Conference, *17 November 2017, Brussels*

Regulating health professions in a European perspective

www.ose.be/hcconference2017/

Speech of **Maggie De Block**, Minister of Social Affairs and Public Health, Belgium

Ladies and gentlemen,
Good afternoon everyone

I would like to begin by thanking the organisers for this initiative.

As Minister for Public Health, I have made a commitment to provide **patients with the best possible quality of care**. One of the means I am using for this is the legislation on health professions, formerly known as Royal Decree No 78. This Law has remained more or less unchanged for half a century, but that didn't stop the healthcare landscape from changing in the meantime. The needs and requirements have evolved, as have the services available. We need to adapt our legislation accordingly, and therefore it is useful to look outside of our borders, as we do here today.

Ladies and gentlemen,

At first sight, the **legislation on health professions** may not appeal to the public, but the fact is that it affects a great many people: patients first of all, but also healthcare providers themselves.

This law defines the professional rules for **almost 500,000 active healthcare providers** in Belgium: 190,000 nurses, 60,000 physicians, 10,000 dentists, 20,000 pharmacists, 37,000 physiotherapists, 110,000 patient care assistants and 43,000 allied health professionals. Every year, there are also about 30,000 people who apply for a visa here to be able to practise a health profession.

Existing legislation regulates the exercise of the **various health professions**:

- the so-called medical professions, such as physician, dentist, midwife and recently also clinical psychologist and clinical orthopedagogist.
- and also the professions of pharmacist, physiotherapist, nurse and patient care assistant, allied health professions and ambulance worker.

By amending the legislation numerously, we have tried to respond to evolving needs and to integrate new professions. This has always been done with the best of intentions, but it has resulted in a lack of clarity and coherence. In the 2014 coalition agreement of the federal government, we therefore set out the ambitious plan to thoroughly reform the entire legislation, based on an **overarching, modern vision of health professions** and built around a number of major principles.

The most important transversal line is the **central position of the patient**. As a society, we need to adapt our healthcare to the patient, not the other way around. This means that we must adapt the healthcare services provided to demographic and other developments in order to be able to offer patients the best possible quality of care at the lowest possible price, in line with their specific needs.

A second transversal principle, to which I adhere closely as a physician, is that of science-based **diagnostics, treatment and prevention**. Healthcare providers should take into account **evidence-based practices** and therefore work in accordance with scientifically sound standards and guidelines. I will pay particular attention to this in the new legislation.

Ladies and gentlemen,

The third major principle is that of interdisciplinarity.

The **demographic and social reality** is what it is:

- People are getting older nowadays. This is a good thing, but it also has implications in terms of health needs.
- The care needs are becoming more complex: people often have a combination of disorders, but with good care and proper guidance they can still live long and have a good quality of life.
- Patients want to stay in their home environment for as long as possible. That requires a tailored care plan.
- Citizens expect care to be more embedded in society, and less linked to services such as hospitals. This trend, which is clearly visible in mental health care, for example, requires a new healthcare model.

The answer to these changing expectations is **interdisciplinarity**. Healthcare providers need to cooperate more with each other, to exchange information, make clear agreements on the division of tasks, while respecting each other's professional autonomy, et cetera.

The old model, in which healthcare providers work independently from each other, is outdated. A new approach is needed in which interdisciplinarity is explicitly included in the law and systematically takes place in the field.

This will lead to greater quality, greater patient satisfaction and greater efficiency in care, as several studies have already shown. The objective of interdisciplinarity is threefold, it is known as the '**triple aim**':

- improving the quality of life of patients and their family carers;
- a population that remains healthy for longer;
- and a more efficient use of available resources.

An important lever to achieve these 3 principles – interdisciplinarity, evidence-based practice and patient focus – is technology. Developments in **medical and communication technology** will radically change professional practice: the number of treatment options is increasing, interventions are becoming less invasive, there are new ways of monitoring patients and communicating with them, patients will be much better able to monitor their own health, decision support will be raised to a higher level, cooperation with fellow-physicians will be facilitated... It is therefore obvious that technology must be given a place in the renewed legal framework.

At the same time, we must ensure that basic principles are not violated. In its current form, the law offers too few **instruments for intervening** in the event of problems with the quality of care or the relationship between patients and physicians. The legal powers of the Provincial Medical Boards – *Provinciale Geneeskundige Commissies* – are currently limited to merely checking whether a professional is physically and psychologically fit to continue their work without risk. That is all. This is

not sufficient for monitoring the quality of care closely. We want to address this too in the new legislation.

Ladies and gentlemen,

The existing consolidated Law of 10 May 2015 is a complex piece of legislation, consisting of no fewer than 187 articles. It is clear that the reform requires thorough coordination and a step-by-step approach.

First of all, I commissioned the legal experts of the Belgian Federal Public Service of Public Health to carry out a **legal analysis**. In the meantime, many informal contacts have been established with advisory councils, representatives of professional organisations and educational authorities and with the relevant health authority officials. I was able to gain insight into a number of important bottlenecks in the existing legislation and then, together with experts, I went in search of innovative solutions.

In October 2015, I asked all advisory boards of Public Health for input on the **generic competences** required within the professional area for which they are competent.

As a relevant aside: in the meantime, the existing legislation has been **brought in line with European Directive 2013/55** on the recognition of professional qualifications. You are, of course, aware that this transposition has given rise to lively debate for certain professions.

In September 2016, I then proposed the main lines of the reform at a well-attended launch conference. It was then up to the people: through a public consultation round, we invited people from within and outside the sector to submit their ideas and reservations, ideas which we've analysed in depth and which we have now taken into account when drafting the legal texts on the quality of care practice. The administration is currently finalising a preliminary draft bill on this subject.

Ladies and gentlemen,

To conclude, I would like to briefly address the issue of **medical workforce planning**, which was the subject of the last conference of the European Health Observatory. It has taken blood, sweat and tears, but this federal government has done what was needed with regards to the quota system. We have stopped the annual exceeding of the federal quota, after five years of exceeding it. We have taken our responsibility, and this is something that everyone has to do for this issue.

In the meantime, I am having the influx of foreign healthcare providers and students examined. In itself, there is nothing wrong with this influx, but we must ensure that it does not compromise the quality of care and self-sufficiency in our country. That is why I am currently examining the need for measures to be taken, albeit within the framework of European legislation.

Ladies and gentlemen,

I would like to thank everyone who participated in this conference today for their input, which we will undoubtedly use as inspiration when drawing up our policy.