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The Impact of the European Union on Nursing in the UK

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Background

In summer 2012 the UK Coalition Government announced a two year programme of reviews of the EU's competence in a number of areas, including health, compared with the UK's own powers. The results of these consultations are intended to inform any future Government proposals for changing the balance of these competences and potentially negotiating a "repatriation" of powers from the EU.

This review and the wider political debate on the UK's future position in Europe, including the commitment to a referendum on EU membership post 2015, formed the backdrop to the European parliamentary elections which took place in May 2014. It is important for the RCN and its membership to be aware of the areas in which the EU has powers and how its use of these powers have influenced nursing and health services in the UK.

This briefing outlines the most significant issues and also provides more detail in the annexes on the RCN's key European alliances and on how the EU institutions work.

The EU and Why it Matters

Today the European Union has 28[1] countries in membership and a number of other countries are in talks with the EU about becoming members, such as Serbia, Albania, Iceland and Turkey. Before joining, every nation must amend its laws to match EU treaties and incorporate new legislation agreed by the EU through their national parliaments. It is estimated that about half the legislation adopted nationally today originates at EU level.

Historically, the EU was largely focused on economic, trade and industry policies and on creating a single European market. This has been balanced over recent years by a stronger social dimension to secure better employment rights and working conditions and address some of the inequalities within and between European countries.

The EU can only act in areas where the European Union treaties have given it "competence" to do so. Often what it can do in each of these areas is clearly defined. A formal remit in health policy was only introduced in 1993 and is largely restricted to "public health" measures and "health protection", although this has since been expanded to ensure a "high level of health protection in the definition and implementation" of all EU policies. Responsibility for the organisation, delivery or financing of health services remains with national and local authorities and is specifically excluded from the EU's remit[2]. However, in practice many initiatives related to other EU policy areas (particularly the single European market) do impact on health service delivery in the UK, including

[1] Current member states are Austria, Belgium, Czech Republic, Bulgaria, Croatia, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom.

[2] Article 168 (Public Health) of the European Treaty states that individual member states retain responsibility for the "definition of their health policy and for the organisation and delivery of health services and medical care", including the "management of health services and medical care and the allocation of the resources assigned to them."

free movement of patients and professionals; public procurement; manual handling policies and standards for medical devices. For those countries, which are part of the Eurozone[3], there are even wider implications from economic policies targeting public sector spending.

EU policies and legislation have had a major impact on policy issues that directly impact on nurses' working lives, such as employment rights; equal opportunities; health and safety at work; environmental and consumer protection. As an EU member country, we are also part of a system for recognising nurses' qualifications, which allows UK nurses to practise in other European countries and lays down common minimum standards for nursing and midwifery education across the EU.

Key Areas of EU Competence Affecting Nursing

Given the significant areas of EU policy, legislation and activity that impact on the health sector in the UK, the RCN has for many years worked directly with the European institutions and in collaboration with similar organisations in other European countries to influence EU decision making and share information and experience. As part of this work, the RCN regularly responds to European Commission consultations and seeks views from its members on significant pieces of legislation. The most significant aspects of the EU's powers relevant to nursing are:

- Public health
- EU's social dimension
- Free movement of people
- Other health workforce issues

Public Health

Article 168 of the EU Treaty defines the EU's role in public health, which is largely to support and complement national governments' actions. It is only in very specific areas, such as quality standards for medical products and devices; and for organs, blood and blood derivatives, that the EU and the UK share competence.

The EU's powers allow it to adopt measures to protect and improve health, particularly in relation to cross-border health threats, such as infectious diseases, but also specifically in relation to tobacco and alcohol abuse. However, harmonisation of legislation at EU level on public health grounds in these fields is ruled out.

In fact the EU has far weaker powers in relation to public health than its powers to improve the way the single European market (or internal market) operates, although the EU Treaty requires that *"a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities"* including internal market legislation.

An area of public health where the EU has been able to make a significant impact has been on tobacco control, with the introduction in 2003 of legislation banning tobacco advertising and

[3] EU countries which have adopted the Euro as a common currency: Austria, Belgium, Cyprus, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Malta, Netherlands, Portugal, Slovakia, Slovenia, Spain.

promotion and in 2009 adoption of recommendations on protecting people from exposure to smoke. The most recent EU initiative in 2013 has been to propose updating existing EU tobacco products legislation based on recent developments including the popularity of e-cigarettes. All of these initiatives have been supported by the RCN.

The EU's Social Dimension

The Lisbon Treaty clearly affirms Member States' responsibilities for defining health policies and for organising, managing, delivering and allocating resources to health services and medical care. However many other EU competences impact on health service delivery in the UK, in particular those relating to the functioning of the single European market and its social dimension, designed to ensure minimum social and employment standards. This is an area of significant importance for the RCN and its membership.

Initiatives relating to the protection of employees have formed part of the European Community's role since its inception, although largely justified by the need to ensure fair competition within the Community. The Single European Act (1989) which launched the single market, strengthened Europe's role in adopting health and safety at work measures, and extended the areas of social and employment policy that no longer required unanimous agreement between member states.

In 1999 the UK finally signed up to the so called "Social Chapter", as part of wider EU treaty changes, having previously negotiated an opt out. This reinforced the EU's social dimension. One of the important innovations of the Social Chapter was to introduce a system called "social dialogue" for involving the social partners – trade unions and employers representatives –in EU decision making. The RCN is formally part of these negotiations as a member of the European Federation of Public Service Unions (EPSU).

The current EU Treaty also contains a social clause, similar to the health protection provision, to ensure a high level of employment and social protection are taken into account in defining and implementing other EU policies.

An increasing proportion of UK employment law originates in the EU and provides important protections for nursing staff. These include EU wide rules governing information and consultation on collective redundancies, safeguarding employment rights in the event of transfers of undertakings under the TUPE legislation and, through social dialogue negotiations, agreement on equal rights for part-time workers and those on fixed term contracts in access to training and annual leave, for example.

The EU's key health and safety related directives also provide a legal framework for employers to reduce the risks of musculoskeletal disorders, biological hazards, stress and violence to health care staff. The implementation of the EU's manual handling directive heralded the introduction of hoists and other lifting equipment in healthcare settings and has significantly reduced the risks for nurses and patients. The European working time directive also emanates from the EU's competence to address health and safety at work and reduce fatigue within the nursing workforce through long working hours, lack of rest breaks and poorly managed shift rotas. The RCN strongly supported its adoption in the 1990s and subsequent attempts at updating. As part of the social dialogue, the RCN was also instrumental with other health unions in gaining agreement on a framework for preventing sharps injuries to healthcare workers, adopted in 2010.

On equalities issues, the right to equal pay for equal work between men and women was enshrined in the original Treaty of Rome (1957) as part of the social and employment provisions of the new Economic Community. In 1999 this was extended to "equal pay for work of equal value" and a new competence was introduced for EU action, with the agreement of all member states, to combat discrimination not just on the grounds of sex, but race or ethnic origin, religion, disability, age or sexual orientation.

Equal pay and equal treatment legislation agreed at European level and implemented in the UK have influenced pay, terms and conditions in the National Health Service so that roles predominantly carried out by women are not discriminated against. Equal pay requirements were a driving factor behind the development of the Agenda for Change pay terms and conditions agreement for NHS staff, which ensures equal pay for work of equal value for nurses and healthcare assistants working for the NHS.

Equal pay legislation has also been very important in outlawing discrimination in occupational pension schemes in the UK including the NHS pension scheme, ensuring equal access to the scheme for part-time nursing staff

Free Movement of People – Health Professionals and Patients

Facilitating the free movement of workers was one of the cornerstones of the original Treaty of Rome establishing the European Economic Community. Initiatives included the introduction of legislation for the mutual recognition of health professionals' qualifications in Europe, based on minimum standards of education across the EU. For nursing, this defines minimum hours of education, the theory/practice split and a set of subjects to be covered. The overarching legislation now covers over 800 professions and was founded on the EU's internal market competences rather than its public health remit, which created some tensions in relation to the balance between free movement objectives and public protection.

Under the current revision of the directive, agreed in autumn 2013, the RCN has sought the strengthening of public protection measures such as clear ability of health regulators to make language checks for all EU nurses, and a duty to alert other regulators if a health professional has been banned from practising in any member state. The RCN and the European Federation of Nurses Associations (EFN) has also pushed for the minimum requirements in the directive relating to nursing to be aligned with today's expectations of nurses as autonomous practitioners who assess and respond to patients needs, develop and manage services, and apply the current evidence base to their practice.[4]

The directive has been an important lever for raising standards in nurse education in countries wishing to join the EU, and in women's access to further education[5] and it has provided some assurances on patient safety. Given its early adoption, it provided a focus for national nursing organisations to begin to contribute collectively to shaping European legislation and has led to collaboration on other EU nursing and health issues.

[4] RCN Response to draft EU Professional Qualifications Directive 2011
http://www.rcn.org.uk/__data/assets/pdf_file/0003/434928/RCN_response_to_December_2011_Mutual_Recognition_of_Professional_Qualifications_legislative_proposals.pdf

[5] http://www.euro.who.int/__data/assets/pdf_file/0004/154516/Eurohealth_Vol-17_No-4_web.pdf

Despite the restrictions on the EU's role in determining the financing, organisation and delivery of health services, it has applied its competence in relation to free movement of people to develop rules, which more directly impact on patients' access to health services within Europe.

One of the early provisions under the EU's competence in relation free movement of workers and social security was to provide access to certain benefits when an EU citizen, who would have been covered by social security legislation in their home member state, was working in another EU country. The categories have been extended over time from workers to cover those visiting or residing in another member state.

Regulations adopted under this provision mean that there are reciprocal arrangements between member states for access to emergency care when visiting another EU country, for pensioners living in another member state (for example, UK pensioners in Spain), and for home health services to send a patient for planned treatment in another country (for example, when highly specialised care is required). UK nationals benefit from these arrangements if they are visiting or living in another EU country, including through the European Health Insurance Card (EHIC).

Under the EU's competence to facilitate free movement and access to services, some patients have also taken their cases to the European courts to seek reimbursement for planned treatment they have chosen to have outside the member state they are living in. Given the confusion about these rights, the European Commission and member states have sought to introduce a clearer legal framework.

To achieve this, the patients' rights to cross border care directive was adopted in 2011 and is due to be implemented in the UK in autumn 2013. It allows patients to seek care in another EU country for a treatment they would be eligible for at home and be reimbursed up to the amount that such treatment would have cost in their home member state. The RCN gave the legislation a cautious welcome as it clarified what patients' rights were but was concerned about a range of issues, including continuity of care and the impact on planning and provision of services domestically.

Other Health Workforce Issues

As part of the EU's public health remit national governments are also encouraged to work together voluntarily on health issues and the European Commission can also initiate work to share good practice and establish guidelines. These non-legislative initiatives provide a means for member states to discuss issues related to health services and agree work funded through the Commission's modestly funded public health programme.

Significant non-legislative developments include a variety of initiatives directly connected to the European health workforce, outlined in an action plan issued in 2012, following a previous green paper in 2009 to explore potential areas where the EU could add value[6].

The EU health workforce action plan, and in particular the joint action on health workforce planning which commenced in 2013 for two years, offers an opportunity for all member states to share data, experience and best practice in relation to addressing the complex issues surrounding their own

[6] RCN Response to EU green paper on the European workforce for health 2009 http://www.rcn.org.uk/__data/assets/pdf_file/0003/306147/Response_to_the_Green_paper_on_the_EU_nursing_workforce_final.pdf

health care workforce as well as the EU workforce as a whole. Such initiatives should also encourage member states to think about the health professional workforce from a global as well as European perspective and to look at innovative ways to retain their workforce, for example through ensuring a healthy health workforce by developing effective occupational health measures and guidelines. These initiatives need to be informed by both front line professionals and health system managers alike. The RCN is involved in this work through its European alliances, EFN and EPSU, and through its UK links with national health workforce advisory arrangements.

Conclusion

Overall, many EU initiatives have heralded important improvements in nurses' working lives here in the UK and across Europe. Whilst the RCN has not always agreed with all the detail of individual legislative proposals it has always sought to engage constructively and negotiate with EU policy and decision makers, both directly and in collaboration with our European alliances, to seek changes, where we think these are necessary. Working at European level has also heralded much closer cooperation between counterpart nursing organisations and greater understanding and sharing of best practice to deliver better health services and improve health.

The RCN does not currently see the need for an expansion of EU competences, nor would it want to see repatriation of the EU's existing powers in relation to health or social affairs. However, the balance between differing EU competences, whose objectives at times may conflict with each other, do need to be addressed. In particular health and social concerns have sometimes been overridden by a strongly market orientated approach in Europe, particularly focused on completing the single European market. The prime consideration for health services in the UK should be to serve the needs of the population and not the liberalisation of services in the EU.

Similarly, in considering recognition of health professionals and their ability to practice in another EU country, precedence has often been given to "removing barriers to free movement" rather than considering the paramount importance of patient safety and public protection. It is also important to ensure that at a time of economic downturn in Europe with a focus on austerity measures and EU policies to boost growth and trade, the EU does not neglect public health concerns designed to improve the health of the population. Given that health is influenced by so many other areas of EU intervention such as environmental policy, agriculture, consumer protection and transport, the EU's health in all policies approach and its remit to *"ensure a high level of health protection"* should be more actively pursued in relation to public health and patient safety implications of its legislation.

The RCN has strongly supported the provision of decent standards of employment and working conditions across the EU as a contributor to economic prosperity and health and wellbeing. The European Commission estimates that the health and social care sector represents on average about 10% of employment in each member state, so this contribution is not insignificant[7]. The RCN would not to want to see a weakening of the EU's functions in continuing to uphold these standards or a repealing of existing social provisions, including social dialogue, in the hospital and health care sector.

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[7] Ibid

ANNEX 1

THE RCN 'S EUROPEAN ALLIANCES

EU action needs to be considered for its impact across 28 different member states, but also provides immense opportunities for learning and for this reason the RCN works closely within a number of key European alliances to help shape EU policy and legislation. The RCN works jointly with nursing and health organisations in its European alliances, such as the European Federation of Nurses Associations (EFNA), the European Public Health Alliance (EPHA), the European Federation of Public Service Unions (EPSU) to influence the European Commission and other key institutions at an EU level.

A summary of the key organisations that the RCN is a member of are outlined below:

The European Federation of Nurses Association (EFN)

Established in 1971 as an independent body, it brings together nurses' associations in the present EU countries, the accession countries and Norway, Iceland and Switzerland to represent nursing interests with the EU. Established a Brussels office in 1996 and since 2002 has a full-time General Secretary based there.

European Federation of Public Service Unions (EPSU)

Made up of public sector trade unions across the EU, including Unison, GMB, Unite and Amicus from the UK. The RCN joined in 2000. EPSU acts as a committee of the European Trade Union Confederation (ETUC) in the social dialogue negotiations to reach collective agreements at European level. EPSU is also involved in negotiations between employers and trade unions in the hospital sector.

European Public Health Alliance (EPHA)

Formed in 1994 after public health became a specific competence of the EU. EPHA brings together about 80 non-governmental and not-for-profit organisations from across Europe, including professional and patient groups, health promotion agencies and academic institutions. It monitors and disseminates information on EU developments and lobbies on public health/health protection issues.

European Health Management Association (EHMA)

A network of policy makers, senior managers, academic and research institutes, professional organisations and health care providers. It seeks to improve health through better management by exchanging experience and co-ordinating research projects to inform EU policy.

ANNEX 2

How the EU Works

The EU has no single government and its three main decision-making bodies do not equate directly to any institutions within the UK's political system.

The ***European Commission*** is the nearest institution to the civil service but it is much more influential because it develops proposals for new laws and policies, oversees their implementation in the member states and administers much of the EU's expenditure. It is a relatively small but open organisation and depends on external expertise to help shape policies. It is headed by 27 Commissioners, including the Commission President José Manuel Barroso, who are appointed by national governments. Their role is not to protect the national interest but to do what is best for Europe as a whole. For this reason, the European Commission often prefers to work with pan-European alliances, many of which now have offices in Brussels, where most Commission services are based.

The ***European Parliament*** is the only directly elected EU institution and is currently made up of 754 MEPs elected every five years. Originally, it was "consulted" on the proposed legislation but it has gained more power over the years. It now "co-decides" with national governments on many issues, including public health, environment and free movement of workers, what final shape the legislation should take.

In the UK, the 72 MEPs are elected for a particular region and there are a minimum of three MEPs in any region[8]. The latest vote took place in May 2014 and so the next election is likely to be sometime in 2019. A comprehensive RCN briefing on the results of the 2014 election and the implications for nursing can be accessed here: http://royalnursing.3cdn.net/82c3aba3cdcd15f36a_sem6b9h58.pdf.

MEPs see themselves as the most direct link between individual citizens and the EU. They are more interested than the European Commission in the consequences of EU proposals for their region and country and in any potential opportunities, e.g. funding, business links, development opportunities.

Within the European Parliament, most MEPs are organised into wider political groups and are allocated to different permanent committees (such as the Environment, Public Health and Consumer Protection Committee or the Women's Rights Committee). This is where one of the MEPs from the relevant committee, the "rapporteur", drafts the European Parliament's amendments to a particular European Commission proposal. This report is then voted on by the

[8] To find out who your MEPs are in the UK, their background and their contact details see: http://www.europarl.org.uk/view/en/your_MEPs.html

committee and then by the whole Parliament. But it is the Council of Ministers that finally adopts legislation.

MEPs also have other powers, for example over agreeing the EU budget, or in calling the European Commission to account by submitting written or oral questions to European Commissioners and by approving their appointment.

The ***Council of Ministers*** is where national governments are represented by the relevant national minister for that particular Council meeting (e.g. Economic and Finance Council, or Employment, Social Affairs and Health Council). On some issues the Council of Ministers still has the final say (such as economic and monetary policy) but on many if it disagrees with the European Parliament's report then the two institutions have to go into conciliation and hammer out an agreement. Most voting in the Council of Ministers is now by qualified majority. This means that no one country can block a proposal, but the bigger countries have more votes than the smaller ones. In practice, governments try to reach compromises amongst themselves or trade off one concession against another. The Council of Ministers meetings are chaired by whichever country has the rotating six-month EU Presidency.

UK ministers are supported in the Council of Ministers by an outpost of the UK civil service or embassy in Brussels called the United Kingdom Permanent Representation to the European Union (UKREP). These civil servants get involved in the detailed discussions on a proposal in preparation for ministerial meetings.

The Council of Ministers should not be confused with the ***European Council*** (the official name for summits of EU leaders held every three months) or the ***Council of Europe***. This is a separate organisation of 47 countries established to promote democracy and human rights and is based in Strasbourg (it developed the European Convention on Human Rights and the associated European Court on Human Rights).

The European Union has also developed a process for formal negotiations between trades unions and employers at European level, called the ***social dialogue***. Instead of agreements and legislation being reached between the European Commission, European Parliament and Council of Ministers, the social partners can negotiate directly with each other and adopt collective agreements. The RCN is involved in this process as a member of EPSU, which acts as a committee of the European Trade Union Confederation (ETUC) on public service issues. These can then also be turned into EU law with approval from the Council of Ministers. This is how EU legislation on paternity leave, part-time workers and most recently protection against needlestick injuries for health workers were agreed.

The ***European Court of Justice*** settles disputes on behalf of individuals and between member countries and the European Union. The judgements it hands down can set precedents that member states must implement and the ECJ can issue infringements against them for not

implementing EU legislation. It is the highest court in the European Union and can overrule national supreme courts.

The EU's official website provides information on the institutions, existing EU legislation, EU citizens' rights and current policy and legislative initiatives.