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The wages of reconstruction – the EU’s new budget and the public service staff shortage crisis on the EU’s eastern periphery¹

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Over the next seven years, €724bn are being made available to Member States from the EU’s *Recovery and Resilience Facility (RRF)* as part of the Next Generation EU budget instrument. Despite being touted as a revolutionary shift in EU economic policies, the RRF in many respects builds on the logic of previous EU budget rounds. Most importantly, it follows a developmental logic aiming to facilitate territorial cohesion by allocating more funds to less developed EU countries and regions.

One of the main purposes of EU budgets has long been to strengthen EU cohesion by reducing territorial inequalities. At the time of their accession in 2004 and 2007, the relative underdevelopment of Central and Eastern European (CEE) Member States qualified them for a larger share of the cohesion and regional funds. Over time, the importance of EU funds in these economies has further increased, in parallel with the shrinking of their fiscal space, in itself partly due to enhanced budgetary surveillance by the EU’s New Economic Governance regime (Bohle and Greskovits, 2019; Erne, 2018).

The RRF has brought a slight readjustment to the distribution of funds across EU peripheries, with southern Member States gaining greater funding as they now have higher unemployment than eastern Member States and were more severely hit by the economic fallout of the pandemic. Even so, Central and Eastern Europe will receive large amounts of EU RRF funds.

Given the continued importance of EU funds for the CEE region and the fact that it has been the main net recipient of past EU budgets, this article explores the impact of previous EU budgets on the region and whether the Recovery and Resilience Facility represents a break with earlier spending priorities. In particular, it focuses on the question of whether the balance of EU funding remains tilted towards infrastructure spending rather than spending on people (human resources).

To start with, CEE countries have been successful in absorbing EU funds, meaning they have the capacity to spend a very high share of the available funds. Despite worries before their accession, the absorption capacity of the eastern EU newcomers ramped up very quickly (Medve-Bálint, 2018). This was partly a result of their upgraded bureaucratic apparatus during the accession process and of a re-orientation of their domestic budgetary priorities, as most EU projects require co-financing.

While they were successful in spending this money, which areas were targeted? What did these countries spend the money on? One thing is almost certain: the influx of EU money since

¹ This article, accepted for publication in March 2022, draws upon Szabó (2021).

enlargement has led to a visible improvement in physical infrastructures in Central and Eastern Europe, with new roads and motorways, refurbished train stations and manicured town centres tangible evidence of the benefits of EU membership for citizens.² Data collected by Gergő Medve-Bálint show that, from 2007 to 2020, the eastern periphery spent €1847 per person on infrastructure investment backed by EU funds (Medve-Bálint, 2018: 235–236).

At the same time, the East-West gap has not disappeared. It has merely changed in nature, no longer being characterised by the contrast between the East's crumbling infrastructure and the West's well-kept public buildings, roads and railways. The main difference as of 2022 lies in the East's crisis of human resources, a fast-burning crisis with damaging effects.

While there is a general shortage of skilled labour in these ageing societies, the lack of personnel in labour-intensive public services — education, child- and elderly care and most importantly health care — is reaching crisis proportions. Due to low public sector wages³ and often humiliating working conditions, fewer and fewer people are to be found working in the essential public service professions of medicine, nursing and teaching. The situation has been aggravated by workforce emigration, driven by higher wages and better working conditions in 'old' Member States and the right to free movement within the EU Single Market (Stan and Erne, 2021).

The COVID pandemic exposed this situation in a tragic way, with the Hungarian example very instructive. In a country where hospitals have been renovated with EU funds and equipped with cutting-edge equipment, the biggest obstacle to the effective treatment of COVID patients were staff shortages.⁴ The government prevented the collapse of the health-care system by introducing military rule⁵ for health-care workers: for the duration of the emergency, legislation prohibited nurses and doctors from quitting their jobs and allowed managers to redeploy staff across distant locations.⁶ The links to the Single Market are nuanced but clear: the ban on resignations during the pandemic served in a roundabout way to limit freedom of movement for health-care workers. While not specifically acknowledging this, the government was forced to rely on such drastic measures as it had not previously taken sufficient steps to address the exodus of health-care workers from Hungary to the West.

EU investment funds have been unable to reverse such developments. Indeed, they were not even intended to do so. EU funds, including the European Social Fund, are not designed to finance wages (apart from fixed-term, project-based employment). Using the same data quoted earlier, Medve-Bálint demonstrated that, compared to the €1847 per person spending on physical infrastructure between 2007 and 2020, the eastern periphery spent €635 per person on human capital over the same period. In sum, EU funding before the RRF was heavily tilted towards investment in physical infrastructures and at best supported a revival of strategic industrial policy in Central and Eastern Europe, as pointed out by Šćepanović and Medve-Bálint (Medve-Bálint and Šćepanović, 2020). At worst, resources were funnelled to a political-business elite with very close ties to the governing party, as seen in Hungary (Scheiring, 2020).

2 How the EU funds its economically disadvantaged regions. Deutsche Welle 08.05.2019. <https://www.dw.com/en/how-the-eu-funds-its-economically-disadvantaged-regions/a-48354538> (accessed 21 March 2022).

3 OECD Health at a Glance 2019. Remuneration of nurses: <https://www.oecd-ilibrary.org/sites/a44d2e24-en/index.html?itemId=/content/component/a44d2e24-en> (accessed 21 March 2022).

4 <https://444.hu/2020/09/18/orban-azonnal-felbeszakitotta-az-orvost-amikor-az-elkezdte-mondani-hogymi-a-gond-a-lelegeztetokkal> (accessed 21 March 2022).

5 <https://koronavirus.gov.hu/cikkek/hetfotol-korhazparancsnokok-segitik-korhazak-mukodeset-es-azegeszsegugyi-keszlet-vedelmet> (accessed 21 March 2022).

6 <https://merce.hu/2021/04/27/levelben-kerik-orbant-az-egeszsegugyi-dolgozok-hogy-szuntesse-meg-a-felmondasi-tilalmukat/> (accessed 21 March 2022).

Can the new EU long-term budget serve as a turning point, allowing CEE countries to escape from this damaging status quo? To cut a long story short, the priorities of the financial framework for structural and investment funds remain unchanged, with the new RRF priorities of climate investment and digital transition similarly weighted towards infrastructure. Even in sectors where human resources are essential, such as health care, the main investment thrust is digital technology.

Looking at the data collected by the Bruegel Institute on National Recovery and Resilience Plans, RRF-funded health-care investment mainly targets health digitalisation across the EU, including the southern and eastern periphery. Health digitalisation is a €1bn item in the Polish recovery plan, while the implementation of an integrated eHealth and telemedicine system is set to receive €400m in the Romanian plan (Bruegel Institute, 2021). The other big health spending item is that of traditional bricks-and-mortar hospital infrastructure projects, replicating earlier rounds of EU development policies. Slovakia plans to spend €998m on the ‘construction, reconstruction and equipping’ of a new hospital network. Finally, medical staff training also features in these plans, for example in Romania. Again, however, investment in training is nothing new, as ESF funding was always to a large extent about skill upgrading.

In sum, we see a persistence of priorities from previous EU funding periods, meaning that governments continue to spend the majority of funds on large-scale infrastructure projects. While these investments may be greener than in previous rounds and may promote digitalisation, they do not address the main problem currently faced by eastern periphery countries: a chronic shortage of staff in essential human services. This is clearly the case in health care.

Digitalisation may have a positive impact on health services in the sense that it relieves health-care workers from administrative burdens, thereby allowing them to focus on their core caring duties (Directorate-General for Health and Food Safety, 2019: 85). There are however limits to digitalisation, robotisation and automation in health care. Research by Frey and Osborne (2017) categorised different occupations according to the likelihood of their replacement by computers and robots. Of the 20 occupations least likely to be computerised, 11 were in health care (Frey and Osborne, 2017: 269). Therefore, it is fair to say that health care will achieve few efficiency gains through the digitalisation pursued through EU funds.

There is one other, more general issue regarding the RRF’s focus. If recovery goals include the creation of new jobs, then labour-intensive public services could be a major source of such jobs. Instead, by focusing on labour-saving technologies, Next Generation EU may in the end actually hinder achievement of this goal.

If Member State governments want to hire more health-care workers or to increase wages in the sector, they generally have to provide funding out of domestic budgets. There is one exception, however. Hungary’s Recovery and Resilience Plan (RRP)⁷ includes a large expenditure item of nearly €1bn partially to cover salary increases for medical doctors, thereby moving the human resource issue more firmly into the domain of EU politics. The appearance of health-care wages in the RRP signals a turnaround in the Hungarian government’s preferences on how it spends EU money, and its acceptance by the European Commission would be close to a sea change in the development of the EU budget (Hungary’s RRP was pending approval at the time of writing in March 2022 and according to government sources, teachers’ wages may also be included in the final plan to resolve a pay dispute with unions).⁸

But why should the EU provide support in an area belonging to Member States’ core competences: the financing of public sector wages? Here, the Hungarian government argues that wage increases are part of the structural reform and anti-corruption measures in health-care services. In

7 <https://www.palyazat.gov.hu/helyreallitasi-es-ellenallokepesege-eszkoz-rrf> (accessed 22 March 2022).

8 https://eduline.hu/kozoktatasi/20220311_Gulyas_Gergely_pedagogusberemeles (accessed 12 April 2022).

particular, they are linked to the fight against the longstanding practice of informal payments by patients to medical professionals in Hungary. The EU Country Specific Recommendations issued to Hungary in the context of the 2020 European Semester also call on the government to address labour shortages in health care.

The current Hungarian proposal is rife with contradictions, most importantly because it does not extend to nurses and other health-care staff. Wage increases received by the latter groups of workers in recent years have been more modest than those offered to doctors, not to mention the continuing wage suppression in other public services such as education. Health-care wage increases were biased towards medical doctors in Romania as well, already before the COVID pandemic (Stan and Erne, 2016).

Moreover, the wage settlement in Hungary is part of a broader health-care reform plan to reduce hospital beds and strengthen out-patient and primary care services – a goal equally to be found in the EU Country Specific Recommendations (Stan and Erne, 2019) and shared by the Hungarian government. While in theory and in the long run ‘shifting care out of hospitals’ is a good idea, in the wake of a historic pandemic any responsible policy-maker should provide some extra capacities in the hospital system for use in the event of another emergency.

Despite these contradictions, and despite coming from an otherwise strictly right-wing government, the idea of financing health-care wages out of EU funds could open the way for more progressive EU budget policies. It could even be read as an acknowledgment that the EU is on the way to doing more to preserve free movement of labour in times when this principle is increasingly contested by host and sending countries alike. This ‘salvage operation’ has the potential to resolve the underlying tensions making free movement of labour a contentious issue, such as the East-West gap in wages that is particularly wide in public services. Acknowledgment of a joint responsibility by the EU and CEE Member States to address the staff shortage crisis in public services could be part of this process.

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