DEVELOPMENTS IN the European Union (EU) have provoked questions about how closer European integration will affect the authority and autonomy of nation states already in Europe (Hooghes and Marks 2002, Liebfried and Pearson 2000).

Nursing in the UK is self regulated; the nature and function of the profession is ostensibly controlled by the nation state but through a state sanctioned regulator, namely the Nursing and Midwifery Council (NMC), which sets standards of conduct and competence for registrants in order to protect the public. But this control is in fact limited and constrained by the EU.

The regulation of UK nursing

Nursing in the UK has been a statutorily regulated profession since 1919, and the NMC is the current regulatory body. Its purpose is to establish and improve standards of nursing care in order to serve and protect the public.

The NMC is elected and funded by the profession. It maintains a register of qualified nurses, sets standards for education, practice and conduct, provides advice on professional standards, and considers allegations of misconduct or unfitness to practice due to ill health. Registration is required to work in the UK as a nurse.

The relationship between the state and nursing in the UK is close, both because the profession is regulated through statute so that major changes to the profession must be approved by parliament and because most nurses work in health services that are provided and funded by the state.

The government departments of health throughout the UK offer guidance concerning the nature and scope of practice through specific policy documents such as the nursing strategy, Making a Difference (Department of Health 1999), and national service frameworks, which, in addition to identifying the standards of service provision the public can expect, also identify the role and competencies of the professionals involved in delivering services (DoH 2000a).

Indeed, even in non-state provided or funded services such as private nursing homes, the government stipulates, for example in the 2000 Care Standards Act (DoH 2000b), the nursing roles and staffing structures required.

Despite this apparent control over nursing by its professional body and the nation state, the EU has already had a significant impact on the essence, structure and function of UK nursing. It may even pose challenges to the sustainability of national nurse regulation particularly because, from a global perspective, ‘more and more, the word regulation has taken on negative connotations in public debate and policy discussions... [and] is now increasingly associated with central control, unreasonable bureaucracy and restraint in international trade and worker mobility’ (Styles and Affara 1999).

Meanwhile, European institutions such as the Council of Ministers and the European Court of Justice are increasingly displacing national institutions as the principal loci of policy change (Sabatier 1998).

The European Union

The UK, along with Denmark and Ireland, became a member of the European Community (EC) on January 1, 1973 after a long process of discussion, debate and negotiation. The EC developed from the European Economic Community (EEC), which came into existence in 1957 following the Treaty of Rome and had six original members: Belgium, France, Italy, Luxembourg, the Netherlands and West Germany. This treaty aimed to develop a common market in which member states could move goods, capital, services and people freely.

Under the terms of the 1972 European Communities Act, which was passed as a condition of joining the EC, European regulations and directives take precedence over UK law.

The EC grew in size with successive waves of accessions: Greece joined in 1981, Spain and Portugal in 1986. In 1992, the Maastricht Treaty introduced new forms of co-operation between the governments of the member states on defence, justice and home affairs, and created the European Union (EU). Austria, Finland and Sweden joined in 1995. A further ten countries joined on May 1 this year: Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.

Community legislation consists of regulations, which are legally binding, directly enforceable laws made by the Council of the EU, and directives, which are also legally...
binding but more flexible and allow national governments to draft laws to take account of different national traditions and socio-economic conditions (Wallace 2000).

The European Commission is a permanent ‘civil service’ headed by a team of politicians, or commissioners, who initiate EU policy, act in the general interest of the EU and ensure that EU policies and laws are implemented. Each commissioner is responsible for a particular policy area; for example, the commissioner responsible for health policy is David Byrne.

The European Parliament (EP) is composed of Members (MEPs) directly elected by EU citizens. The EP does not initiate but amends policy, and EP approval is required for all EU laws and spending decisions (Duncan 2002).

Education and training

The EU Health Policy Forum (2003) notes that Article 3 of the Treaty of Rome states that the ‘internal market [is] characterised by the abolition, as between member states, of obstacles to the free movement of goods, persons, services and capital’.

In addition, Article 152 of the same treaty lays down that ‘a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities’.

In 2000, the Lisbon European Council set, as a target, that the EU should become the most competitive and dynamic knowledge based society in the world by 2010. High quality education and training, best use of human resources and developing flexible labour markets are seen as key to achieving this objective. Consequently, European Commission directives covering nursing are intended to ensure that training and qualifications comply with agreed minimum standards throughout the EU, and this allows nursing regulators in the member states, such as the NMC, to have confidence in giving automatic recognition to qualifications held by migrants from other member states so there can be free movement of nurses across the member states.

Since 1977, UK nurses have been involved in setting training standards for nurses in the EU through the Advisory Committee on Training in Nursing (ACTN), an officially recognised body that advises the EU on shaping, updating and harmonising requirements for nurse education and training so that nurses can practise throughout the EU.

Each member state appoints three ACTN members: one to represent its nursing schools, one to represent its nurse licensing authority – the NMC for example – and one to represent its nursing unions – in the UK, the RCN.

However, despite the work of the ACTN, there remain across the EU considerable differences in the numbers of nurses per head of population and their function, autonomy and scope of practice (Tornquist 1997).

EU impact on UK nursing

Most EU countries offer only general nursing qualifications, whereas the UK registers four distinct types of nurses: adult (general), child, mental health and learning disability.

In 1977, EC member states agreed two directives with significance for nursing that are still extant. The first, 77/452/EEC, concerns the mutual recognition of diplomas, certificates and other evidence of formal qualifications for a range of professions including nursing responsible for general care. This aimed to help the movement of professionals in the EEC, in line with one of the basic rights of individuals living here, namely ‘freedom of movement’.

The second, 77/453/EEC, specifically concerns the minimum standards for training nurses responsible for general care. This directive, enacted in the UK through a statutory instrument, the 1983 Nurses, Midwives and Health Visitors Rules, stipulates that preparatory courses must comprise 4,600 hours of practical and theoretical instruction, and identifies the subjects to be studied and the type of clinical instruction required.

General nurses who have completed programmes of study that meet the EU requirements can automatically register in any EU country. Registration in the country of employment is essential to work there.

Courses in general care nursing in the UK already meet the EU requirements as laid down in the 1977 Nurses, Midwives and Health Visitors Act, but qualifications in children’s, mental health and learning disability nursing are perceived by the
Influencing the EU

High profile events such as the Bristol Royal Infirmary inquiry and the case of GP Harold Shipman have challenged the value of professional self regulation, but it is difficult to pinpoint, it is clear that the Commission takes their input seriously'.

On the other hand, the response of the nursing profession was declining because their existence is seen as a barrier to the desired labour mobility (European Commission 2000).

The EU has an agenda to哐ing nurses is declining because their existence is seen as a barrier to the desired labour mobility (European Commission 2000).

A recent European Commission report, for example, celebrates the fact that the number of such 'specialist' nurses is declining because their existence is seen as a barrier to the desired labour mobility (European Commission 2000).

The UK's health and social care regulators joined forces to maintain a regulated standard of education and training. Such perceptions and concerns have resulted in the establishment of its own press release on this issue, headlined 'Mutual Recognition of Professional Qualifications: A Success Story' (RCN 2003).

We are pleased that the regulators have recognised the professionalism of the people in charge and have not been deterred by the threats this directive poses and are prepared to take action' (AURE 2002).

In a parallel initiative, the Standing Committee of Nurses of the EU, recognised by EU institutions as the voice of nurses in the European arena and, while their power is limited, it is clear that the Committee recognised the importance of professional regulation in the education and training of nurses, and that they have managed to increase their credibility by securing the support of the Patients Association (PA) to raise awareness of their concerns.

The Standing Committee of Nurses of the EU 2003). As a result the Committee has been able to lobby other European countries in how it educates its nurses. It has also managed to increase its credibility by securing the support of the Patients Association (PA) to raise awareness of their concerns.

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Despite their often different agendas, the participating organisations have all, on the grounds of 'patient safety', rejected a proposal in the directive that healthcare professionals should be allowed to work for up to 16 weeks a year in the UK without being registered with the relevant regulatory bodies before taking up employment, and that member states should exchange information about action taken against professionals listed on their registers. This last amendment should ensure that nurses found guilty of professional misconduct in one EU country cannot practice in another (Batty 2003, Watson 2004).

In a parallel initiative, the Standing Committee of Nurses of the EU (SCNE) has been able to lobby other European countries on how it educates its nurses. It has also managed to increase its credibility by securing the support of the Patients Association (PA) to raise awareness of their concerns.

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individuals who wish to move from one jurisdiction to another. The vote is good news for patients throughout the EU (Watson 2004).

Nevertheless, despite AURE's success in shaping a particular aspect of the directive, it has only belatedly been able to raise press and UK ministerial interest in arguably the more pressing threat to maintaining national control of nursing standards posed by EU enlargement.

The impact of EU enlargement

As previously noted, professional self regulation in nursing is intended to protect the public and Article 152 of the Treaty of Rome requires that all EU policy should contain a high level of health protection.

On May 1 2004, ten new states joined the EU. General care nurses from these states are now entitled to automatic registration with the NMC provided that their qualifications meet minimum EU training standards (DoH 2004).

Current shortages of nurses in the UK are well documented and many employers see recruitment from the accession countries as a potential solution to these problems (BBC 2004).

In preparation for EU enlargement, the European Commission undertook a series of evaluation missions to establish how ready accession countries' were to join in terms of mutual recognition of professional qualifications. Several had already transformed their nurse education in preparation for entering the EU; Poland for example had extended the length and type of nurse training it offers (Lipinska and Osicka 2002).

The missions have identified shortcomings, however, in many other accession states and at present the NMC rejects more than 90 per cent of applications from these countries because the training they provide fails to meet the minimum requirements specified in directives 77/452/EEC and 77/453/EEC (AURE 2004b).

Recent UK government guidance in relation to EU enlargement states that, where health workers' experience is unclear and training is completed before May 2004, cases should be assessed individually and adaptation periods should be considered. Nurses who finish training after May 1 2004 can register with the NMC automatically (DoH 2004).

The European Commission has not audited the training and regulatory systems in the ten new states (BBC 2004), however, and has yet to confirm whether they all now comply with the minimum training requirements (AURE 2004b).

Significant concerns have been raised by AURE and other commentators about the adequacy of training in many of these countries (AURE 2004b).

Meanwhile, the DoH guidance does state that it 'would expect employers recruiting overseas qualified staff to provide appropriate, structured and sympathetic induction programmes to enable them to adapt their practice and, where necessary, their communication skills to their new environment' (DoH 2004). This apparent fudge, which allows for a significant degree of supervised practice to ensure competence but arguably shifts control of professional standards from the NMC to employers, may have implications for public protection and patient safety.

Indeed the Health Commission, previously the Commission for Healthcare Audit and Inspection, which is responsible for regulating and inspecting healthcare standards in England and Wales, seems not to have engaged with these debates at all.

Conclusion

Many writers, such as Leibfried and Pierson (2000), identify actual and potential assaults on national sovereignty with respect to health policy posed by the EU desire to create a free market for labour and services.

As Duncan (2002) notes, the EU rarely intends to make health policy but it does make policies – in this case the commitment to freedom of movement and smooth functioning of the internal market – that can affect health matters significantly.

Directives about the mutual recognition of qualifications, for example, emanate from the internal market directorate general.
be seen as evidence of this race to the bottom. The way EU directives have affected nursing in the UK could undermine national sovereignty. The label 'race to the bottom', by which de-regulation and state and labour standards describe a phenomenon that undermines national sovereignty, suggests that advocacy coalitions can be used successfully by the NMC to influence EP decisions. But time may be running out for the profession to ensure the competence of nurses from the EU, to lobby against the proposal that health professionals regulated in one EU country can practise in another without being registered, and to collaborate with the PA and professional associations such as the Standing Committee of Nurses of the EU to meet its demands. Nevertheless, AURE's apparent success, in coalition with the PA, professional associations and the NMC, suggests that advocacy coalitions can be used successfully by the NMC to influence EP decisions. However, the NMC's advocacy is likely to be met with resistance from other member states, particularly from those that are not in favour of mutual recognition. The impact of globalisation on the welfare state and national sovereignty, and it may be time to run out for the profession to ensure the competence of nurses from the EU, to lobby against the proposal that health professionals regulated in one EU country can practise in another without being registered, and to collaborate with the PA and professional associations such as the Standing Committee of Nurses of the EU to meet its demands. Nevertheless, AURE's apparent success, in coalition with the PA, professional associations and the NMC, suggests that advocacy coalitions can be used successfully by the NMC to influence EP decisions. However, the NMC's advocacy is likely to be met with resistance from other member states, particularly from those that are not in favour of mutual recognition.