**MEMORANDUM**

# Government Response to the House of Lords European Union Committee's 22nd Report of Session 2010-12:

# "Safety First: Mobility of Healthcare Professionals in the EU"

**Submitted by the Department for Business Innovation and Skills jointly with the Department for Health**

# Introduction

1. Directive 2005/36/EC on the recognition of professional qualifications (the **Directive**) is a vital part of the single market, enabling skilled workers to move more freely in the EU. The Directive has brought expertise and filled jobs and skills gaps in many sectors, including the UK health system. That said, aspects of the Directive need improving, and differences in national practices have led to concerns related to the free movement of health professionals.

2. The European Commission is in the process of conducting a review with the aim of reforming and updating the Directive. After experience reports on individual professions in 2010, the Commission ran a public consultation from 7th January to 15th March 2011, followed by a Green Paper exercise, which ran from 22nd June to 20th September 2011. The European Commission plan to publish a firm legislative proposal on 20 December.

3. In June and July of this year, the House of Lords European Union Committee (Sub-Committee on social policies and consumer protection) - the **Committee** - conducted its Inquiry into the Directive, mobility of healthcare professionals across Europe, and associated issues arising.

4. This is the Government's response to the Committee's subsequent report. It has been prepared jointly by the Department of Business Innovation and Skills, the lead Government Department for the Directive, and the Department of Health.

## Summary of Response

5. The Government welcomes the Committee's Inquiry, and its findings, which were published on 19 October 2011 (the **Report**). The timing of the Committee's Inquiry was opportune, in that it took place while both the Department for Business, Innovation and Skills and the Department of Health were considering the Green Paper and its proposals.

6. Both Departments listened carefully to the evidence taken by the Committee, which helped shape and influence the Government's response to the Green Paper.[1]

7. The Government's key priorities in terms of the Review of the Directive are:

   - A reduction in the number of regulated professions: the inclusion in a new Directive of a mechanism through which Member States check their regulatory provisions, apart from those related to healthcare professions, and remove them if they are not proportionate.

   - Further evidence before introducing professional cards. An impact assessment is needed to show the economic and practical costs and benefits of this proposal.

   - Greater mutual assistance between Competent Authorities to speed the processing of applications. In addition to mandatory use of IMI and a proactive alert system, networks of Competent Authorities should meet to share best practice and to understand different regulatory systems.

   - Modernising the minimum training standards related to doctors, nurses, midwives, pharmacists, dentists, veterinary surgeons and architects. To build further trust, all courses related to these professions should be reported for compliance to the Commission at least every ten years.

   - A requirement to make application forms and more information available online. These should be linked to Points of Single Contact set up under the Services Directive.

8. Like any piece of legislation that has been in place for a number of years it is right that the Commission regularly ensure that the Directive remains fit for purpose. As the Committee's report highlights, there

[1] The Government response to the Green Paper can be accessed at: http://www.bis.gov.uk/assets/biscore/europe/docs/e/11-1297-ec-green-paper-professional-qualifications-directive-uk-response

have been significant concerns expressed by partners and stakeholders as to the applicability of aspects of the Directive and its provisions to health professionals. We agree with the Committee that there are a number of areas in which the Directive could be refined and improved.

9. In particular, the Government believes that there are additional safeguards that could and should be incorporated into any revised Directive to ensure that its operation retains the trust and confidence of citizens across member states.

10. The Committee picked upon many of these areas of concern, and the Government's detailed response to the Recommendations made by the Committee in its Report, are set out below. As the Inquiry's focus was on the operation of the Directive in the context of healthcare, **this response is limited to the Government's position on the health professions.**

# Detailed Response to Inquiry Recommendations

| Ref | Recommendation | Response |
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| **Chapter 2: Automatic recognition, training and access** | | |
| **Automatic Recognition and training requirements** | | |
| Para 26, Pg 12 | We agree that the concept of automatic recognition of the qualifications of health professionals is welcome, aiding mobility and helping to improve training standards. However, patient safety must be the overriding concern. The system can only function with confidence for patients, professionals and regulators if it reflects modern practices. | We agree with the Committee's conclusion on this point. |
| Para 27, Pg 12 | There are clearly instances where the Directive is out of step with modern practice. We therefore agree that the minimum training requirements and training durations in the Annex of the Directive ought to be reviewed and amended. We would welcome the inclusion of more practical competencies alongside minimum training durations but recognise the reality that an entirely competency based approach across the EU is unrealistic at present. | We agree with the Committee that the minimum training provisions in the Directive require updating.<br><br>As expressed in the Government's response to the Green Paper, we would advocate a move to fully competence-based minimum requirements in the long term but would prefer retention of references to lengths of training as a safeguard in the short to medium term. Moving towards competence-based minimum requirements may well necessitate a significant shift in processes across many Member States. Trust and confidence in the reforms could be supported by maintaining training length safeguards, though we consider that there should be greater flexibility in respect of the recognition of prior learning where a professional already holds a degree with some relevant content.<br><br>Further, as the Government highlighted in its response to the Green Paper, it would be important to ensure that any revision of the minimum training standards is not seen as a one-off. The Government believes that any revised Directive should be flexible enough to allow for training requirements to be periodically updated in the future, with full member state consultation. |

| Ref | Recommendation | Response |
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| Para 28, Pg 12 | It is clear to us that an audit of current training practices and curricula around the EU, above and beyond the minimum training requirements, would be helpful. While we reject the development of a single European curriculum, the sharing of information among educational establishments and practitioners may lead to the development of curricula that are more aligned, while allowing Member States to fit curricula to their national circumstances. In the longer term, this might assist in the move towards a more competency based approach. | We agree that this proposal would generate valuable learning, and engender greater cooperation amongst Member States. In the Government's response to the Green Paper we suggested that:<br><br>*"automatic recognition based on minimum training standards increases the need for mutual trust, as well as cooperation in aspects such as revising minimum training standards.*<br><br>*We would therefore strongly recommend that the Commission organises regular meetings of expert working groups for each of the seven sectoral professions."*[2] |
| Para 29, Pg 12 | In terms of the broader competences that we would wish to see included in the Directive, we recommend that anomalies between the different healthcare professions be removed, while recognising the different roles of each profession. It is reasonable to expect that healthcare professionals are aware of medical ethics and the legislative framework and it is therefore unacceptable that understanding of these two vital issues is not required of all automatically recognised healthcare professionals, including doctors to whom the requirement does not currently apply. | We would concur with the Committee's view that there are core common training standards which could be reasonably expected from all health professionals whatever their nationality (e.g. ethics), and that any revised competency based approach to education and training within the Directive would benefit from including a requirement for training in such fundamental matters.<br><br>We would point out however that any healthcare professional practising in the UK is bound to observe the professional standards, including the ethical standards, set for the profession by the UK regulatory body and that potentially, fitness to practise action could be taken against a professional who failed to observe those standards. |

[2] *ibid,* at Page 19

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| **Ref** | **Recommendation** | **Response** |
| Para 30, Pgs 12-13 | We stress the importance of adopting a flexible approach, respecting the responsibility of Member States for delivery of healthcare and education policies. Employers, including agencies, must accept a degree of responsibility. We would support an obligation in the Directive for employers to provide a period of induction. Such an obligation would fall on the competent authority to oversee should the professional intend to operate in a self-employed capacity, such as some pharmacists, dentists and general practitioners. A particular role of induction must be to inform the professional of the health delivery structure in the Member State and the applicable legislative framework. | Whilst we concur with the underlying point the Committee is making (that employers play a key role in ensuring that safe and competent professionals are employed) we do not think that placing an obligation on employers in the Directive is the way forward. The focus of the Directive is the mutual recognition by competent authorities, such as our health professions' regulators here in the UK, of the professional qualifications of migrants, rather than whether a professional is competent to perform a particular role in the delivery of healthcare in another member state. Placing obligations on employing organisations directly would mean significantly expanding the scope of the Directive.<br><br>That does not mean to say that wider regulation does not have a role to play in terms of ensuring compliance. Under the Health and Social Care Act 2008, providers of regulated activities (which include NHS and independent sector providers) must register with the Care Quality Commission (CQC) in England. As such, they must ensure that they meet the registration requirements set by the CQC, which include requirements around staffing skills, experience and fitness. The responsibility for ensuring that staff employed to carry out a regulated activity are fit to practise rests with the provider, and CQC can take enforcement action against the provider if it does not meet the requirements.<br><br>Induction is vitally important for all new staff appointees, regardless of their country of origin. We would further agree with the Committee that a key component of induction which would be of benefit to EEA nationals would be training which provided an understanding of how healthcare services are delivered in the UK. This understanding of UK service provision would ease migrants' establishment within the UK and aid their orientation. |

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| Para 32, Pg 13 | We do not advocate the extension of the automatic recognition principle beyond the healthcare professions that are currently covered but we emphasise the need for flexibility in the regulatory framework to allow for future extension. | We agree with the Committee's conclusion on this point. |
| **Return to practice and revalidation** | | |
| Para 35, Pg 14 | It is unrealistic at present to require Member States to introduce systems of revalidation for all healthcare professionals. Nevertheless, it is crucial that competent authorities are able to assure themselves, through testing if necessary, that an individual who has not practised for a significant length of time is fit to practise. This necessity must be reflected in the Directive. | When engaging with our partners and stakeholders in order to prepare the Government's response to the Green Paper, we heard deep concerns on this issue. The Government strongly believes it is vital that health professionals keep their skills up to date, especially in a sector where there are regular and significant advances in technology and practice. To this end, the Government suggested the addition of a requirement of two years' experience in the last five years in a revised Directive, unless the applicant graduated in the last three years. |
| **Continuing Professional Development (CPD)** | | |
| Para 39, Pg 15 | We recommend a strengthening of Article 22 in order to oblige Member States to require healthcare professionals to undertake CPD. Such a strengthening can only function in reality if those Member States that do not operate CPD across healthcare are assisted in their efforts to do so. We recommend that different approaches to CPD be considered alongside the informal sharing of information relating to the content of training courses. Given its importance to healthcare professionals outside the automatically recognised professions, we would also welcome a reference to CPD in the general framework of the Directive. | The Government would strongly wish to see a general requirement for CPD to be introduced for health professionals in all member states. This requirement should not be overly prescriptive, but should highlight the fact that CPD is a vital component of safe practice in any Member State.<br><br>Clearly, requirements for CPD to be demonstrated as a condition of continued practise as a professional vary in different states across the EEA. Therefore, we would also agree with the Committee that this is an issue where greater collaboration amongst member states would be beneficial. |

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| **Compensation measures and partial access** | | |
| Para 43, Pg 16 | We heard no support for application of the principle of partial access to healthcare professions subject to automatic recognition. We therefore concur with the Commission that it would be helpful to make the right of Member States to deny partial access in the interests of patient safety explicit in the text of the Directive. We see substantial risk in application of the principle to healthcare professionals falling outside the automatic recognition regime. | We agree with the Committee that, for the sake of clarity and avoidance of doubt, it would be advantageous to clarify in the text of the Directive the limitations of the concept of partial access to the health professions.<br><br>As the Government stressed in its response to the Green Paper:<br><br>*"partial access should not apply to the health professions or those who care for vulnerable people, since the possibility of patients, the public, and service users being misinformed about the restricted nature of a professional's activity could pose greater risks than for other professions."*[3]<br><br>We believe that explicitly excluding the health professions from partial access provisions furthers the public interest. |
| **Temporary and occasional practice** | | |
| Para 47, Pg 16 | Registration and continuing training and assessment of those performing healthcare duties in another Member State on a temporary or occasional basis must be no less stringent than for those registering on a permanent basis. If that were to be the case, clarification of the term "temporary or occasional" would not be so important. But if the concept is to be maintained, guidance on its interpretation would be helpful. | We agree with the Committee that greater guidance from the European Commission on this issue might be beneficial.<br><br>We would strongly resist moves to allow professionals access to a health profession without prior notification to the competent authority and checks of their qualifications. In addition to the public health risk, health regulators are only responsible for professionals on their register, so competent authorities must be able to register professionals before they practise in the UK. |
| **Ref** | **Recommendation** | **Response** |
| **Chapter 3: Administrative Cooperation and Fitness to Practise** | | |
| **Sharing of information between competent authorities** | | |
| Para 55, Pgs 18-19 | It is essential that competent authorities are able to satisfy themselves that individuals who have had restrictions placed on their freedom to practise in one Member State are not able to circumvent these by establishing themselves in another Member State. We consider the current situation to be | We concur with the Committee's findings on this issue, which is vital for engendering trust in the current system of mutual recognition. It is surely a benefit to citizens of all member states and for the reputation of professions across Europe for the relevant competent authorities to have the ability to share information about the small minority of professionals whose activities may pose a |

[3] *ibid,* at Page 11

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| | unacceptable. The provision of an adequate framework for the proactive sharing of fitness to practise information is key to building confidence in the free movement of healthcare professionals. We recommend that use of the Internal Market Information System be made compulsory for competent authorities of all healthcare professions. We favour option 2 in the Green Paper as offering a greater degree of protection to patients. | risk to public safety. We agree that the IMI system seems the most appropriate vehicle to facilitate this sharing of information and would agree that the second option presented in the European Commission's Green Paper appears to be the most appropriate (subject to further comments below). |
| **Data protection** | | |
| Para 59, Pg 20 | We consider that the provision of a proactive alert mechanism for the sharing of fitness to practise information will be ineffective if it is not accompanied by changes to the current restrictions on data which can be shared. We recommend that there be a specific article in the Directive dealing with administrative cooperation within the healthcare professions which would require the sharing of categories of information agreed to be critical to patient safety. This should ensure that the sharing of information is not obstructed by reference to data protection legislation in individual Member States. We commend the work of the Healthcare Professionals Crossing Borders group as a good starting point for consideration of these necessary categories of information. | We agree with the Committee that the issue of data protection is a key pre-requisite to there being in place a robust system for the sharing of information in a timely and effective manner. We share the views European Commission officials expressed in evidence to the Committee, that a system for sharing information on a proactive basis could be developed in a manner that does not unduly interfere with individual freedoms.<br><br>In the interim, pending any revision to the Directive, we believe that there are some steps that the European Commission could take on this issue. The Directive already contains provisions relating to the sharing of information of this nature. We would welcome guidance from the European Commission on the relation between these provisions and European Data Protection legislation. |
| **Ref** | **Recommendation** | **Response** |
| **Appropriate point of information exchange** | | |
| Para 64, Pg 21 | In deciding at which point to share information, as well as what information to share, the overriding concern must be patient safety. There should be an obligation on competent authorities to share promptly information relating to fitness to practise cases where there is a risk to patient safety from the point at which a case is initiated. This should be limited to a neutral | The Government would agree that the overriding concern relating to information sharing should be patient and public safety. The Green Paper contemplates sharing of information once a migrating health professional loses his right to practise due to sanctions in a Member State. However, our view is that the threshold for an alert should be where a competent authority has made a decision which in some way limits a professional's ability to practise, for instance |

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| | account of the established facts of the case and the allegations. Competent authorities of Member States should then have discretion to act in accordance with their national systems as to whether an individual should be temporarily suspended whilst investigation is ongoing. It is essential that the Internal Market Information System is regularly updated in order to ensure that the rights of individuals are respected and to ensure that those who have had cases against them dismissed should not face discrimination. | when it has suspended them, or imposed restrictions on their practice short of an outright bar.<br><br>It is very important not to lose sight of the purpose of an alert system. More efficient sharing of information is not being sought for punitive reasons, rather:<br><br>*"…to provide vital information so that regulatory authorities and employing organisations in host Member States are aware of the professional's background. Information given should explain the nature of the restriction of the professional, and the reason for this if possible, so that other Member States can make an informed decision about whether to register the professional in their state. This also enables authorities to give the professional the support they need where relevant."*[4] |
| **Differences in structure of competent authorities** | | |
| Para 69, Pg 22 | Each Member State should provide a single contact point for competent authorities from other Member States. This should facilitate contact with the most appropriate body with regard to fitness to practise information. | Contact points which fulfil this purpose are foreseen in the current Directive and are in place in all member states. The UK National Contact Point can be found at www.ukncp.org.uk. The full list of such contact points can be obtained from the European Commission's website.[5] |
| **Ref** | **Recommendation** | **Response** |
| Para 70, Pg 23 | Regarding differing models of regulation, the focus must be on delivering the necessary outcomes. However, there is clearly a potential conflict of interest where a regulator simultaneously acts as a professional body, acting in the interests of its members. We consider it would be helpful to move towards a common understanding among Member States as to the distinction between a representative and regulatory role, while respecting national legal systems and traditions. | It is the Government's belief that that there should be a clear separation of professional regulation from professional representation functions. Clearly, the status of a competent authority is primarily a matter for Member States to decide, but we think that there is a potential conflict of interest if a situation exists where a regulatory body might potentially be swayed or influenced by the interests of members of the professions it regulates. |
| Para 71, Pg | We do not consider harmonised models of regulation to be realistic. | The Government agrees with the Committee's conclusions. Again, this is an |

[4] *ibid,* at Page 21
[5] Accessible at: http://ec.europa.eu/internal_market/qualifications/contactpoints/

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| 23 | It is however essential that competent authorities understand systems in other Member States and how to work effectively with them. Each Member State should therefore inform the Commission and other Member States of its legislative, administrative and regulatory arrangements for fitness to practise criteria and the sharing of information. This information could then be used as the basis for identifying and promoting best practice, potentially encouraging a movement towards greater alignment of national systems. | area where closer cooperation amongst competent authorities, facilitated by the European Commission, could deliver real benefits. It is highly likely that greater cooperation will enhance trust and confidence amongst competent authorities, which is vital to the Directive being implemented and operated in a coherent and consistent manner. |
| **Ref** | **Recommendation** | **Response** |
| **Chapter 4: Language Competence** | | |
| **Language testing at the point of recognition** | | |
| Para 82, Pg 27 | We consider that the Directive currently strikes the wrong balance between facilitating mobility and ensuring patient safety, which must be the overriding concern. Furthermore, the current system undermines public and professional confidence in the mobility of healthcare professionals within the EU. | We agree with the Committee that public protection must be the overriding concern with regards to healthcare professionals who may pose a risk of harm to the public. |
| Para 83, Pg 27 | Language testing should be permitted at the point of registration if deemed necessary for patient safety by the relevant competent authority and changes to this effect should be made to the Directive. The ability of regulators to test language is particularly important in the case of professionals who are self-employed. The current lack of provision to assess the language competence of this group of migrant professionals represents a serious failure of the current system. | Given the time it will take to implement a new Directive and the unpredictable nature of negotiations, it is important that changes are made within the scope of the current regime. The Government is planning to consult on its proposals to give new powers to Responsible Officers to check language ability, detailed below.<br><br>As set out in the Government's response to the Green Paper, we would value clarity from the Commission about scope for proportionate language checks by the competent authorities in relation to self-employed health professionals. We are |

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| | | pleased that the Commission stated it is considering this issue in evidence given to the Committee and we look forward to considering its proposals on this issue. |
| **Ref** | **Recommendation** | **Response** |
| Para 84, Pg 27 | Whilst we consider legislative change to be essential we recognise that achieving this can be a lengthy process. Given the patient safety implications we recommend that the Commission as a matter of urgency clarifies with competent authorities their understanding of what the Directive currently permits in terms of language testing and make changes to the Code of Conduct as necessary. | The Government would certainly value greater clarity from the European Commission in its Code of Conduct to the Directive concerning the issue of language competence, in particular, as to (i) what scale and extent of language checks that may be permitted and be considered proportionate, (ii) at what point such checks may take place, and (iii) who/which body may undertake such checks. We need to ensure that nothing fetters scope for meaningful checks to be undertaken at a local level. |
| Para 85, Pg 27 | We consider that option 2 in the Green Paper, which permits a one-off test of language skills before professionals come into contact with patients, is insufficiently rigorous. Testing should not be restricted to professionals who come into direct contact with patients. | We would agree with the Committee's comments that language ability is not only needed for professionals who come into direct contact with patients. As the Government said in its response to the Green Paper:<br><br>*"Checks are not only important for healthcare professionals who only have direct contact with patients. Many health professionals work within multi-professional teams. They need to communicate, orally and in written form, with other members of this team, just as much as they need to be able to communicate effectively with patients and services users. Member States should also be able to ensure that adequate language checks are in place for health professions covered by the general system for recognition."*[6] |
| **Proportionality of language testing** | | |
| Para 88, Pg 28 | Strengthening the rules on language testing to allow a one-off test at the point of registration would potentially strengthen the system of free movement of healthcare professionals by increasing confidence in its provisions for | The key for the UK is achieving clarity about what is possible and ensuring that any reform does not hinder scope for effective and meaningful checks on language and communication competence being undertaken by employers and organisations contracting with health professionals. |

[6] http://www.bis.gov.uk/assets/biscore/europe/docs/e/11-1297-ec-green-paper-professional-qualifications-directive-uk-response, at Page 22

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| | assuring patient safety. The form of the language test should be left to the discretion of the competent authorities, depending on their assessment of the risk for individual professions. | Where it is proportionate to undertake language checks, a migrant may offer a range of types of evidence which compellingly demonstrate a suitable level of knowledge. Any discretionary powers would need to reflect this. |
| **Ref** | **Recommendation** | **Response** |
| **Role of the employer** | | |
| Para 93, Pg 29 | The nature of language competence and communication skills required will inevitably vary according to the specific role to be undertaken. We consider it unlikely that a one-off test conducted at the point of registration would be sufficient to assure employers. It is therefore vital that changes to the Directive should not restrict the flexibility of the employer to assess applicants proportionately according to the specific requirements of a job. The nature of this assessment is likely to be different and of a less formal kind from that undertaken at the point of registration and we therefore do not believe that this would result in a disproportionate system of dual testing for the same competences. (93) | As we have stated above, we would not wish for any changes to the Directive to limit the checks employers or contracting bodies undertake.<br><br>We agree with the Committee that language requirements vary post to post. And we note the Inquiry's view that a system of checks by both the competent authority and employers or contracting organisation could be justified on proportionality grounds. Any changes to the Directive would need to be consistent with the broad principles on freedom of movement established in case law, and revisions would still need to provide for arrangements that were proportionate. Our view is that local organisations employing or contracting with healthcare professionals are best placed to make evidence-based judgements on the requisite competencies needed to fulfil the role expected of a prospective employee or contractor. We consider patient protection is better served by an assessment which anticipates the specific role the professional will be undertaking. |
| Para 94, Pg 29 | We welcome the Government's engagement with the issue of language testing and their work to strengthen assurances of language competence at local level in the UK. We encourage them to press ahead with their work in this area along with working to collate and disseminate best practice. | The Government recently announced its intention to amend the Responsible Officer Regulations to build on the existing statutory duties that responsible officers have to vet applicants for medical posts, so that Responsible Officers have an explicit and mandatory duty to ensure the satisfactory language competency of doctors.<br><br>In addition, we are exploring scope for amendment to the Medical Act to provide the GMC with more explicit powers to enable it to take action where concerns arise about the communication skills of doctors. |

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| | | We are focusing at this stage on arrangements for doctors because it is in this profession where risks are perhaps most acute (especially in the context of general practice). However, we are also in discussions with the Nursing and Midwifery Council and we will consider what steps are required in relation to other health professions through working with regulators and identification of key risks, and in light of our experiences with doctors. |
| **Ref** | **Recommendation** | **Response** |
| **Chapter 5: European Professional Card** | | |
| **Further risks: maintaining confidence and preventing fraud** | | |
| Para 104, Pg 33 | The case for the added value of the professional card for the healthcare professions, particularly those covered by automatic recognition, has yet to be made although we acknowledge that the concept may have greater value for those professions covered by the general system. However, it is essential that priority is given to ensuring changes to the Directive are introduced as soon as is possible. If necessary, work on the professional card should be decoupled from this process. | As was made clear in the Government's response to the Green Paper, we remain open to the concept of the professional card. It has the potential to deliver some benefits, but the Government is of the view that further analysis is required. In particular, we would like to see any refined proposals from the European Commission subjected to cost-benefit analysis and impact assessment. We also believe that piloting of arrangements which take account of the differences between professions would be highly desirable before any proposed roll-out.<br><br>The European Commission's thinking on the card is clearly still developing, and we look forward to hearing plans for pilot professional cards which the Commission has promised to initiate in the new year. |
| Para 105, Pg 33 | The aim of increased sharing of information between competent authorities is clearly a laudable one, working both to improve mobility and increase wider confidence in the system. There is much to be welcomed in the Commission's proposals to mobilise home and host Member States, for example the host Member State having automatic electronic access to documents proving qualifications. However, many of these measures would be possible through strengthening of the existing Internal | As above. In addition, we would agree with the Committee that many of the benefits that the European Commission foresees being delivered by the professional card might be deliverable through refinements to the existing IMI system. |

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| | Market Information System (see chapters 3–4) in which significant resources have already been invested. | |
| **Ref** | **Recommendation** | **Response** |
| Para 106, Pg 33 | We acknowledge that thinking on the professional card has yet to be fully developed but consider there are clear risks associated with the concept. In particular, issues surrounding the accuracy and currency of the data need to be addressed. We believe the idea of a physical card to be incompatible with satisfactorily addressing these. To go down this route would be to adopt an inappropriate 'one size fits all' approach to mobility and we welcome the fact that the Commission's thinking appears orientated towards a 'live', continually updated system. Nevertheless, whilst the idea of a virtual card may have greater potential, the Commission should be alive to the danger that a card would represent, for those professions covered by automatic recognition, a costly and unnecessary measure, failing to command the confidence of professionals and patients alike. | As above. In addition, the Government would wish to be assured that any professional card system contained rigorous safeguards to prevent fraudulent use of the card and identity theft and other unintended uses of protected data. |