“Trends and developments in Europe with an impact on health services, nursing education, nursing practice and working conditions for nurses”
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The EU is the most thoroughgoing example of regional economic and political integration. As an international organization it goes beyond traditional intergovernmentalism and has substantial elements of supranationality. The EU has undergone a considerable expansion of membership and consequently of influence and power. The distinctions between European politics and national politics as far as the member states and EEA states are concerned are becoming less and less clear. The increasing focus and discussion about health politics is a good example of this. Health has traditionally been an area left to the national political arena and not EUs political domain. However, this has changed and with a new directive scheduled to be implemented to protect health workers from sharps injuries, as a result of committee work in the social dialogue, a Green paper launched in December 2008 on EU health workforce and a much debated proposed directive on “patients’ rights in cross-border health care”, health is no longer only the responsibility of the nation state, but an increasingly important area for the EU. As a consequence, nursing organizations and unions must pay closer attention to discussions, proceedings and developments and with this as a backdrop the Northern Nurses Federation dedicated the conference of September 2009 to political developments in Europe with special relevance to nurses.

Anne Berit Rafoss
Special Adviser
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Following is a report based on the presentations given during the conference:
European institutions and organizations

Per Godtland Kristensen,
International secretary Norwegian Nurses Organisation

Europe WHO-EURO
WHO EURO, established in 1948 consists of 53 member states, covering approx. 900 million inhabitants across Europe. The WHO/Europe’s nursing and midwifery programme aims to support countries by helping nurses and midwives, which are an integral part of the health care system in any country. With the Munich Declaration (2000) providing the guiding principles, the WHO-EURO seeks to be a force for health and strives to harmonize nursing and midwifery education in the European region, create evidence-based knowledge on nursing and midwifery and to ensure the provision of high quality health services in an accessible, equitable and efficient manner. Europe has around 6 million nurses and midwives, accounting for approx. 60%, in some countries 70% of national health care budgets. The significance of nurses and midwives in terms of numbers and significance in services provided as part of the health care system is not sufficiently reflected in the WHO Europe budgets and programs. There are currently 6 collaborating centres on nursing and midwifery in Europe.

A separate forum was established in 1996 – European Forum of National Nursing and Midwifery Associations and the WHO. The forum aims to promote the exchange of information, ideas and policies between nursing/midwifery associations and the WHO, contributing to the debate on improving health and quality of health care in Europe. Furthermore, the forum aims to make sure that the focus on equitable health services is well integrated into education and practice for nurses and midwives as well as in the political agenda. The forum has 43 member countries and has thus far adopted 13 statements, the latest in 2009 on “International recruitment on health personnel”.

For more information:
WHO Europe’s home page: http://www.euro.who.int/
Nursing and midwifery: http://www.euro.who.int/nursingmidwifery
Forum statements: http://www.euro.who.int/efnnma/work/20040210_5

Council of Europe (CoE)
CoE, established in 1949 is an intergovernmental consultative organization with a current membership of 47 member states. Areas of focus for the CoE are human rights, education, culture and cooperation in fields such as discrimination against minorities, crime, medical ethics and the environment. In addition the CoE concerns itself with constitutional and legislative reform, especially in central and eastern Europe in order to strengthen democratic stability. The main institutions of the Council are the Committee of Ministers, the Parliamentary Assembly and the Congress of local and regional authorities. The Secretary General recently elected is a Norwegian, Thorbjorn Jagland. The European Court of Human Rights, based in Strasbourg has in recent years been a highly profiled institution within the CoE. The Conference of International Non-Governmental Organisations also forms part of the CoE.
In terms of its importance for nurses and midwives it is worth mentioning the Recommendation on Nursing Research, adopted in 1996, and by EU some years later and the Recommendation on Trans-border Mobility of Health Professionals and its implications for the Functioning of Health Care Systems, adopted in 2006.

Also worth mentioning are INGOs and their participatory status in the CoE. They may address memoranda to the Secretary General for submission to the parliamentary committees, they may also be invited to provide expert advice on CoE policies, programmes and actions and thus receive agendas and public documents pertaining to meetings and proceedings in the Parliamentary Assembly. EFN is one of the NGOs with participatory status and is represented by EFN’s General Secretary, Paul de Raeve. The participation is linked to the Committees concerned with gender equality, social cohesion and eradication of poverty.

For more information:
INGOs: [http://www.coe.int/T/E/NGO/Public/](http://www.coe.int/T/E/NGO/Public/)

The European Union (EU) is by far the most influential political organisation in Europe. It consists of 27 member states and the European Economic Area (EEA) includes Iceland, Lichtenstein and Norway in addition to the 27 MS. Switzerland has a separate bilateral agreement. Croatia, Macedonia and Turkey are candidate countries.

The three main pillars of the EU are the European Parliament, the Council of the European Union and the European Commission. The Court of Justice of the European Communities, based in Luxembourg is the final arbiter in disputes arising from the Community treaties or legislation based upon them.

The EU adopts legislation, usually in the form of directives, that must be implemented in the national legislation of the MS and most of the legislation is EEA relevant (80-90%).

Legislation of relevance to nurses and nursing:
The Directive on Mutual Recognition of Professional Qualifications;
The Working Time Directive (not resolved);
Sharps Injuries (aimed to be adopted spring 2010);
The Services Directive;
Patient Rights Directive
EU and the Social Dialogue

The European social dialogue entails discussions, consultations, negotiations and joint actions between representative organisations for employers and employees. The agreements made through the work of the committees in the social dialogue may result in EU legislation. It is cross-industry and sectoral and there are 35 sectoral committees. The social dialogue in the European hospital sector, established in 2006 is of particular relevance to nurses. The partners are HOSPEEM and EPSU and the current priorities are: Retention, Strengthening Social Dialogue Structures, the Ageing Workforce, Third Party Violence and New Skill Needs.
European Federations for nurses and unions
Two of the main federations at the European level for nurses are The European Federation of Nurses Associations (EFN) and The European Federation of Public Services Unions (EPSU).
EFN, established in 1971 has members from the 27MS and Croatia, Norway, Iceland and Switzerland which are members of ICN. EFN Associate members are three mandated representatives of the European Nursing Specialist and Generic Organisations (ESNO) and EFN Observers are the ICN, WHO and the European Nursing Students Association (ENSA). The EFN secretariat is in Brussels. General Assemblies are held twice yearly, the executive committee consists of 7 members which meets 4 times per year. The current president is from Denmark, Ms Grete Christensen and the General Secretary is Belgian, Paul de Raeve. The mission of EFN is to promote and protect nurses and the nursing profession with particular reference to the EU, by lobbying the European Institutions; the European Commission, the European Parliament and the Council of Europe.

There are some umbrella organisations for professional interest groups, such as Workgroup of European Nurse Researchers (WENR) and FEPI – European Council of Nursing Regulators
European Federation for Public Services Unions (EPSU) represents the European region for the Public Services International and is made up of unions. It is the sectoral branch of the European Trade Union Confederation (ETUC) and also a social dialogue partner. Several of the EFN affiliates are in membership. EPSU has 4 standing committees: health and social services, local government, national government and utilities
The following is an overview of the international affiliations of the NNO, and although this will vary between the NNF members, it provides a good overview of professional and trade union affiliations.
Acronyms:
ICN: International Council of Nurses
EFN: European Federation of Nurses Associations
WENR: Workgroup of European Nurse Researchers
WHO FORUM – Short for EFNNMAWHO: European Federation of National Nurses and Midwives Associations and WHO
PSI: Public Services International
EPSU: European Federation of Public Services Unions
NPSU: Northern Federation of Public Services Unions
UNIO: Confederation of Unions for Professionals, Norway;
ITUC: International Trade Union Confederation;
ETUC: European Trade Union Confederation;
CNTU: Council of Nordic Trade Unions.
EU and the decision making process in the EU. Kim Øst-Jacobsen, international consultant, Danish Nurses Organisation
EU and the decision making process in the EU
Kim Øst-Jacobsen, international consultant, Danish Nurses Organisation

About 70-75% of national legislation in EU and EEA countries originates from EU initiatives. This is an important fact that many are unaware of and it provides the backdrop for how important it is to understand and try to influence the EU decision making process. The three main pillars of EU; The European Parliament, the Council of the European Union and the European Commission share the power in the EU and have different roles in the decision making process.

The European Commission
consists of 27 commissioners, 1 from every MS, they are independent and their focus is European and not national. The Commission has the right of initiative. Before a proposal is forwarded, the Commission will have consulted a wide range of relevant stakeholders. The Commission is responsible for the implementation of legislation, budget and programs that the European Parliament and the Council have agreed upon. The Commission supervises the implementation of the treaties and legislation.

The EU Parliament (EP)
with 785 MEPs consists of 20 committees and 7 political groupings and one independent group. It has legislative power together with the Council and may approve the budget. The EP has increased its legislative power gradually in recent years (together with the Council), especially in terms of the common market. The EP and the Council also share the responsibility of the EU budget; furthermore the EP is controlling the Commission through debates, question time etc. A new Commission must be approved by the EP and the EP may propose dissolution of the Commission. The EP may persuade the Commission to forward a proposal, which given a majority backing, will enable the EP to ask the Commission to agree to a proposed directive, which again may be turned into legislation.

The political groups in the European Parliament
are as follows (listed according to size):
EPP – groups of the European People´s party (Christian Democrats)
S&D – group of the progressive alliance of socialists and democrats
ALDE/ADLE – group of the alliance of liberals and democrats for Europe
Greens/EFA – group of the Greens/European free alliance
ECR – European conservatives and reformists group
GUE/NGL – Confederal group of the European United Left – Nordic Green Left
EFD – Europe of Freedom and Democracy group

The Council of the European Union (Council of Ministers)
is the most important legislative institution in the EU. The Council coordinates the MS’ financial policies and enters international agreements on behalf of the EU. There are 9 council of ministers according to political areas; these meetings are not regular, but according to need. The Council of Ministers with heads of governments meets twice yearly. The EU member states take it in turns to hold the Council presidency for a 6 month period. The Council has legislative power on its own and in collaboration with the EP and the Council is the body within the EU which has adopted the most legislation. The Council and the EP share responsibility for adopting the EU budget and the Council will enter into international agreements negotiated by the Commission.
Court of Justice of the European Union
is the judicial authority of the EU and in cooperation with the courts and tribunals of the MS, it ensures the application and interpretation of the EU law. If there is a dispute in terms of interpretation of EU law, the Courts decision will be legally binding for the MS. In recent years there have been a number of cases concerning cross border health care services, where the rulings of the Court have, for example in the Watts case, where a hip patient went from the UK to Belgium for an operation, which the UK government did not want to pay for, but the Court ruled in favour of the patient and the UK government had to pay.

The Treaties,
also known as `primary legislation` is basically the EU constitution, on which all decisions of the EU are to be based. It is the basis for `secondary` legislation consisting mainly of regulations, directives and recommendations adopted by the EU institutions. The current treaty is the Nice Treaty.

The decision making processes of the Nice Treaty
The Council may have a procedure without a hearing or there may be a hearing with the Council and the EP. A common position may be developed, whereby the EP will approve or not approve a proposal. Furthermore, there is the cooperation procedure with 2 hearings, whereby the Council has the final say in the decision and under the co-decision procedure, the legislative power is shared between the Council and the EP.
According to the Treaties, the Council has to take its decisions either by a simple majority vote, a ‘qualified majority’ vote or unanimously, depending on the subject to be decided. The Council has to agree unanimously on important questions such as amending the Treaties, launching a new common policy or allowing a new country to join the Union. In most other cases, qualified majority voting is used. This means that a Council decision is adopted if a specified minimum number of votes are cast in its favour. The number of votes allocated to each EU country roughly reflects the size of its population.
Co-decision procedure step by step (now only available in the updated version according to the Lisbon treaty)
The Lisbon treaty
The new treaty will bring a number of changes to EUs institutions, its decision making processes and ultimately its citizens. Previously the Council had to reach unanimous agreement, whereas under the new treaty there will be an increased use of qualified majority vote rather than the unanimous vote. Proposals regarding health for example will be adopted according to a qualified majority, whereas taxes and foreign policy will need a unanimous decision. The powers of the EP will be increased, as the co-decision procedure (the Council and the EP) will be applied in the adoption of the majority of EUs legislative acts.

The Directive on services in the internal market, commonly referred to as the Bolkestein Directive was adopted under the co-decision procedure (please see the graphic scheme of the process above). The proposal was made by the Commission on the 13.01.2004; 20.04.2005 was the first reading in the EP and 12.12.2006 it was adopted by the Council and the EP. The original proposal included health services, but during the proceedings and negotiations, it was removed and does not currently form part of the services directive.

In terms of influencing the decision making process, the earlier the better. Ideally, lobbying interests or positions should occur even before the Commission makes its proposal, if not possible, then during the first reading, after this point in time, the chances of influencing the decision decreases, although it is possible. There are various channels in which lobbying may occur, through national politicians, MEPs, committees, consultations and through collaboration with other stakeholders within the same area, for example unions and professional organisations and NGOs. It is essential to be present both at formal and informal gatherings and present your case professionally and have sufficient documentation to back up one’s position. In order to be successful, a suitable strategy is necessary, including estimated use of resources and evaluations of potential alliances. It is important to note that initiatives may come from many sources and make their way to proposals and in some cases ultimately a directive through both formal and informal proceedings.

Open method of coordination (OMC)
The Lisbon strategy set out in March 2000, aims to make the EU “the most dynamic and competitive knowledge-based economy in the world. “, creating more jobs, economic growth and increased social cohesion throughout the union.
One of the instruments created as part of this strategy is the OMC. It is another means for collaboration between the Member States, in this intergovernmental collaboration, the MS are learning from each other by “best practice”, evaluated by one another. The method does not include or involve the EP or the Court of Justice. The MS may jointly define objectives, guidelines, statistics, benchmarking within areas such as education, employment, social inclusion. The OMC may have “soft law” implications, which may be binding in varying degrees, but not in the form of directives or regulations, i.e. “hard laws”.
The EFN and the EU decision making process
Unni Hembre - vice president, Norwegian Nurses Organisation

The EFN was established in 1971 and represents nurses and the nursing profession and its interests to the European institutions. It is one of the most important partners of NNAs in the NNF in terms of lobbying and follow-up of relevant issues within the EU.

Dictionaries define lobbying as influencing decision makers, originally and still to some degree to this day, gathering in hallways/lobbies in parliaments before and after debates. Individuals, groups, organisations attempt to influence politicians outside the ordinary channels such as the parliamentary debates and consultations or more directly by utilizing the relevant politician’s party meeting points.

Ms Hembre challenged the audience in terms of the terminology; lobbying and its implications. What does the audience define as lobbying, how, when and where? A lively discussion followed and many views were expressed. A recurring theme was the importance of the informal meetings, the lunches, coffees, the networking, which is often underestimated by people from the Nordic countries. Its importance underestimated may to some degree be explained by our democratic and formalistic traditions concerning politics and decision making processes. Whichever the explanations – the conclusion is that NNAs and their members need to improve their lobbying skills.

The decision making processes, previously outlined by the international consultant of the DNO are important to know and learn how to influence and one of our most important tool in that regard is EFN. EFN has developed a solid strategy for influencing the relevant EU institutions on issues which will affect nurses, be that in terms of education, training or professional practice. EFN has built up a solid base of knowledge and data which is utilized in the lobbying activities of the EU institutions. Members contribute through sharing information and experiences, through the meetings and working in the committees of EFN. Position statements and strategy documents as well as press releases are developed and distributed through established networks and organisations.

In conclusion Ms Hombre shared some of her experiences in the first period of her involvement with EU politics, how complex and at times confusing EU and its political system may appear and that at times, it may feel as if the more you learn, the less you know and understand. Be that as it may, it is very interesting and important and this conference is a good platform for us all to build on in terms of knowledge and understanding of EU and EU politics relevant to our profession.
Health Care Integration in the European Union. Towards an Internal Market for healthcare? EU as a healthcare regulator – overall implications
Dorte Sindbjerg Martinsen, University of Copenhagen

EUs increasing involvement in the area of healthcare implies a construction of an additional level of healthcare regulation, with patients getting new exit-opportunities. Furthermore, it implies a shift in perspective from the system perspective to the rights perspective of the individual. So far, the patient mobility has not been significant; however, there is reason to believe this may change in the decades to come.

Integration and Europeanisation of welfare – a political paradox?
The paradox lies within the fact that welfare is formally a national competence, governed by the principle of subsidiarity. There is political reluctance to delegate the welfare mandate, among other things, due to social contracts having long been established between the state and its citizens and thus far this has been a judicially driven process. This paradox exemplifies that the EU has internal market principles affecting all parts of public policies, EU regulation as increasingly redistributive consequences and there is an increased focus on the citizens.

The established tradition for EU healthcare regulation
According to regulation 883/2004 (former reg. 1408/71), the EU/EEA citizen has a right to free acute or necessary treatment during a temporary stay in another MS, where the expenses are paid by the competent national institution. The European health insurance card certifies this right. In addition a citizen also has the right of free treatment in another MS on the basis of prior authorization from the competent national institution, expenses paid by the competent national institution. The number of people requesting and obtaining prior authorization for treatment in other member states is still relatively low, but increasing.

Dynamic welfare regulation in the EU
The original objective of welfare regulation in the EU was to ensure free movement for qualified labour, through community prohibition of national barriers, dynamic development of the personal scope and the meaning of services with a gradual constitutionalization of the free movement principles. The present objective is to promote the mobility of European citizens, adding real rights to the bones of European citizenship, promoting free movement of services and ensuring patient mobility and safety.

How far has judicial interpretations brought us?
Up until 1998 health policies were not related to the internal market. ECJ interpretations concerning the internal market and healthcare concern among other cases;
C - 158/96 Kohll and C-120/95 Decker 1998
C – 157/99 Geraets-Smits and Peerboms 2001
C – 385/99 Muller-Fauré and Van Riet 2003
C – 372/04 Watts 2006
C – 444/05 Stamatekali 2007

One of the first major steps came with the C - 158/96 Kohll and C-120/95 Decker 1998 case, whereby the ECJ established that healthcare is a service within the meaning of the Treaty. The case puts forward an interpretation of non-hospital care and interprets the healthcare system of Luxembourg based on cash reimbursement of costs.

With the C – 157/99 Geraets-Smits and Peerboms 2001 case it clearly emerged that prior authorisation constitutes a barrier to the free movement of services. This is, however, justified provided that the decision on whether to grant it or not is based on international
medical science`. An equivalent treatment can be provided in the competent MS without `undue delay `taking into consideration the medical situation of the patient, considered as a whole.

The case of C – 157/99 Geraets-Smits and Peerboms 2001 (repeated in the Watts case) showed that prior authorisation to grant free hospital treatment in another MS is only a justified barrier to the free movement principle of the EU, provided that it is based on: “objective, non-discriminatory criteria which are known in advance, in such a way as to circumscribe the exercise of the national authorities’ discretion, so that it is not used arbitrarily. Such a prior administrative authorisation scheme must likewise be based on a procedural system which is easily accessible and capable of ensuring that a request for authorisation will be dealt with objectively and impartially within a reasonable time and refusals to grant authorisation must also be capable of being challenged in judicial or quasi-judicial proceedings” (paragraph 90 of the judgement, emphasis added).

The judgement in the case of C – 385/99 Muller-Fauré and Van Riet 2003 introduces a distinction between “hospital” and “non-hospital care”. For hospital care, the procedure of prior authorisation is a justified barrier to free movement, under certain conditions; implying some national control. For non-hospital treatment the MS are obliged to reimburse costs as if the treatment had been provided in the MS of insurance, thereby strengthening free movement.

The recent cases of C – 372/04 Watts 2006 and C – 444/05 Stamatekali 2007 state that free movement of services applies to all types of healthcare systems, disregarding how they are organised or financed. Prior authorisation can only be refused if the MS of insurance can provide the same treatment without undue delay. In the judgement of the Stamatekali case, article 49 does not distinguish between public and private case. To reimburse the costs of a treatment cannot be refused on the sole ground that the treatment is carried out in a private hospital.

Reluctant implementation – Denmark as an example
Denmark was one of the first MS to implement the rulings. Certain non-hospital services can now be provided outside Denmark (response to Decker/Kohll); dental care, physiotherapy, chiropractic, GP and specialist care for insured under group 2. Denmark maintained for long its re-definition of a service within the meaning of the Treaty as; “Article 50 defines services as services normally carried out in return for remuneration (...) Characteristic for a service is thus that a service provider offers a service in return for remuneration” (Danish report on the Decker/Kohll rulings 1999, p.23 repeated as response to parliamentary question §20, S4967  17th of May 2006.

Preliminary consequences for Danish healthcare policy
Non-hospital treatment: amendment of the executive order in 2008 provides access to specialist treatment without prior authorisation for insured under group 1, but referred from the GP. Patients are reimbursed up to the cost of treatment in Denmark. Hospital treatment: regions can authorize treatment in another MS. They are obliged to do so if treatment cannot be provided without undue delay in Denmark. If the region cannot provide treatment within one month, the patient has a right to be treated at a hospital in another MS, but only one which the Danish authorities have concluded an agreement with. In terms of further implementation, the Commission has sent an opening letter against Denmark.
The Commission proposal

The Patient Rights Directive was proposed 2nd July 2008. It is part of a larger social package, now negotiated in the EP and the Council. The proposal is codifying and building on the Court’s interpretation, presented as ‘no choice’ and reasoned in previous judicial actions; `as the Court has already laid down`. The major areas of conflicts are the distinction between hospital care and non-hospital care, who are to be the gate keepers in the system, should it be based on subsidiarity, what should constitute the legal bases and the perspective of social equality; needs or means based?.

Article 5 of the proposal lays out the responsibilities of the MS of treatment:
Healthcare providers provide all relevant information to enable patients to make an informed choice, in particular on availability, prices and outcomes of the healthcare provided, details of their insurance etc.

Patients have a means of making complaints and are guaranteed remedies and compensation when they suffer harm arising from the healthcare they receive.

Patients from other MS shall enjoy equal treatment with the nationals of the MS of treatment Article 6 of the proposal states that the MS of affiliation shall ensure:
That a patient will not be prevented from receiving healthcare provided in another MS where the treatment in question is among the benefits provided for by the legislation of the MS of affiliation.

The costs of healthcare provided in another MS shall be reimbursed by the MS of affiliation up to the level of costs that would have been assumed had the same or similar healthcare been provided in the MS of affiliation.

The MS of affiliation may impose the same conditions, criteria of eligibility and administrative formalities for healthcare in another MS, in so far that these are neither discriminatory nor an obstacle to freedom of movement of persons

Article 7 and 8 of the proposal state that for non-hospital care, prior authorisation is an unjustified barrier to free movement. For hospital care and specialised care, a community definition has been defined as healthcare which requires overnight accommodation, minimum one night. A system of prior authorisation may be justified, however, it should be limited to cases where there s evidence that the outflow of patients due to cross-border hospital care undermines or is likely to undermine the financial sustainability of health, organisation, planning and delivery of health services.

Article 9 of the proposal concerning procedural guarantees states that the MS shall ensure that the procedural system for the application of authorisation is easily accessible and that it is based on objective, non-discriminatory criteria published in advance. The application shall be treated within a set time limit and taking into account the patient`s degree of pain, ability to work, medical conditions etc. Administrative decisions are subject to administrative review and also capable of being challenged in judicial proceedings.

Negotiations in the EP

This proposal constitutes a most complicated piece of legislation, involving 7 committees, a large number of proposed amendments, whereby 115 amendments are thus far adopted. The major controversies concern the definition of hospital care, prior authorisation, method of payment, equality and subsidiarity. When put to the vote in the EP, 297 votes were in favour, 120 against and the PES abstained from voting.
As for some of the main adopted amendments, they are as follows:

A European patient ombudsman will handle complaints regarding prior authorisation, the quality of treatment and reimbursement etc.

Continuity in the treatment between MS of treatment and MS of affiliation must be ensured and the MS of affiliation is obliged to post-treatment, if necessary.

Patients affected by rare diseases should have the right to access healthcare in another MS and to get reimbursement even if the treatment in question is not among the benefits provided for by the legislation of the MS of affiliation.

Regarding prior authorisation, the EP has amended Art. 8(4) stating that the prior authorisation system (...) shall be limited to what is necessary and proportionate, shall be based on clear and transparent criteria, and shall not constitute a means of arbitrary discrimination or an obstacle to the freedom of movement of patients. Where prior authorisation has been sought and given, the MS of affiliation shall ensure that patients are expected only to pay upfront any costs that they would be expected to pay in this manner had their care been provided in the health system of their MS of affiliation. MS shall seek to transfer funds directly between the funders and providers of care for any other costs.

**Forthcoming negotiations**

The proposal has now been negotiated in the Council of Ministers. After the Council meeting in December 2008, the Danish healthcare minister said that: “We will choose what is best for the patient” and that “Danish authorities control the process and the final decision will be based on a medical assessment” and “I imagine that Danish authorities make a prior agreement with a hospital in another MS (...). The system chooses what is best for the patient”. In conclusion, reflections on which consequences this directive will have for national healthcare need to include the perspectives of factors motivating patient mobility and the content and regulation of the public service. The factors are many; economic motivation, efficiency of supply/waiting time, national supply, quality of supply, information on supply, healthcare services trust and EU rules.
Directives of significance for nurses’ working conditions. The influence of EU on working conditions

Søren Sass, Danish Nurses Organisation

The tradition in Denmark is that the parties of the labour market, through collective agreements regulate conditions in the labour market. However, EU has increased both its influence and thus significance concerning labour market issues. The partners of the labour market were included in the Maastricht Treaty of 1993 and thus their role in the legislative process was formalised with regards to regulation of the labour market. According to article 138/EC, the Commission is obliged to consult the partners before making a proposal. If the partners reach an agreement within the time limit of 9 months, the Commission may officially forward the proposal. The proposal will then go through the decision-making procedure on the basis of the current treaty.

The directives on parental leave, part-time work and temporary employment are examples of directives initiated as an agreement between the European partners and consequently proposed formally by the Commission. If the partners cannot reach an agreement, as was the case in the negotiations over temporary employment, the initiative will go to the Commission, which in turn, as is tradition forwards the proposal. The implementation of EU directives in the MS is normally through laws, communications or other national legislative instruments.

EU directives cannot be implemented only through agreements between the partners of the labour market. The agreements are valid only for the part of the population organised in unions, whereas directives are universally binding. Consequently it is necessary with additional regulation in order for Denmark to implement the directives. The first instance when this occurred was with the working time directive (93/104/EC) which was partly implemented through collective agreements and partly through laws and communications.

Significant as the right of initiative of the Commission is, the ECJ also plays a crucial role as it is protecting laws and regulations through interpretations and implementation of EU law. The ECJ has played an important part in the development of the social and labour market politics of EU, in particular in cases involving equality and social rights in conjunction with the free movement, the rulings of the ECJ have resulted in increasing number of proposals for EU regulation of this area. Many of the rulings of the ECJ focus on the protection of the individual. As a consequence of many of the rulings of the ECJ, legal practice and directives need to be changed according to the ruling and this is also relevant for the labour market. Denmark has had a ruling against it in a case concerning equal pay where “equal work” according to the ECJ was interpreted too widely in Denmark. The rulings of the ECJ have also influenced other directives, such as the working time directive.

Two crucial rulings; the cases of Simap and Jaeger – in both cases the ECJ ruled in favour of the employees. In the Simap case, the ECJ considered whether back-up duty is included in the working time term, as defined in article 2 of the directive. The ECJ states that back-up duty fulfils the criteria implied for working time and the fact that doctors are required to be present and available for medical practice must be considered working. In the Jaeger ruling of 2003, the ECJ considered whether inactive time during a back-up duty is to be considered working time. The case involved a German doctor on duty, where it was possible to rest. The ruling stated that inactive periods, for example used for rest is a natural part of a back-up duty and therefore to be considered working time.

Even if the ruling was in favour of the employee, the reactions from the MS have been strong. Many countries have claimed that they would not be able to make the health care
system work properly if the directive is implemented fully. According to the Danish government, the healthcare sector will suffer consequences as a result of the recurring use of back-up duties in the working environment. It is mostly relevant for doctors.

From a Danish perspective, the most influential ruling of the two is the Jaeger ruling as it limits the possibility of postponing the compensatory rest. The principle for when compensatory rest is to be taken is stated in premise 94: “periods of compensatory rest is to be taken immediately after the working period, which the compensatory rest is provided for, in order to combat tiredness and sensation of overload by the employee as a result of many continuous working periods”.

According to healthcare authorities the ruling will cause difficulties, given that the healthcare workers according to collective agreements mostly postpone a part of the compensatory rest period (3hours) until later and consequently is in breach of the ECJ ruling. The affected workers are doctors, nurses, midwives, social and healthcare assistants. The Danish government has concluded that the problem may only partially, according to group of workers, be resolved through reorganisation. It is expected that up to 80 chief physicians more will need to be employed and an unknown number of nurses. This presents a major challenge with the current recruitment situation.

The two aforementioned rulings have resulted in the Commission forwarding a proposal for a new working time directive. After 6 years, there is still no solution to the working time directive. In essence the conflict is about the rights of employees, the sovereignty of the MS and the conditions or running a healthcare system and a working environment.

Given the uncertainty surrounding the rulings, the MS have started to find their own solutions, which they wish to be included in the directive. Great Britain and other countries would like the possibility of an opt-out arrangement, enabling them to entering into individual agreements of a working time exceeding 48 hours. That is not in the interest of the employee and both the Commission and the EP are against. An alternative being discussed is a longer period of reference (the normal average working time over 12 months rather than 4 months), which would signify that an employee may work more than 60 hours a week in the first months of the year and then take the rest of the year off. This would have severe consequences for the working environment and patient safety.

The issue of inactive working time, implications of working time and rest is also at stake. The crucial aspect is the content of an inactive work period and how much would be possible to negotiate. This directive is crucial for the working condition of nurses and DNO and the rest of the union movement are very keen to find solutions safeguarding the working environment and patient safety. For the employers the significant issues are managing and planning healthcare.

The EP rejected the Council’s proposal 27.04.2009, it is now up to the Commission to forward a new proposal. It is necessary to find a solution between the MS and the EU community, as EU is only as powerful as its members. It is important to avoid that the MS will implement what they find suitable, especially when the ECJ rules in favour of the employees.
The social dialogue – the impact for nurses. Emphasis on the hospital sector dialogue
Kim Øst-Jacobsen, international consultant, Danish Nurses Organisation

The interpretations of social dialogue varies, it originated in France signifying the social dialogue between the employers and the employees. The interaction between employers and employees may consist of exchanging information, consultation, negotiating and binding agreements. The partners in the social dialogue need to be perceived to be on equal terms, with rights and abilities to negotiate and a mutual respect needs to be in place. Since the Treaty of Rome in 1957, the social partners have been mentioned in the EU treaties and thus the three party social dialogue as a concept was established in an EU perspective. The social dialogue committees were established in 1985 and in the 1997 Amsterdam Treaty the social partners were confirmed as part of the treaty.

Treaty decisions
Article 138 – the Commission is required to facilitate consultation of the partners of the labour market at the community level and make all the necessary preparations in order to enable the dialogue and simultaneously supporting both partners equally and hearing them.
Article 139 – if the partners wish, the social dialogue may result in binding agreements.
The Lisbon treaty states that the union recognises and promotes the role of the social partners at its level, taking into account the diversity of national systems. It shall facilitate dialogue between the social partners, respecting their autonomy. EU is not the third partner in the dialogue as such, but part of it as facilitator.

Requirements for the social dialogue
In order to take part in the social dialogue, a partner is required to be representative at national as well as European level. The collaborative dimension of the two partner social dialogue requires bargaining powers. The autonomy of the social partners must be respected and administrative capacity is required. The partners need to be able to provide documentation of their ability to organise, negotiate and demonstrate a willingness to enter into agreements. Furthermore they need to have the capacity to implement agreements via national negotiations and have the right to be consulted on the relevant area.

The social dialogue in the European hospital sector
The initiative to this dialogue came from the Danish social dialogue partners in 1998, in order to establish a system whereby common challenges could be discussed and to develop the collaboration between the social partners nationally and at the European level. It was formalised in 2006.

The partners are on the employee side; European Association of Public Service Unions (EPSU) and on the employer side; European hospital and healthcare employer’s association (HOSPEEM). Worth noting is that primary healthcare is not represented.
The social dialogue committee meet twice a year and has the right to establish working groups according to need. The Commission shall facilitate the process, providing rapporteurs, fund meetings and may suggest topics for discussion in the committee. There is pressure from the Commission that agreements are reached. The partners must report to the Commission on a yearly basis, ensure national implementations and show a will to negotiate. 27 employers and 27 employees are represented, Norway is present as an observer with right to speak, one representative from the Commission and one representative from the secretariat of both HOSPEEM and EPSU are present in the committee. The mandate is to be a national reference group, Nordic reference group and to meet on behalf of workers at the European level.
3 working groups of importance to nurses concern themselves with retention, the ageing workforce and skill needs/mix.

**Results**

Results worth mentioning are a common position on health care, adopted in 2007 and EPSU-HOSPEEM guidelines and follow up on ethical recruitment and retention in the hospital sector across borders. Furthermore, a directive, likely to be adopted in 2010 on sharps injuries in the hospital and healthcare sector. The social dialogue in the hospital sector has been strengthened in the new MS and candidate countries.

Working program 2008-2010 contains retention, strengthening of the social dialogue structure, the ageing workforce, 3rd party violence and skill needs/mix.

The social dialogue may grow weaker. Demographic, organisational and technological challenges emphasise the importance of the hospital dialogue, but it is important to keep in mind that EU work is time consuming. The advantages are that the partners are able to choose topics, they may choose the method of proceedings, the discussions are structured and decisions may have significant influence on the healthcare sector in Europe. On the down side, there is a risk involved if topics are chosen for discussion and negotiation where the partners would have been better served by legislative initiatives. The cross-sectorial dialogue as opposed to the sectorial dialogue represents a challenge as well as the constant pressure from the Commission to reach agreements.
EFN is the independent voice of the nursing profession and lobbies on EU pipeline legislation. The European Federation of Nurses Associations shall strengthen the status and practice of the profession of nursing for the benefit of the health of the citizens and the interests of nurses in the EU and Europe.

EFN was established in 1971 much as a response to developments in the EU regarding nursing based on the nursing education and free movement Directives being drafted by the European Commission at the time.

Directive 85/384/EEC established the principle of mutual recognition of diplomas in order to facilitate free provision of services and freedom of establishment, thus ensuring the free movement of professionals throughout the union.

There were a number of directives concerning qualifications and diplomas of various professions not being implemented and during the 90s and well into the 2000, the Commission took a number of cases of infringements of directives concerning qualifications to the Court of Justice. In many various professions, qualifications obtained in one country were not recognised in another country, thus precluding establishment and work opportunities for professionals. It became clear that simplifications and flexibility were required and for regulated professions such as nursing it became clear that a sectoral directive and a special regime would safeguard the quality of education and thus diplomas and in turn professional practice. Relevant professional associations and social partners needed to be involved in order to guarantee quality and ensure that the system would be able to adapt to changes in the education systems and labour markets.

Discussions, consultations and negotiations led to the launch of a revised directive DIR 36/2005 on the Recognition of Professional Qualifications and it came into force 20.10.2007. Currently 23 MS are involved in infringements due to non-implementation of the directive. A report is being developed, to be completed in 2012 where all countries will be evaluated and a status report will show who if any has implemented the directive and what the main obstacles are for implementation.

In terms of education and training, there are two systems that schools and universities are guided by, the DIR 36 which is a legislative document, whose non-implementation will have legal consequences and the Bologna process, which is a voluntary process. The directive includes 7 sectoral professions, whereas the Bologna process concerns the European Area of Higher Education. The directive is professional and Bologna is academic. The directive operates with hours when quantifying requirements, and Bologna uses the European Credit Transfer System. The qualification in the directive is referred to as a bachelor or the equivalent and the Bologna process has a Life Long Learning perspective. Implementation and follow up are done by a Committee MRPQ for the directive and Bologna Follow-up group for the Bologna process.

Criteria
The criteria of DIR 36 dictate a completion of general education of minimum 10 years, followed by a bachelor degree or equivalent and 4600 hours. Of these hours, at least 33% is to be theory and 50% clinical training on a full-time basis and finally in the directive there is a specified list of topics to be covered. The criteria to be fulfilled in the Bologna process are...
learning outcomes, autonomy for the institutions, recognition of prior learning and CPD with a 3 cycle structure.

**Solutions**

As seen by many of the infringement cases, the two processes have been mixed, focus on one and not the other, but it is important to note, that they are not mutually exclusive. In fact, it is to the benefit of the education and profession if both processes are observed. How can we integrate the two processes? CPD could be included in the EU legislation as a commitment to patient safety and quality of care, it should go to DG Sanco White Paper on EU workforce. A European accreditation mechanism to be put in place in order to peer review learning outcomes and institutions, public and private. This is a solution, but it is also important to consider how it can be measured and what might be an acceptable measure parameter. If Recital 29 of DIR 36 is used to submit reasoned amendments, there is the prior condition that there exists strong consensus among professional, student, academic and regulatory bodies.

As for the degree system, a bachelor should be the main qualification ensuring one European level of nurses complying with the requirements of Dir 36. There may be different pathways, but the bachelor would be the generic tool for bridging courses. In the Master degree the focus would be harmonization and a regard for skill mix/needs. As for the PhD level, an idea could be to initiate a pool of nurse professors to support those MS starting with a nursing faculty.

**EFN actions**

EFN supports writing the implementation report for DIR 36 by 2012 by MAPPING the nursing profession at EU level. EFN will target its lobbying of the relevant DGs:

- DG Internal Market – EU accreditation of nursing curricula and institution
- DG Sanco – EU legislation for EU workforce for health
- DG Employment – Skill mix-skill needs – task shifting
Nursing practice in Europe with a focus on patient safety
Paul De Raeve – General Secretary EFN

The Bolkenstein Directive, the directive on services is significant due to its implications on collective bargaining, the European social model, national labour markets and ultimately the quality of healthcare.

DG Sanco advocates common values and principles, a stakeholder approach focusing on universal access and solidarity.

EFN is working towards an effective stakeholder approach at national and European level, involving nurses and nursing in all stages of policy making. EUNetPaS is a European network for patient safety, which is one of the avenues EFN has chosen in order to place importance on patient safety. The project concerns itself with the perspective of patient safety and how to improve knowledge and research of patient safety to be included in education and professional practice. EFN aims to provide strategic support for a qualitative and equitable health service in Europe by developing a workforce of efficient, competent and motivated nurses. It is of vital importance that EU invests in human capital by ensuring better education provision and steadily increasing qualification levels.

EU health services legislation is essential for patient safety and quality. Therefore, it is important to use patient sensitive indicators, gather information on the quality of service and putting in place safeguards and mechanisms to address complaints. Furthermore, to develop clear lines of accountability for the continuity of patient care and a clear system of information exchange to assist patients making informed choices regarding their healthcare.

EFN needs to make progress regarding the ‘soft law’ initiatives led by DG Sanco. EFN is a stakeholder in the High Level Group on patient safety and quality.

This working group aims to examine EU added value in relation to the reduction of harm to patients and the reduction of variations in care by making sure that procedures are in place ensuring comparable outcomes for patient. The group also works towards creating a more compassionate healthcare environment in which a patient-centred approach with full respect for the dignity and rights of patients and their families is central.

The group will reflect on how to increase the quality of life for the patients, empower patient choice with clear and comprehensive information and how to support the patient and relatives in difficult decisions, ensuring that patients may have an active role in their healthcare. The group aims to develop a reflection paper by the end of 2009, a platform of information exchange on current work in the field of healthcare quality at MS and European levels; an EU project on quality standards. EFN is committed to communicating EFN members ‘experiences in relation to guaranteeing high quality and safe health services. Accreditation could be a way of ensuring quality and safety by confirming that individuals, programmes, institutions and services meet with agreed EU standards.