The Bologna Process and the Recognition of Professional Qualifications: an update on developments

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Abstract

The interface between the Bologna process and Directive 2005/36/EC on the Recognition of Professional Qualifications is complex and shifting. This article provides an update of material previously published in the *Bologna Handbook* in September 2006 (A 3.3-1). Since that date, the Directive has come into force, while at the same time the three-tier Bologna qualifications structure has been progressively consolidated in National Qualifications Frameworks. These in turn are being referenced to the European Qualifications Framework for Lifelong Learning. Meanwhile, academic, professional, regulatory and student bodies have become increasingly aware of the lack of alignment between Bologna and the Directive. Discussion has focused on qualification structures, competence-based and student-centred learning, recognition of prior learning in a lifelong frame, continuing professional education and quality assurance. These issues effectively constitute the agenda for a 're-engineering' of the Directive, which – in many instances – Member States have failed to transpose into national law. A window of opportunity is available, since the review period fixed at the time of the passing into law of the Directive is scheduled for 2012. In 2009, with the advent of a new Parliament and a new Commission, an updated overview of the situation is appropriate.

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0. The Bologna process and the recognition of professional qualifications: an update on developments

The story so far

An article in the first edition of the *Bologna Handbook*[1] set out the context and the principal features of Directive 2005/36/EC on the Recognition of Professional Qualifications (hereinafter referred to as the Qualifications Directive). Its main points are summarised below:

- Article 47 of the Treaty allows legislation on the mutual recognition of diplomas, as a tangible expression of the freedom of movement of persons, services and labour in the EU.

- The Qualifications Directive, which came into force in October 2007, streamlined fifteen legal instruments which had been in operation since the 1970s. It did not significantly change their substance.

- Faced with the continuing low level of cross-border service delivery in 2005, the EU institutions were simultaneously engaged on the preparation of a Directive on Services in the Internal Market (which passed into law as 2006/123/EC and is hereinafter referred to as the Services Directive). Streamlining the Qualifications Directive was a key part of this legislative and political process.

- The scope of the Qualifications Directive is considerable. It covers over 800 professions. Not all of these are relevant to higher education institutions [HEIs][2]; in this respect, the picture is not consistent across Europe. At the same time, some HE-relevant professions (such as the legal profession) retain their own dedicated legislation and remain outside the scope of the Directive.

- Two categories of profession are important. The first is the *sectoral* – medical doctors, dentists, general care nurses, midwives, veterinary practitioners, pharmacists and architects; their basic qualifications enjoy automatic recognition, thanks to the existence of agreed minimum training conditions.

- Secondly, there are the numerous professions which fall into the *general system*: here, a grid of HE attainment levels allows host Member States to calibrate the knowledge and skills of incoming professionals and to grant recognition accordingly. Host countries may insist on adaptation periods or aptitude tests.

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[1] Davies H, The Bologna process and the Recognition of Professional Qualifications, Bologna Handbook (A 3.3-1), September 2006.

[2] A list of acronyms appears in annex to this article.

- The scope of the Qualifications Directive is also wide in geo-political terms. It covers – or will cover in due course – EU27, the countries of the European Economic Area [EEA] and Switzerland, accession countries, as well as countries holding relevant bilateral trade agreements with the EU in the framework of the European Neighbourhood Policy.

How has the Bologna process developed since 2006?

At the time of the *Bologna Handbook* article in 2006, it was evident that the Bologna process and the Qualifications Directive were not in alignment. Despite attempts by the European Parliament to bring the two realities closer together, the Commission and Council held to the view that streamlining meant precisely what it said. No new elements would be introduced. Nor were reform proposals welcome. Besides, the draft Services Directive – the so-called 'Bolkestein Directive' – was already proving controversial. Academic, professional, regulatory and student bodies tended to regard the Directive as a rampart of legal certainty, on which the voluntary initiatives of Bologna had little purchase.

What has changed since 2006? At first glance, the gulf in legal competence remains the same. The EU continues to have exclusive competence in the management of the internal market and also, therefore, in the matter of the cross-border recognition of professional qualifications. Bologna continues to function as a package of policy imperatives, with which signatory countries fall into line in a manner of their choosing and without fear of legal sanction.

Nevertheless, the situation in 2009 is not what it was three years ago.

- Bologna signatory countries, in general, have enshrined Bologna much more extensively in national or regional legislation, although without consistent regard to the requirements of the Qualifications Directive.

- They have consolidated Bologna's three-cycle qualifications architecture, backing it up with national qualifications frameworks [NQFs].

- They have adopted the European Standards and Guidelines on quality assurance [ESG], which – among other things – prioritise student-centred learning and competence-based curricula defined in terms of learning outcomes.

- They have endorsed the principle of lifelong learning, with a strong commitment to the recognition of prior learning [RPL] and to continuing professional development [CPD], in respect of which the Qualifications Directive has little or nothing to say.

- Finally, they propose to strengthen facilities for the mobility of students and staff, by setting a threshold target to be reached in 2020.

Progress in Bologna has been supported by the European Commission, and specifically by DG Education & Culture, because it is regarded as key to the success of the revised Lisbon Agenda and to the construction of the knowledge economy. The acceleration of the Bologna process has nevertheless sharpened the tensions which characterise its interface with EU legislation. It has also – at least to some extent – displaced them. They now inhabit the Commission and are visible in the policy gap which separates DG Education & Culture and DG Internal Market.

It is therefore unsurprising that DG Internal Market has begun to feel somewhat beleaguered. Under pressure from some of the stakeholders, it has turned its attention to the extent to which the Qualifications Directive might be 're-engineered'.

Article 60.2 requires the Commission to 'draw up every five years a report on the implementation of this Directive'. The review date falls due in October 2012. A window of three years thus exists, in which the alignment of the Directive with aspects of the Bologna process could be attempted. This article will look at some of the issues. The illustrative points made in it are drawn mainly from the sectoral professions and from the healthcare sector in particular. The basic argument, which asserts the desirability of aligning Bologna and the Qualifications Directive by whatever means, nevertheless holds good across the broad range of professions.

To what extent do Member States comply with the Qualifications Directive?

The academic community frequently debates the question of Bologna compliance. By this, it typically means adherence to whatever interpretation of the Bologna precepts has been enshrined in national or regional legislation; Bologna itself cannot command supra-national compliance, since it is not a Treaty. The Qualifications Directive, on the other hand, has force of law. Yet it is rare to hear rectors, students and academics asking how far their government complies with it. Only in occasional headline cases – such as the decision by Austria and Belgium to impose quotas on the numbers of foreign medical and veterinary students – does non-compliance attract publicity.

It may be that HEIs, which provide the training specified in the Directive and which deliver the appropriate qualifications to potentially mobile professionals, assume that their government is in compliance. If so, they may be mistaken. The Commission has the power to institute infringement proceedings and to refer recalcitrant EU Member States to the European Court of Justice [ECJ]. In the period between 2006 and 2009 it has not been reluctant to use this power.

There exist particular instances of infringement. The cases of Austria and Belgium have just been mentioned. Another example is ECJ case C-36/08, which held Greece to be in breach of the Treaty by virtue of its insistence on additional training requirements for incoming general medical practitioners.

But there are also what might be called 'generic' infringements – instances of apparent collective failure by Member States to fall into line. One such is the requirement (articulated in Directive 2006/100/EC) that national lists of professional qualifications be updated to incorporate the equivalent Bulgarian and Romanian qualifications, following the accession of these two countries in 2007. The Commission sent a 'reasoned opinion' (that is to say, the first warning) to 22 Member States in October 2007. In April 2008 it instituted proceedings against Austria, Belgium, Cyprus, France, Greece, Ireland, Luxembourg and Spain. Italy, Poland, Portugal and UK were added to the list later that summer. By the end of 2008, France and Portugal had been deemed to be in breach of the Treaty, while Luxembourg, which had ignored a previous ECJ ruling, was facing a financial penalty.

Such recalcitrance may be studied defiance, or simply – as is more often the case – the dragging of feet of governments grappling with issues of higher priority. In fact, it should be seen against the backdrop of a more spectacular failure to comply. The Qualifications Directive was enacted in October 2005. Governments then had two years in which to transpose it into national legislation and to demonstrate 'forthwith' to the Commission that they had done so. In April 2008, the Commission took Belgium, Czech Republic and Spain to task for apparent failure to transpose. In June, it sent a reasoned opinion to Estonia, Germany, Latvia, Lithuania, Netherlands, Poland, Sweden and UK. A reasoned opinion also went to Denmark in September, while Austria, Belgium, Cyprus, France, Greece, Ireland, Portugal and Spain were referred to the Court of Justice. By October, the Commission's patience had run thin – Germany, Hungary, Luxembourg, Poland, Sweden and UK, were all referred to the ECJ. In November, four more were added to the number: Estonia, Latvia, Lithuania and the Netherlands. Since the recent series of infringement proceedings began, only four Member States have remained uninvolved: Finland, Malta, Slovakia, Slovenia.

Does this extraordinary catalogue of non-compliance mean that the Qualifications Directive is falling into disrepute? Can the apparent disaffection be explained by the fact that governments are waiting for the Directive to be aligned with Bologna? This is unlikely. Bologna and the Directive are, in many countries, handled by different ministries – just as, in the Commission, they are handled by different Directorates-General, and by different Council formations in the Council of Ministers. There is no evidence that the transposition of the Directive is being held back for the sake of congruence with NQFs, most of which are still on the drawing board. Pressure of work and lack of joined-up thinking are the most likely explanations.

Also relevant is that fact that EU governments are labouring hard to transpose the Services Directive – a task they must complete by December 2009. This may cause them to regard the transposition of the Qualifications Directive as a secondary and subsequent activity. In the case of the UK, for example, the successful implementation of the Services Directive has high priority. It is seen as likely to raise the value of output in the service sector by between GBP 4.1b and GBP 6.1b per annum and to increase trade by up to 6.1 %. Prices will fall and employment will rise, with up to 81,000 new jobs being created. Perhaps it makes sense to transpose the Services Directive and then to tailor the transposition of the Qualifications Directive accordingly.

What does this work involve? As part of the process of transposing the Services Directive, each Member State is committed to certain measures. In the words of the UK's May 2009 impact assessment[3], three of these are:

- the establishment of a Point of Single Contact (PSC) through which service providers will be able to find the information and complete the requirements needed for doing business in another Member State
- administrative cooperation between EU regulators, thereby improving supervision across the Single Market whilst reducing burdens to service providers
- provisions for quality of services which should increase consumer confidence in services being provided by firms established in other Member States

These measures will expedite the eventual operation of the Services Directive. They are all relevant to the Qualifications Directive. How, then, might they affect its interface with Bologna?

The point of single contact

The PSC will expedite cross-border service delivery by increasing the volume and reliability of the information necessary to support it. Three initiatives are worth noting. Each features a mobility instrument which could eventually operate in conjunction with the Diploma Supplement and EUROPASS.

[3] Department of Business Enterprise and Regulatory Reform [BERR], Services Directive – Impact Assessment, London, May 2009. See http://www.berr.gov.uk/files/file51323.pdf (accessed July 6 2009)

1. Internal Market Information [IMI]

IMI is designed to facilitate good and rapid communication between national authorities handling professional mobility within the scope of the Qualifications Directive[4]. A first pilot phase involved accountants, medical doctors, pharmacists and physiotherapists. IMI has now been extended to all professional qualifications, allowing the electronic exchange of information between national agencies responsible for the registration of migrant professionals. It permits the checking of qualifications and the screening of criminal records. By the end of 2009, IMI will handle all aspects of inter-agency communication required by the Services Directive.

2. The Cederschiöld Report

Recital 32 of the Qualifications Directive reads as follows:

> The introduction, at European level, of professional cards by professional associations or organisations could facilitate the mobility of professionals, in particular by speeding up the exchange of information between the host Member State and the Member State of origin. This professional card should make it possible to monitor the career of professionals who establish themselves in various Member States. Such cards could contain information, in full respect of data protection provisions, on the professional's professional qualifications (university or institution attended, qualifications obtained, professional experience), his legal establishment, penalties received relating to his profession and the details of the relevant competent authority.

In February 2009, Parliament adopted as a non-legislative resolution the report on the European professional card produced by Swedish MEP Charlotte Cederschiöld[5]. It calls for coordinated action by the Commission to facilitate professional mobility, using the Qualifications Directive, the EQF, EUROPASS and the EURES employment portal in conjunction with one another. It also urges professions to fund the issue of cards which would facilitate cross-border mobility and service delivery, but without imposing burdensome conditions.

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[4] See the presentation made by Nicholas Leapman to the European Parliament in 2007, at http://www.europarl.europa.eu/comparl/imco/speeches/071126_leapman_en.pdf. See also the IMI websites at http://ec.europa.eu/internal_market/interactive_info/imi_en.htm and http://ec.europa.eu/internal_market/imi-net/index_en.html

[5] See the Cederschiöld report at http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+REPORT+A6-2009-0029+0+DOC+PDF+V0//EN&language=EN

3. The HPro Card project

The HPro[6] project, in which a number of regulatory bodies participate, is currently examining the feasibility of the professional card. It covers the five sectoral healthcare professions. While the prime concern is patient safety, the project team sees potential for using the card in the validation of continuing education.

Cooperation between regulators

The historically low level of cross-border service delivery helps explain the otherwise surprising fact that comprehensive networks of sectoral regulators are not already in place. It is true that in some countries regulation is undertaken directly by government and no independent body exists. The imminent coming into force of the Services Directive has nevertheless prompted a flurry of activity. A new Dublin-based European Network of Architects' Competent Authorities [ENACA] has recently come into being[7].

Although they were excluded from the Services Directive, the healthcare professions face comparable challenges, notably in the form of the Commission's Green Paper on the European Workforce for Health[8] and the draft Directive on the application of patients' rights in cross-border healthcare, which is currently in co-decision. FEPI, the European Council of Nursing Regulators, is working to establish an updated database of regulators in its field[9]. The French Order of Midwives and the UK's Nursing and Midwifery Council convened a meeting in May 2009 to establish an informal network of eighteen national midwifery regulators, with a view to deepening understanding of the variety of training regimes within the EU and to improving the sharing of information on the fitness to practise.[10]

The most ambitious and significant initiative is undoubtedly Healthcare Professionals Crossing Borders [HPCB], an informal network of 45 national and EU-level regulatory bodies[11].

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[6] See http://www.hprocard.eu/

[7] See http://www.enaca.eu/

[8] COM(2008)725

[9] See http://www.fepi.org/

[10] See http://pr.euractiv.com/press-release/eu-midwifery-regulators-agree-new-network-9881

[11] See http://www.hpcb.eu/hpcb/index.asp

Quality assurance

Chapter Three of HPCB's 2007 'Portugal Agreement'[12] points out that poor or impaired performance by professionals, following their qualification and registration, lies beyond the scope of the Qualifications Directive. It therefore stresses the role to be played by regulatory authorities in researching and delivering 'competence assurance' in the interest, primarily, of patient safety. Competence is but one of the questions of quality assurance raised in different ways by Bologna and the Qualifications Directive. Others include the co-existence of academic and professional quality assurance agencies, together with their mode of operation at transnational level.

The issue of competence has come to assume great importance. The sectoral professions have become increasingly dissatisfied with the lists of required knowledge and skills set out in Annex V of the Directive. The lists were drawn up in the 1970s and do not reflect contemporary professional aspirations and shifting professional boundaries, scientific and technological advances, or changes in curricula at secondary school level. To these objections the Commission has customarily replied that the purpose of the Directive is to streamline, that the prescriptions are framed at a level of abstraction which accommodates professional and scientific evolution, and that in any case the Directive contains mechanisms for its own modification.

These objections have not prevented – and may even have encouraged – the sectoral training providers, largely inspired by the Tuning Project, to set about building Europe-wide consensus regarding which generic and specific competences are appropriate to each of the three Bologna qualification levels. Pioneering work by nurses within Tuning has been followed up by a number of EU-funded thematic networks: for example, DentEd[13], EHNSA[14] (architecture), Medine[15] and Pharmine[16].

In doing so, the training providers are acting in line with the standards and guidelines on quality assurance set down in ESG, that is to say, with quality assurance processes located on the academic side. The professional bodies, too, have begun increasingly to act in concert at European level. Since October 2008, the European Association of Establishments for Veterinary Education [EAEVE], which has a long-standing tradition of site visits and peer review, has applied to join the

[12] See http://www.hpcb.eu/hpcb/activities/documents/The_Portugal_Agreement.pdf

[13] See http://www.adee.org/cms/index.cfm?fuseaction=page&pID=280&ppID=200

[14] See http://www.enhsa.net/tuning.htm

[15] See http://www.tuning-medicine.com/index.asp

[16] See http://www.pharmine.org/Pharmine/

European Association for Quality Assurance in Higher Education [ENQA]; the Standing Committee of European Doctors [CPME] has drawn up a set of framework guidelines for quality assurance site visits to postgraduate training providers; the European Union of Medical Specialists [UEMS] has announced its intention to set up a European Accreditation Council for Postgraduate Training [EACPT] and has published a set of specifications for the accreditation of e-learning materials; the European Federation of Nurses Associations [EFN] has called for the European accreditation of nursing qualifications, based on criteria defined through stakeholder consultation. Regulatory bodies, in their turn, and whatever their particular remits, will have a strong interest in following these developments and in forming a view of the weight they might carry in future discussions on 're-engineering' the Qualifications Directive.

Debates surrounding the splitting of long integrated training programmes into Bachelor and Master elements, in line with Bologna, have in the past prompted the Commission to pose a pertinent question. Which agency will assure the quality of a training programme which involves a Bachelor in one country and a Master in another? The establishment of the European Quality Assurance Register [EQAR] significantly increases the chances of this question finding a convincing answer.

What of continuing professional development and the recognition of prior learning?

However, none of the above considerations get to grips with two of the issues which most exercise academic, professional, regulatory and students bodies: CPD and RPL. What makes these so strategically important, particularly in the current economic downturn, is that they are key elements of lifelong learning provision, which itself is central to the construction of the knowledge society. The two merit separate consideration, since the implications they have for the interface of Bologna with the Qualifications Directive are not the same.

In the case of the sectoral professions, CPD is 'beyond' the scope of the Directive. In other words, the education and training that follow the acquisition of the basic qualification are superfluous to the satisfaction of the requirement to complete the agreed minimum training. They may well be significant in virtually every other respect. They may have implications for patient safety, fall within the remit of regulators, require accreditation and satisfy a wide range of economic, educational, professional and social objectives, but this is not the business of the Directive. This, at least, is the view of DG MARKT, as expressed by Commissioner McCreevy in answer to a Parliamentary question:

> 'The Commission is aware of the fact that Continued Medical Education (CME) can differ greatly between the different Member States. Not only with regard to its compulsory character but also the ways in which it is implemented and organised. However, the Commission is not aware of the fact that some Member States are currently making use of the American CME Credit system for the mutual recognition of CME courses in Medicine and Physics. Currently, CME credits cannot constitute an obstacle to doctors wishing to establish themselves in another Member State, since the recognition of medical qualifications under Directive 2005/36/EC is based on harmonised minimum training requirements and automatic recognition of medical qualification titles. Member States may impose continued professional development on professionals established on their territory. However, they cannot require it for the purpose of migration, be it on a permanent or temporary basis. The introduction of a binding system of recognition of CME could only be based on minimum harmonised CME standards, in order not to prejudice the automatic recognition of medical professional qualifications. This would require unanimity among all Member States. Nevertheless, the Commission welcomes initiatives taken by and between stakeholders, such as the European Accreditation Council for Continuing Medical Education (EACCME), established by the Union of European Medical Specialists (UEMS), which facilitates recognition of CME events throughout the European Union and helps to bring about more transparency and comparability of CME at national level.'[17]

The argument advanced by some in the healthcare professions is strategic, rather than legalistic. It holds that CPD ought to be covered by the Directive, since concerns over patient safety now demand that healthcare professionals provide assurances of fitness to practise and of revalidation. While this matter in the first instance is the responsibility of Member States, such is the scope for professional and patient mobility – not to mention telemedicine, which delivers virtual healthcare across borders – that it should fall within the remit of the internal market. In this view, CPD is not merely an option open to professionals seeking to better themselves; it is a necessary component of their day-to-day professional practice. A team from the European Observatory on Healthcare Systems and Policies, having reviewed a wide range of different CPD arrangements in a number of EU Member States, observed recently that 'diversity on this scale in the absence of any European legal framework creates obvious problems, and the reasoning that a sufficient level of quality is assured through formal

[17] See http://admin.uems.net/uploadedfiles/1050.pdf

qualifications, as enshrined in European secondary law and followed by the Court of Justice, therefore seems unrealistic'.[18]

In the healthcare professions not all CPD takes place post-registration. As far as RPL is concerned, it is evident that much of it takes place pre-registration. In the case of the general care nurse, for whom the Qualifications Directive prescribes 4,600 hours of training, there is legally no scope whatever for exempting students from elements of the training programme on the basis of recognition of prior learning, whether formal, non-formal or informal. In this respect, the Directive is on collision course with Bologna, the aspirations of professionals and the needs of the labour market.

Only the general care nurse is regarded as a sectoral profession. Other categories, such as (in UK) children's, mental health, and learning disabilities, fall into the general system. The qualifications grid against which their professional attainments are set in the event of cross-border mobility was purpose-built in 1989. Certainly, it allows host Member States to make their own assessment of the qualifications of incoming professionals, which may include elements of recognised prior learning. It nevertheless pre-dates the Bologna process by a decade and in the context of the European Higher Education Area [EHEA] looks eccentric. Its HE levels contain a significant ambiguity resulting from a political compromise won by the UK during the Luxembourg presidency. It is not referenced to ECTS, EUROPASS or EQF. Indeed, DG MARKT expressly advises relevant parties as follows: 'When national authorities receive an application for the recognition of a qualification with a view to accessing a regulated profession, the examination of such a qualification must be done exclusively by applying Directive 2005/36/EC. No use can be made of the EQF level in which the qualification will be classified.'

DG MARKT's legalistic posture is intelligible – it has exclusive legal competence and, in the field of the recognition of professional qualifications, is bound to represent the Commission as the guardian of the Treaty. Its reluctance to accede to demands for new legislation is equally understandable, given the requirement of unanimity in EU27 and the complexity of the issues. The current situation is nevertheless one of malaise, exacerbated by the looming crises in EU healthcare provision. One glance at DG SANCO's Green Paper on the European Workforce for Health is sufficient to reveal the urgent need for clarification, facilitation and legal certainty. These are just some of the areas identified for potential action:

[18] Mossialos E et al, Health Systems Governance in Europe: the role of EU law and policy, draft version p. 271, presented to a DG SANCO conference in Brussels December 2008; forthcoming, European Social Observatory.

- Considering recruitment and training campaigns, in particular to take advantage of the growth in the proportion of over-55s in the workplace and those who no longer have family commitments
- Providing for a more effective deployment of the available health workforce
- Considering "return to practice" campaigns to attract back those who have left the health workforce
- Focusing on health professionals' continuous professional development (CPD)
- Developing training courses to encourage the return to the workforce of mature workers
- Providing management training for health professionals
- Fostering the cooperation between Member States in the management of *numerus clausus* for health workers and enabling them to be more flexible
- Developing possibilities for providing language training to assist in potential mobility
- Creating an EU mechanism e.g. an Observatory on the health workforce which would assist Member States in planning future workforce capacity, training needs and the implementation of technological developments
- Fostering bilateral agreements between Member States to take advantage of any surpluses of doctors and nurses
- Investing to train and recruit sufficient health personnel to achieve self-sufficiency at EU level
- Encouraging cross-border agreements on training and staff exchanges, which may help to manage the outward flow of health workers while respecting Community law
- Promoting "circular" movement of staff (i.e. staff moving to another country for training and/or to gain experience, and then returning to their home countries with additional knowledge and skills)
- Ensuring suitable training to enable health professionals to make the best use of new technologies
- Making more use of the support offered by structural funds to train and re-skill health professionals
- Improving the use of the structural funds for the development of the health workforce

The action points set out above are only part of a long agenda. They explain why UEMS has called explicitly for the urgent revision of the Directive, in respect of the duration of training, the designation of specialties, and the specification of new competences. They show why the Council of European Dentists [CED] wants the Directive to be updated, in order to bring into the basic skills set such things as management, how to deal with ethnically diverse patients, and second language competence. And why EFN, in conjunction with ENSA, ESNO and ICN, demands synergy between the Directive, Bologna and the EQF.

What does it mean to 're-engineer' the Directive?

The term 're-engineering' came into conversational usage at the point when it was realised by the broad range of stakeholders, including DG MARKT, that the Qualifications Directive would have to evolve. The utility of the term is that it specifies the end without specifying the means. This is important, because it is essential at this stage not to close off particular options. What are the options?

The first is to draft and enact new legislation. This is ambitious and uncertain: ambitious, because of the sheer complexity of the matter; uncertain, because as the situation stands at the time of writing (July 2009), it is not known under which Treaty the legislative process would take place, nor with what complexion of Commission and Council, nor with what committee formation in Parliament. New legislation might be required were the healthcare professions ever to be hived off completely, something which was assumed to be about to happen when they were excluded from the scope of the Services Directive. The new draft legislation on patients' rights, however, does not point in this direction.

The second option is to amend the Directive. As Commissioner McCreevy has pointed out, however, this requires – at least in some circumstances – the unanimity of 27 Member States. This is a daunting prospect, one not to be embarked upon without complete confidence in the outcome.

A third option is to 'adapt' the Directive. Adaptation is a formal process, which falls short of amendment and does not require any legislative procedure to be initiated. Instead, changes can be made by comitology – that is to say, by the multi-formation advisory Committee set up by the Directive, and which has access to expert opinion. A new Regulation 1137/2008[19] has, in fact, already amended the text of the Directive, precisely to allow comitology to adapt its 'non-essential' elements. These are elements which are not essential to the structure and to the fundamental purpose of the Directive. They include such

[19] See http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:311:0001:0054:EN:PDF

items as the skills and knowledge required of each sectoral profession; the introduction of new medical specialties; and the minimum periods of training. However, the Commission, through the Committee, can adapt only in the light of 'scientific and technical progress'. Whether this concept embraces reforms of the type promoted by the Bologna process is uncertain and would have to be the object of debate and political agreement.

There exist further opportunities to modify the Directive. Recital 29 allows the Commission to consider drafting an amendment to the sectoral provisions, on receipt of a reasoned request from 'a national and European-level professional organisation or association'. To assist the evolution of the disparity management which constitutes the general system, the Directive introduced the concept of the common platform. This is the set of agreed criteria which determine the compensation mechanisms to be used by the host Member State when dealing with an application from an intending incoming professional. These criteria depend on the degree of variation between the qualification frameworks of the Member States regulating the profession concerned. Article 15 says that the differences shall be identified by comparing the content and duration of training in at least two thirds of Member States, including all those in which the profession is regulated.

Thus far, it is not clear to the observers outside the Commission what mix of measures might be used to approach the tasks of re-engineering the Directive and of aligning it with Bologna. One important prerequisite is that some consensus emerge from the academic, professional, regulatory and student bodies active in the field. This is urgent, given the timeframe.

Is there a window of opportunity?

The Qualifications Directive came into force in October 2007. It comes up for review in 2012. It is worth recalling Parliament's First Reading of the original draft in 2005, one passage in which read as follows:

Amendment 218

The Commission shall evaluate 5 years after the entry into force of the Directive the workability in practice of the level [i.e. general] system […] If in practice the level of qualifications of the diplomas shows an evident difference between the Member States, the Commission will come forward with proposals for a points and credit system linked to the quality and contents of the education and professional training in the different Member States. The Committee referred to in Article 54 shall supervise the allocation of points to the various training courses.

The Bologna instruments now in place would allow this work to be done. This therefore remains a possibility. However, there is scope for informed debate well before 2012. Member States are required to make biennial reports on the operation of the Directive – in a series beginning in October 2009. These could usefully be fed in to the Bologna stocktaking exercise. Flanders and Ireland, which are currently conducting impact assessments of their implementation of Bologna, could lead the way by drawing conclusions relevant to both Bologna and the Directive. In 2010, Parliament's Committee on Internal Market and Consumer Affairs [IMCO] (if indeed it continues to exist in the same form in the new Parliament) will itself conduct an impact assessment of the implementation of the Directive. In 2011, the first review of the implementation of the Services Directive is scheduled to take place. Finally, there will be the Bologna stocktaking in Bucharest in 2012. Not only, therefore, is there a three-year window in which to look again at the Qualifications Directive, but there is also a guarantee of ongoing focus and analysis in the interim. It is crucial that all stakeholders participate fully in the debates.

List of acronyms

CED	Council of European Dentists
CME	Continuing medical education
CPD	Continuing professional development
CPME	Standing Committee of European Doctors
EACCME	European Accreditation Council for Continuing Medical Education
EACPT	European Accreditation Council for Postgraduate Training
EAEVE	European Association of Establishments for Veterinary Education
ECJ	European Court of Justice
ECTS	European Credit Transfer and Accumulation System
EEA	European Economic Area
EFN	European Federation of Nurses Associations
EHEA	European Higher Education Area
EHNSA	European Network of Heads of Schools of Architecture
ENACA	European Network of Architects' Competent Authorities
ENQA	European Association for Quality Assurance in Higher Education
ENSA	European Nursing Students Association
EQAR	European Quality Assurance Register

ESG	European Standards and Guidelines for Quality Assurance in Higher Education
ESNO	European Specialist Nurses Organisations
FEPI	European Council of Nursing Regulators
GBP	UK pound sterling
HEI	Higher education institution
HPCB	Healthcare Professionals Crossing Borders
ICN	International Council of Nurses
IMCO	Committee on the Internal Market and Consumer Affairs
IMI	Internal Market Information
MEP	Member of the European Parliament
NQF	National qualifications framework
PSC	Point of single contact
RPL	Recognition of prior learning
UEMS	European Union of Medical Specialists

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Linking the Bologna process and other European processes

The recognition of professional qualifications