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EU ACCESSION: A POLICY WINDOW FOR NURSING?

By: Paul De Raeve, Anne Marie Rafferty and Louise Barriball

Summary: European enlargement provides an opportunity for the nursing profession to gain traction on policy change but our research demonstrates that the European Commission mechanisms to process compliance need to be robust and designed to deliver such change. These opportunities also increase when the nursing leadership operates across a united front and articulates its agenda with a clear political voice. In addition to a united leadership, we argue that nursing needs support from civil servants and EU officials so that it can influence the EU accession policy agenda relating to nursing and shape successful policy outcomes.

Keywords: *Acquis Communautaire, EU Accession, Nursing Leadership, Stakeholder Engagement, Taiex, Health Policy*

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Introduction

European enlargement has been the subject of extensive investigation in a wide range of policy areas.[1] However the impact of European Union (EU) enlargement upon one of the largest health professions, nurses, has been largely neglected in health policy research. European institutions are currently halting EU enlargement although there are Commission negotiations and preparations with five candidate countries: Albania, the former Yugoslav Republic of Macedonia, Montenegro, Serbia and Turkey, Bosnia and Herzegovina, Kosovo, Georgia and Ukraine are potential candidates. Becoming an EU Member State entails working towards a well-functioning democracy with stable institutions and the rule of law being guaranteed, with human rights and the protection of minorities being legally guaranteed and respected in practice.[2] In addition to these political requirements, membership of the Union requires a functioning market economy and the capacity to cope with competitive pressures and market forces within the Union.[3]

Acquis Communautaire

The EU accession process consists of negotiations between national governments and the European Commission with the aim of aligning national legislation with the European Directives set out in the *Acquis Communautaire*. The Acquis comprises several chapters reflecting the broad sectors of EU responsibility, including Chapter 3, incorporating the free movement of "nurses responsible for general care" (Directive 2005/36/EC, recently modernised by Directive 2013/55/EU). This Directive includes the recognition of

professional nursing qualifications, and transposing the minimum requirements of the Directive relating to the minimum entry level of general education; the full educational programme of 4600 hours; a minimum one third of the educational programme being theoretical and at least 50% being spent on clinical training on a full-time basis. Most importantly, new Article 31, sets out eight competencies and makes it clear who is a general care nurse according to EU Legislation. As the nursing profession is one of the most mobile professions in the EU, compliance with the European Directive on Mutual Recognition of Professional Qualifications (MRPQ) is key for patient safety and quality of care[4] [5] and protecting the individual nurse willing to move within the EU.

TAIEX

The compliance policy process for EU membership is supported by the European Commission's Technical Assistance and Information Exchange (TAIEX) peer reviews and capacity building seminars. Taiex is the instrument responsible for all technical assistance elements in relation to preparations for the application of the *Acquis*. Peer reviews are the main mechanism for determining whether adequate administrative infrastructure and capacity are in place to ensure full implementation of the Acquis and they also pinpoint areas that require further strengthening. The Taiex capacity-building seminars are therefore largely demand driven, facilitating the delivery of appropriate tailor-made expertise. The peer review reports tend to be an important source of information for the Commission's comprehensive monitoring reports upon which political leaders from the European Commission, the European Council and the European Parliament make informed decisions on progress towards compliance with the Acquis.

Lessons can be learned from the Romanian and Croatian EU accession process. The main criteria for selecting Romania and Croatia relate to their historical and political contexts, their different positions within the EU accession process – especially timing and the stage reached in the overall accession process at the time of the study – and the different levels of development of nursing as a profession.

Nursing after Ceausescu and Tito

The starting point at which the Romanian and Croatian nurse leaders entered EU accession differed from economic and political perspectives. While Croatian nurse leaders lived through a well-functioning free market economy but had to endure a terrible Balkan War, the Romanian nursing leadership found itself in a collapsed economy, inefficient state institutions, a highly politicised and unaccountable judiciary and public administration, corruption, political apathy and mistrust. Although Romania and Croatia differed on the political and economic EU membership criteria, the status of nursing education post-communism was quite similar: nursing education at the secondary level was located within vocational and technical schools and as such, 'nurses' were called medical assistants.

Romania and Croatia both share the legacy of a Soviet-influenced health care system, based on the hospital-focused Soviet Semashko model, including informal payments.[6] Moreover, the nursing profession in both cases shared similar conditions and mind-sets from the post-communist conservative regime ensuring that nursing education continues to be medically dominated. This position was exacerbated by the perception of policy-makers that it was not necessary to develop the nursing profession and health care system by transitioning to higher education. The contextualisation of Romanian and Croatian nursing education history within the wider political and policy context indicates that the minimum requirements, as set out in the Directive 2005/36/EC, were not met prior to EU accession.

Case studies

We explored two case studies, Romania and Croatia, of nurse leadership engagement in the EU accession policy-making process and the extent to which EU accession provided a policy window to advance a professional agenda. A comparative two – stage case study approach was adopted within an ethnographic, multi-method design involving qualitative interview and documentary analysis, exploring the mechanisms used by the Commission to process compliance and the degree to which the nursing leadership was able to capitalise upon the opportunity to formulate and implement a professional agenda and achieve policy goals in both cases.[7]

> one of the most mobile professions in the EU

Findings

The findings relate to the robustness of the EU compliance mechanisms and the degree to which the nursing leadership engaged in agenda setting and policy-making. Three policy mechanisms were identified which were used to reach compliance with the Acquis: the Commission's comprehensive monitoring reports, the Taiex peer review reports, and the Taiex capacity-building seminars. Findings suggest that these three policy mechanisms were not robust enough to deliver successful legislative outcomes, although the comparison of Romania and Croatia showed that the Taiex capacity-building seminars enabled the nurse leadership to influence the process to gain capacity building funds in the case of Croatia to put a plan in place to upgrade nursing education. Nevertheless, findings indicate that the Taiex peer review and capacity building mechanisms were too weak for the recommendations to be picked up by the Commission's comprehensive monitoring reports, signed off by politicians in the three European Institutions: European Commission, European Parliament and Council of Ministers.

Commission Comprehensive Monitoring Reports

Based on the study findings, it transpired that compliance with Directive 2005/36/EC was not a major priority for governments, further weakening the

capacity of the Commission's comprehensive monitoring reports in EU accession negotiations to upgrade nursing education. The case study findings show that the comprehensive monitoring reports failed to ensure that recommendations for compliance were carried through to align with legislative change. Non-implementation was not an impediment to closing chapters of the Acquis and therefore no sanctions were applied. As such, it can be argued that the Commission's comprehensive monitoring reports were not well designed for multi-level governance and, consequently, are not sufficiently robust to respond to the nursing education challenges prior to EU accession.

> EU compliance mechanisms were unable provide traction

Government's lack of preparation

Similarly, although the Taiex peer review reports pinpoint areas requiring further attention, the recommendations do not tend to be an important source of information for the Commission's comprehensive monitoring reports. These reports are important since they form the basis upon which EU political leaders make informed decisions. As both cases show, Chapter 3 of the Acquis was provisionally closed, although there was no evidence of the Taiex recommendations having been addressed adequately. Rather, the Taiex peer review reports were treated as a negotiation tool between the government and the Commission, with minor engagement of stakeholders and specifically, no engagement with the nursing leadership in formulating solutions to address the Taiex recommendations. The weaknesses in nursing education identified in the Taiex peer review reports were not addressed due to the government's lack of readiness and attitude towards upgrading nursing workforce competencies towards EU standards (Directive 55).

Although the Taiex recommendations could have a political impact on the negotiations, government reluctance to acknowledge non-compliance with the EU Directive 36/55 criteria impacted negatively on the development of the nursing profession in both cases.

Consequently, nurses in Romania and Croatia are still called medical assistants (not nurses) and therefore face problems accessing free movement in the EU based on MRPQ.[8] These challenges have remained unresolved as the Romanian and Croatian national governments see the Acquis as a potential exit route for nurses lured by better working conditions in other EU Member States. Both governments agreed with the Commission that they would install a new nursing education curriculum at university level in compliance with Directive 2005/36/EC, from the date of entering the EU, leaving the existing secondary school level nursing workforce in non-compliance. It can be argued that this represents a missed opportunity for a predominantly female profession to develop their skills and competencies and hence promote their ability to move within the EU on the basis of MRPQ. Romanian and Croatian nurses will move in the EU, but not as nurses benefiting from the mutual recognition regime, potentially impacting negatively on the national and European workforce composition.

Capacity building

Finally, the third mechanism, the Taiex capacity building seminars, addressing the weaknesses set out in the peer review reports, can be extremely helpful in bringing stakeholders together, facilitating a better understanding of how to transpose Directive 55 into national legislation and how to address the challenges set out in the Taiex peer review reports. However, requesting funds from the EU for nursing implied admitting there was a problem to be fixed. This failure to demand EU financial support seems to have missed a major policy window opportunity to bring together relevant stakeholders to design new national nursing legislation in compliance with the European Directive. The nursing leadership was severely constrained in raising agreed challenges to their ministry officials since they recognised that moving Taiex recommendations up the political agenda itself was reliant on the goodwill of civil servants negotiating EU accession itself. Therefore, the imperative to drive the process through may have militated against the nascent nurse leadership being able to influence the uptake of the Taiex peer review recommendations and the capacity building seminars. Furthermore, ministries did not seize the opportunity to upgrade the nursing workforce. Indeed, there are signs of a residual intention to block free movement by some ministries in order to retain the nursing workforce which otherwise would migrate as a consequence of Directive 2005/36/EC (DIR 2013/55/EU).

Unified voice in agenda-setting

It can therefore be argued that EU compliance mechanisms were unable to provide the necessary traction to move from legislative endorsement to legislative implementation through lack of governmental commitment and stakeholder engagement.[9] However, although these mechanisms acted as a barrier to effective compliance, the leadership of the nursing community (e.g. professional association, nursing regulator, nursing union, chief nursing officer) were not mobilised to work together or provide a united voice in agenda-setting or framing professional and legislative outcomes. With respect to the leadership needed to engage in the EU accession policy process, the evidence suggests that the nursing leadership was imbued with the culture of the Communist regime in which nurse leaders' interests, their patterns of interactions and subordinate roles in policy design set the level of compliance with Directive 2005/36/EC (DIR 2013/55/EU). Consequently, a persisting cultural legacy maintains nursing education at the secondary level. Nevertheless, a strong strand of opinion supporting the development of nursing as a profession at university level is emerging and growing, with the potential to consign vocational training to the past.

Medical-dominated Soviet Semashko model

Findings suggest that the nursing profession's overall capacity to influence the policy process was weakened by challenges in harnessing a unified

and coordinated position in relation to influencing the political agenda. Conflicting agendas between nursing leaders left leverage for politicians pursuing their own agendas and responsibility for acceptance of the legislative and professional outcomes in the hands of civil servants, mainly physicians and lawyers. It is equally possible that nurse leaders were marginalised from the process since they had little track record of operating within the complex politico-legal environment of the EU. The nursing leadership's divided positions seemed to undermine nursing leaders in seizing EU accession as an opportunity to move nursing towards a position of being part of the European Single Market, benefiting from free movement. Nursing is the most mobile profession and each nurse in principle should be able to benefit from the unique mutual recognition regime in the EU.

Credentialing rivalry

Finally, evidence suggests there was rivalry between the respective ministries of education and of health in which newly created agencies, governmental departments and committees fragmented the mutual recognition credentialing process. Rivalry over responsibility for the recognition of credentials between the ministries reflected the tensions within the nursing community, each trying to maintain their own influence and control over the recognition of professional qualifications, thereby constraining the future professional development of the largest occupation in the health sector. It can be argued that the power differentials and rivalries between ministries as well as the structure of the nursing leadership weakened the nursing advocacy efforts and helped to explain why the nursing leadership was unable to capitalise upon the EU accession policy window.

Conclusions

Based on the above findings, it can be concluded that EU accession was not a destination but rather a starting point for nursing education to comply with European standards as set out in Directive 2005/36/EC (DIR 2013/55/EU). The failure of the nursing leadership to achieve successful legislative and professional outcomes at national level in compliance with EU nursing education standards relates to inherited policy; the political context of the Communist regime; the weakness of the Commission's mechanism to achieve compliance; and the lack of unity within the nursing leadership community in setting a joint professional agenda. It is clear that the process itself, in its initial phase, militated against engagement for a complex mix of reasons. Therefore, it can be argued that EU accession was an important starting point for stimulating nursing leadership advocacy work in Eastern European countries, such as Romania and Croatia, and for providing some exposure to the mechanisms of process compliance. However, the Comprehensive Monitoring and Taiex peer review were weak levers to hold back EU membership when targets were not met. The Taiex capacity building seminars, if properly used, could be a tool to build the capacity of the nursing leadership to design an advocacy strategy to address critical gaps in the future.

Finally, the findings form part of the wider argument that nurses need to increase their engagement in multi-level governance and political decision-making processes at all levels of the policy system.[10] [11] The study findings provide evidence that the lack of multi-level and lateral governance[12] – as a system involving different institutions and stakeholders with diverging views and perceptions – impacts negatively both on the policy process and the outcomes achieved. Leadership becomes the key driver for successful policy outcomes but needs to be harnessed according to a coherent strategy designed to modernise EU accession mechanisms and align that leadership to achieving policy consensus between the key state and non-state actors.

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