Wales people do not pay for prescriptions, but in England they do.

**The UK Model: Integrated Regulation**

Our model is fully integrated in the sense that there are no scopes of practice set by the legislature. The regulator sets the scope of practice, which we call standards of proficiency. We do not have examinations, nor do we use a credential service. The regulator instead accredits individual university programs. Beyond that, we do the usual discipline process as well as the fitness-to-practice process. At the tribunal, there will be somebody from your profession and a legally qualified chair, but there will be no board members.

Regulation is completely based on protection. There are no controlled or prescribed acts and there is no prescribed scope of practice. The regulator controls the threshold requirement, which is the items one needs
to practice this profession, but it does not do any more than that. It is a very minimalist approach. In theory, someone who is not qualified can perform the functions of the physical therapist provided he does not suggest or imply that he is registered. Amazingly, it works.

The practical realities are that a huge amount of provision is by the state and the state will not pay for anybody to provide care that is not on the register. In the independent sector, insurers do the same. You cannot get reimbursed for care that is provided by someone who is not registered. Part of the reason that it can work is the demographics of the United Kingdom. About 61 million people are squeezed into a land mass the size of Wyoming. If you squeeze that many people into a space, you don't have that diversity of problems that you are going to find in a more sparsely-populated country.

Emergency medical services are completely funded by the four health services. There are 15 emergency services for the whole UK; one in Wales, one in Scotland, one in Northern Ireland and 12 in England. It is a completely full-time, paid professional service. Every person employed as a paramedic is trained to a single national standard.

Describing a registered paramedic is a very easy task compared to what regulators in the U.S. have to determine because requirements are entirely dependent on a densely populated country. An ambulance has to get to you anywhere in the United Kingdom in eight minutes. To suggest to somebody in Montana that eight minutes is a reasonable response time would be fantasy. It is one issue that tends to be missed in the current onslaught of healthcare debates. You can't pick and choose bits of a system without recognizing the reality of how these things are delivered.

**A soccer story**

A physiotherapist has strong brand recognition in the UK. We do not need to have 1,000 chiropractors and 1,000 osteopaths because people do not believe in them.

Consider that there was a soccer game in Manchester City, with about 75,000 - 80,000 fans attending. A multi-million-pound footballer called Eduardo went down a few minutes into the game. The man who looked after him on the field was Gary Lewin, the team physiotherapist. Eduardo went into shock and began speaking in his native Portuguese, which Mr. Lewin did not understand. However, he radioed to the bench and another player who could speak Portuguese came onto the field. Lewin and Eduardo were able to communicate, and the player was sent to the regional trauma center which is a National Health Service Hospital.

So Lewin basically saved the guy's playing career. (These were not life-threatening injuries, but getting your ankles cracked up when you are a multi-million-pound football player is not good news.) Anyway, the crowd began chanting Lewin's name. I do not know how many physical therapists in the United States have crowds chanting their name, but I am pretty sure it is unusual.

There is a serious point to this story and that is the phenomenal U.K. brand recognition of physiotherapy as a profession. In theory, I can set up my sports massage clinic or whatever I want to call it, but nobody is going to come unless I have that document that says I am a physiotherapist.

So the system does work because of geography, very strong brand recognition and the reality that the independent sector will follow the state sector.
Traditional discipline to fitness to practice

A relatively new development for UK regulators is that we have moved away from a traditional discipline model to fitness to practice. This has not been easy, and certainly the courts have struggled with it because there is always a bit of a crisis when you change the law. We do not talk about prosecuting people, discipline, charges or fines. Fines were taken out because they were a punitive measure. The process is about fitness to practice. It's quite a complex issue.

Cases are reported in the normal way and a final determination is made whether the practitioner’s fitness to practice is impaired. It is entirely possible, for example, to find there was a lack of competence but no impairment, so therefore no sanction is imposed. It is all about remediation and insight. Persons who have admitted their failings and cleaned up their acts have taken whatever remedial steps were appropriate by the time the case gets to hearing. There is no “guilty,” anymore; that is gone. Or, the sanction may be at the admonishment level or a practice restriction, rather than something more severe.

It is not been an easy transition, because it requires fundamental changes to the legal process. We are used to a model where you apply a legal rule to set a fact, and you say, “Well, did this person do it or not?” With fitness to practice, it is much more difficult because some of that mitigation will go to whether the person is impaired. You admit doing this thing; does it mean you are impaired going forward? The process is still pretty much intact with one exception - misconduct. The courts have told us, “If you found there was misconduct, you ought to be finding that there is impaired fitness to practice. Misconduct by its nature is a deliberate harmful act. This person is not sorry. They are just sorry they are in trouble. There is a big difference.”

And that is the wonderful world of the United Kingdom.

Elsewhere in Europe

The European Union and the European Economic Area can get very confusing. The European Union has fully signed up to the treaty. The European Economic Area includes a few countries that join in every now and again. Switzerland is entirely separate. It likes the free movement of professions and items such as that. But membership in this club also means abiding by banking transparency laws and that makes Switzerland a
little bit jittery. But because they are rich, we let them play in this club even though they do not pay the membership fee.

The European Union is an economic union, a NAFTA-type arrangement about free movement of goods, people and services. There is no board of controls between the mainland countries. The UK has the controls, but that is because we live on an island. If you fly to Rome, for example, and then travel around the rest of Europe, you will not be asked for your passport until you get back to another airport.

Regulators are the collateral damage in the process of professionals moving about Europe. The process was designed to allow a company to travel freely through Italy, Spain or Greece without any problem. But suggesting that a podiatrist who is qualified in Greece can go wandering around and have a go at peoples' feet wherever he likes is an entirely different issue.

There were several attempts to harmonize professions over the past 40 years. There would be a set of rules and a common education for each profession, so if you qualify as a doctor in France, you will be able to practice anywhere in Europe. After 20-odd years, about nine professions were done.

With 465 professions to go, they decided to go to come up with a different model. It provides a “full faith in credit” approach. A person who is qualified to practice a profession in one member state has the right for mutual recognition in another member state if that profession exists there. He gets full faith in credit for what he has done up until then in terms of education and training. In other words, “Hi, I am a Dutch physical therapist. This is where I went to school. This is what I have been doing in the meantime.” An assessment is carried out. If there are significant items missing, the therapist has an adapting period to learn those things before being allowed to practice. It is a bit flimsy, but it is done off the back of a process designed for companies, not people.

By and large, it is not a problem. This is a community where there are 27 official languages, and people tend not to move unless they can speak the language where they want to go and practice. The people who can do that tend to be a highly mobile population and the reality is that the Italian PT that wants to practice in the UK has usually been there before. The most bizarre element, however, is that you are not allowed to language test somebody moving from one member state to the other. That is regarded by the European Court of Justice as an unreasonable restraint on free trade.

Another interesting aspect is temporary registration. If someone wants to practice in another member state on a temporary and occasional basis, he can just give notice to the regulator in the member state and say, “Hi I’m here. I am only going be here a little while. Thank you very much.” If these folks can show that they have registered in another member state, they are allowed to do it. They can only practice under their home state title. This is quite significant in border regions. There is an inter-service probability agreement between Northern Ireland and the Republic of Ireland where paramedics on either side of the border will answer emergency calls. Beyond that sort of arrangement, it is far from an ideal situation.

The academic community has responded to this very poor attempt to fix free movement and mutual recognition by looking at it from the other end of the telescope. If we try to harmonize education, a lot of these problems will go away. Because this is a task taking place without intervention of government, it is actually working.
The Council of Europeans, which has nothing to do with the European Council, set up a project so one can take the first year of a PT degree in one place, move to another country and do the second year without it being problematic. The idea was to develop a European Credits for Education. It is slowly getting there. The European Commission, the government of the European Union, has joined in with a similar process. I believe we will see quite a high degree of commonality within the next three or four years.

**Does anyone in Europe regulate the way the US regulates healthcare practitioners?**

An independent regulator protecting the public is completely alien in the European Union with two exceptions, Ireland and Yugoslavia. The model elsewhere is very different, and in some member states it’s impossible to identify a regulator, or if there is one.

Many of the ex-Soviet states have never needed a regulatory model, as healthcare was completely controlled by the state. These are planned economies, so in places such as Romania and Bulgaria, people were pushed out of medical school one year early because their governments were behind on meeting a set target in the planned economy. As you could only work in a state hospital or one run by the Ministry of Health, there was absolutely no need to set up a regulatory body. If you were fired from your job, that was the end of the matter. There was also a view within the Soviet Union that psychiatric illness didn’t really exist. It is only beginning to recognize the existence of psychology and psychotherapy, and it is certainly a long way from regulating them.

Countries such as France, Germany and Italy have models that are very similar. They have a register, but you cannot be removed from it. You meet requirements of registration, get registered and that’s it. There is no continuing competence and no discipline process. However, they can make an order to remove you from the list because of something else you may have done illegally. The Netherlands has a big register as well. It actually doesn’t carry the same weight or meaning as we would understand it because a discipline record is nonexistent.

These countries, of course, are all recent democracies and liberal professions have had a very significant role in their development. As a result, there are very different approaches to the concept of controlling professions or even the idea that professions need any control. France is a very good example. A French physical therapist simply says, “I went to Toulouse University and have a diploma in physical therapy. Nobody needs to know any more about me.” You may register with a local town as a business, much like a plumber or a shopkeeper would, but nobody maintains a register or regulatory process. Trying to track somebody’s good standing if he moved around a few times is virtually impossible.

This is the history and cultures of these places and it works for them - healthcare delivery is fine. It’s difficult getting other countries to understand what we regard as the normality of regulation. A colleague in Belgium said, “Explain this to me again. You pay money to join a physical therapy group in England and when people complain about you, they investigate you? Why would you join that?”

**Random comments**

- The Spanish government is currently considering regulation, although it would be voluntary. That’s because it tends to focus on the trade union function, which is to represent all relevant professions and forever push up salaries and make demands. So the government said if this registration is voluntary, it wouldn’t develop as a union.
• In Greece, the election for the president of the medical order is national news. It runs on the front page of newspapers. This person is a very significant voice in the community. Usually, the doctors elect a person who is not from the government, so professions wield quite an astonishing level of power.

• There is an economic reality to regulation in Europe. The original European community was 12 member states with fairly similar economic conditions. Today, the average income in Romania is 1/10 of that in the United Kingdom. If you have a common area where you can travel with no passport and where doing the same job in a certain part of that area could pay ten times as much, it’s not surprising lots of people migrate. There is a lot of motivation in the former Soviet states for people to go elsewhere with their skills.

• There is a much higher level of regulation in the U.S. than in the UK. For example, beyond the main healthcare professions, we don’t license barbers, cosmetologists and contractors.

• Physiotherapy in the UK is a completely autonomous profession. You don’t need a referral from a doctor, and the physiotherapists can diagnose, treat, discharge and make prescriptions. At a sports function, there are doctors present, but they don’t run onto the field and treat a player - it is the physiotherapist’s right to do that. Doctors would never go onto the field unless the physio allows them.

• In the UK, you can add supplementary insurance. It can put you in a single-person room if there is a clinical need for it and it can provide for non-essential items. Originally, the idea was that taxpayer provides health insurance, and it provides it free of a point of view of what you need. Now it’s taken quite a big culture shift. The hospital is not a profit business, it stands alone. The family practitioner gets the commission of service with you and it is more business-like. Many people buy additional insurance to cover minor things.

• Typically in a district general hospital, there are 15 hospital employees in the physiotherapy department. The hospital is simply being more responsive to a need. The number does vary from place to place across the country, but it goes back to the point that hospitals are within easy reach of most people. It’s the demographics and volume that make a big difference in staffing. This is, by the way, one of the struggles in Canada. It is trying to use the UK model over a very big geographic area with small numbers of people.

• One of the reasons healthcare works in the UK is because people have that grown-up conversation. If it’s a serious injury, you are going to get everything that’s needed, and no one is going to send you a bill for anything. But if it’s a leisure sports injury, maybe you could put your hand in your own pocket to pay 50 pounds so you don’t take treatment free of charge in the national health service. There has been a lot of focus in the UK on the U.S. health debate. One item that needs to be brought up in the debate is that you need to put your hand in your pocket occasionally.

• The French play both ways. If you have a diploma from one of their schools, they let you alone. But if a UK or a Dutch graduate was to go there and register with a degree of the same nature, they would not be allowed to practice. You get shuffled to the central ministry of health and your
request disappears into the system. I have tried very hard to get registered there, but I do not get answers to my letters.

- The biggest single barrier for a PT coming to the UK is autonomous practice. You are going to be asked if you can do this on your own, without anybody telling you what to do. We have an autonomous PT profession which is a function of a government having a hand in how much money is spent on healthcare. For instance, if your doctor requests an x-ray, the radiographer will not just take the image requested, but he will also take any images he thinks are appropriate. He will look at them, diagnose in 95% of cases, put you out the door and send you back to treatment as he sees fit. What the British Medical Association says pretty much goes, but the big brake on it is the government picks up most of the tab.

- The model of education in virtually the whole of Europe is quite different compared with the U.S. When I got my degree in chemistry, I got a degree that was 99.2% in chemistry. Kids in the UK are expected to make some choices about classes and subjects at the age of 16. Those choices will determine what they can pursue in a university. The final year of general education is much more like a freshman year at college. The fundamental way we educate people in terms of the level of education and the number of years needs to be realized.

- If you are qualified, we are not looking for credentialing, licensing or board certification. If you say, “I tried to do this for a patient and it all went wrong," we are going to ask how you came to be doing this or what was the basis of you trying to this. If you say, “I have been on this course, I have done this, I had worked with this person and I have got this training and experience,” then you are essentially okay. You don't have to have a piece of paper that says you know how to do this stuff. You learned it over a ten-year period. So we just apply the normal common law negligence principles.

- It boils down to this. We approved all the physical therapy programs delivered throughout the UK, so if you don't take one of the approved programs, you don't get qualified.

- Fewer than 10% of the cases we deal with are about competence. The other 90% concern people who sleep with patients.

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Jonathan studied law at the University of East London and the College of Law, London and forensic science at the University of Edinburgh. He is a Fellow of the Royal Society of Medicine and was described in the Legal 500 directory as a lawyer who gives "excellent advice, which goes to the heart of the matter."

No stranger to the United States, Jonathan was Visiting Scholar at the Law Library of Congress, Washington DC from 2000 to 2005 and is a regular participant in programs at the National Judicial College in Nevada and the Harvard Kennedy School of Government. More importantly, his wife (Elaine) is American.