

Professionals on the road to contention: Social movement unionism in healthcare labour disputes across Europe

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Abstract

The recent upsurge in healthcare labour disputes across Europe signals a shift in the attitude of public service professionals towards contentious politics. However, the analysis of these events so far has neglected the specific dilemmas of contention among professionals. To fill this gap, the article builds on social movements theory and claims that to achieve success, professional organizations adjust the protest repertoire of the labour movement along the three dimensions of targeting, framing and coordination. As an alternative to mass strikes, the targeted use of the protest repertoire minimizes the costs and maximizes the visibility of collective action. Framing around service quality links wage demands to wider justification themes that resonate with the public. Coordination across groups with different skill levels strengthens the effect of both targeting and framing. A comparative study of four healthcare campaigns in four countries (Denmark, Estonia, Hungary, Ireland) confirms the key role that these dimensions play.

Keywords

Comparative industrial relations, employee voice, industrial conflict, public sector, labour relations

Introduction

Unrest at the workplace is today a much less common phenomenon in Western societies than it used to be a few decades ago (Gall, 2013; Shalev, 1992; van der Velden et al., 2007; Vandaele, 2011). Traditional strongholds of labour militancy (such as mining and heavy industries) occupy a marginal position in advanced economies, high-end manufacturing is dominated by cross-class coalitions, and collective action in private services is slow to take off (Ebbinghaus and Visser, 1999; Rhodes, 2001). However, some employee groups defy these trends: public service professionals, who in the past rejected the idea of open confrontation with employers, are now increasingly involved in large-scale industrial unrest. Nurses, teachers and doctors do not only take part in strikes, but organize other forms of collective action, such as mass resignation campaigns, sick-outs, work-to-rules and recruitment boycotts (Altwicker-Hámory and Köllő, 2013; Briskin, 2011: 490; Spillane, 2015).

The appearance of contention among public service professionals is puzzling from the viewpoint of industrial relations and labour studies. These employee groups are unusual suspects for contentious politics. Historically, professional ethics and prohibitive legislation held them back from taking industrial action (Hyman, 1978: 43). Walkouts did not feature in the repertoire of their professional associations who kept their distance from the labour movement not only organizationally but also in the selection of their bargaining tools.

Industrial relations scholars have noted the turn towards militancy among public service professionals, but their analysis relies on the framework that was developed for blue-collar trade unions and therefore has yet to incorporate the dilemmas that professionals confront when organizing collective action. To fill this gap, this study explores the way in which professional associations adjust the protest tools of the labour movement to their own struggles. It looks at the challenges of collective action in state-financed professional human services and at the tactical choices professional associations make to overcome them. In specific, the study identifies the

conditions for successful protest campaigns in the face of conservative organizational legacies and the claims of professional irresponsibility by the employer side.

This study proposes that the expansion of protest among public service professionals is part of the broader process, in which the links of professional associations to the state, to the public and to their own members are being redefined. Long-term economic pressures and opportunities (increasing consumer demand, management reforms and austerity) explain the changing attitude of professionals towards militancy in general, but during a specific labour dispute professional associations make short-term tactical decisions to resolve issues with legality, resource management and communication to the public.

From the review of the social movements literature and from the comparative analysis of four protest campaigns in healthcare in four European countries (Denmark, Estonia, Hungary and Ireland), over the period 1999-2012, three key elements of these tactical decisions emerge: replacing the mass strike with a more targeted repertoire of contention, framing wage demands in a broader fight for improved healthcare services and coordinating protest action across employee groups with different skills.

The purpose of this study is theory-building, and to achieve this, it relies on a mixture of inductive and deductive reasoning. The concepts of targeting, framing and coordination are deducted from the social movements literature but are then linked to professionals' specific dilemmas of organizing protest. Therefore, the study also teases out new insights inductively from the experience of contention among professionals on the ground and uses them to refine the concepts borrowed from the social movements literature.

This contribution focuses on healthcare, but a similar argument could be applied to education and social services. I use evidence from healthcare because that is the branch of public services where the question of how professional status affects protest attitudes can be looked at in the most detailed way. Healthcare providers include medical doctors, one of the classic professions, that have however become subject to state-led managerial and fiscal control

(Noordegraaf, 2007: 762). In the meantime, however, nurses and non-medical grades have undergone a process of professionalization in terms of an upgrade of skills and responsibilities, while they also face the same managerial pressures as physicians. In sum, healthcare is a complex, integrated service area, with different skill requirements for different tasks and often contradictory pressures of proletarianization and professionalization.

Moreover, the stakes of collective action for service users are the highest in healthcare. In the case of a school strike, parents may have to arrange for childcare or may be forced to take extra days off from their workplace. However, the disruption is more directly felt in healthcare because the clients of the healthcare system are in a more vulnerable position to start with.

The article starts by pointing out the need to incorporate the professional dimension into the analysis of labour disputes in public services. Second, it outlines the constraints that healthcare professionals face when they organize collective action against the state. Third, it uses the cases of the four protest campaigns to demonstrate the importance of targeting, framing and coordination in overcoming these dilemmas. The article concludes by outlining the major implications of the findings for the study of labour protest in the 21st century.

The long road to contention and professionals' dilemmas

Industrial relations and labour studies scholars associate the rise of labour militancy in public services with economic opportunities and pressures. (Kaminska and Kahancová, 2011; Silver, 2003; Stan and Erne, 2016). As an influential representative of this position, Beverly Silver argues in her book “Forces of Labor” that education has become one of the new epicentres of labour protest due to opportunities that increase teachers’ structural power: increasing consumer demand, labour intensity and immunity to relocation. These factors allow teachers to formulate proactive demands against the state and stand up for them militantly (Silver, 2003, pp. 113–119).

Even though Silver focuses on teachers, the same argument can be applied to healthcare professionals: aging Western societies require more health and care services, which increases demand for labour. At the same time, as healthcare is an activity that is built around real-time, face-to-face human interaction, the structural power of labour is difficult to diminish by labour-saving technologies or by relocation (Oesch, 2006). In one respect, the structural position of healthcare professionals is even stronger than educators'. While pre-tertiary education is still bounded by language and national regulation, healthcare labour markets are international. Emigration deepens the grievances of remaining employees in sending countries through creating further labour shortages, but it also opens opportunities for collective action. (Adăscăliței and Muntean, 2019; Hardy et al., 2015; Kaminska and Kahancová, 2011; Stan and Erne, 2016; Szabó, 2014).

Other researchers focus on grievances instead of opportunities as the main driving force behind the increasing participation of healthcare professionals in contentious politics. The creation of public healthcare systems brought increasing managerial oversight, creating grievances especially for the traditionally independent profession of medical doctors (Immergut, 1992). Since the turn towards austerity and new public management in the 1980s, public service professionals have been targeted by measures that reduce not only their professional autonomy but also their salaries. Healthcare is a labour-intensive activity - wage costs can run as high as 60–85 per cent of operating expenses -, therefore the largest savings during fiscal adjustment periods can be achieved by cutting wages. Healthcare wages were particularly heavily affected during the most recent round of austerity (OECD, 2013: 82; Schwartz, 2001: 28).

However, let it be grievances or opportunities, there is a long chain between them on the one hand and the outcome of protest on the other. Economic pressures may create grievances and structural power may create opportunities, but whether these opportunities are acted upon depends on organizational decisions. For example, labour migration in the first instance means exit at the individual level and it is the task of organizations to turn that into collective voice (Hirschman, 1970). Certain aspects of this “intervening variable problem” are

addressed in the mentioned studies: Kaminska and Kahancová deal with collective bargaining strategies (Kaminska & Kahancová, 2011) and the value choices of organizations in the work of Stan and Erne (Stan and Erne, 2016).

Alas, none of these studies deal with the intervening variable of professionalism. In other words, they do not identify and incorporate the specific constraints and opportunities on collective action that result from the (semi-) professional status of the protesting healthcare employees.

Intervening factors of professionalism: organizational legacies and work logic

This study argues that when it comes to contentious politics, healthcare professionals have two characteristics that separate them from other employee groups: the first is the conservative legacy of their representative organizations and the second is their interpersonal, high-responsibility work logic.

It is a well-established fact in political sociology that public service professionals — including those working in healthcare — are better organized than the average of the workforce (Oesch, 2006: 219). However, the literature overlooks that the original function of professionals' associations is different from that of trade unions. The traditional organizations of professionals were not formed in the class struggle. They were chambers and craft guilds whose goal was to control licences and to enforce standards of practice rather than to represent members in conflicts with employers. This was especially the case in traditionally independent professions such as medicine. To quote Harry Eckstein, medical professionals had a “deep inhibition towards anything that smacks of trade unionism” (Eckstein 1960 p. 29). Similar attitudes were characteristic of nurses' organizations, who often internalized the idealized, gender-biased view on nursing as a charitable feminine activity — which implies devotion, subordination, and the acceptance of low pay (Stallknecht, 2011).

As mentioned previously, the pressures of managerialism, austerity and increasing demand have pushed professional associations to change their attitudes towards contentious politics. This change occurred at different times in different countries and for different professional grades. In several countries, medical doctors organized strikes in protest against the expansion of public healthcare systems— Immergut reports a strike from Sweden in 1957, from France in 1960 and from Canada in 1961 (Immergut, 1992: 66,121,217). Scandinavian nursing unions had their first strikes in the 1960s and 1970s, while the Royal College of Nursing in the UK had a no-strike rule in its constitution until 1995 (Leifer, 1995; Stallknecht, 2011). Discussed in this study, the first Irish nurses' strike took place in 1999 and the first Estonian healthcare strike in 2012.

Despite this diversity in their starting date, the processes in all countries point in the same direction of increasing conflict with employers. Organizational legacies however make this process cumbersome. These legacies mean that high membership density does not translate into a higher level of resources that organizations could use during a conflict. These organizations lack experience with organizing protest campaigns and traditionally had little or no strike funds. They are further weakened by the financial asymmetry of an industrial dispute in the public sector: a public sector strike can do little damage to a country's budget, as the government continues to collect taxes while it suspends the payment of public sector wages during a walkout, and in this way can even save money (Crouch, 1982: 103). By contrast, professional associations are supposed to cover the lost remuneration of striking members from their strike funds, if they have one in the first place.

The second major distinction between healthcare professionals and other employee groups has to do with work logic. Most skilled employees in public services, including healthcare belong to the occupational class category of socio-cultural professionals (Kitschelt and Rehm, 2014; Oesch, 2006). Socio-cultural professionals work according to an interpersonal logic, meaning that the main product of their work is the direct, face-to-face interaction with their clients. In

healthcare, this interaction takes place in the context of power asymmetry between them and their patients.

Recent work in political sociology has pointed out that socio-cultural professionals enjoy a high degree of work autonomy and face a high degree of uncertainty about the structure of the tasks they perform (Kitschelt and Rehm, 2014; Oesch, 2006). I argue that autonomy and uncertainty are also linked to a high degree of responsibility for the content and quality of the service. This responsibility is not only apparent at the level of individual professionals, but it is also reflected in the goals of professional associations, who still have the ambition and the resources to influence training regimes and employer policies on professional standards. By contrast, most blue-collar trade unions have lost control over the content of task structure and training with the transition to Fordism (Braverman, 1975).

The single most important implication of high responsibility and interpersonal work logic is that consumers (the more precise terms in the context of healthcare are clients, service users or patients) feature more prominently in the cost and benefit calculations of protest organizers compared to other economic activities. In every economic sector, consumers are the ultimate victims of work stoppages, but there are significant differences across sectors regarding how the disruptive impact on consumers is incorporated in labour protest strategies. In manufacturing for example, consumers may become involved as direct allies, as it is the case in boycotts organized against global brands. In these boycotts, consumers actively take a sacrifice by deciding not to consume a non-essential and substitutable product (Klein et al., 2004).

By contrast, in essential public services such as healthcare, the consumption of the product is typically not an active choice but a necessity. Moreover, due to the interpersonal nature of public services, industrial action affects consumers more immediately. Care cannot be stored or transported, and it also takes time to set up alternative providers, also due to general labour and skills shortage in the sector. Even a one-day healthcare strike can force patients to take notice: consultations must be cancelled or delayed right away.

In turn, the potentially disruptive impact of a healthcare strike on patients also increases the risks that professionals face during these events. The benchmark of labour protest in industrial societies is the mass strike, a complete shut-down of production with maximum disruptive impact (Luxemburg, 1906). While healthcare workers have the capacity to cause large-scale disruption, a mass strike is inconceivable in healthcare, as this would go against professional ethics. A wide range of legal restrictions also apply to workplace-related protest in healthcare. These restrictions differ from country to country regarding the exact legal instrument through which they are implemented. In the most conservative case, healthcare employees may be prohibited from taking strike action completely. Even if employees are permitted to go on strike, procedural guarantees and emergency service requirements are in place to prevent abrupt service disruptions (International Labour Office, 2006).

Apart from issues with legality, professional organizations also must bear in mind the reputational damage that disruptive action can cause. The upsurge of contention among public sector professionals is taking place in an era that is otherwise characterized by labour quiescence, therefore the public is not used to strike-related disruption of services. Moreover, public opinion and the mainstream media tends to be hostile to trade unions in several countries (Cawley, 2012; Cramer, 2014). The problem is aggravated by the fact that professional organizations historically devoted few resources to influence public opinion in their own favour, their public relations were underdeveloped (Eckstein, 1960: 73). The employer side may accuse professional of irresponsibility and of advancing particularistic claims of privilege instead of respecting the obligations to provide public services.

To summarize, there are several barriers to professionals' protest in healthcare: conservative organizational legacies and an interpersonal, high-responsibility work logic create hindrances on collective action in terms of low or non-existent strike funds, potentially disruptive impact on patients and accusations of irresponsibility from the employer side.

Addressing barriers through social movement unionism

This study claims that professionals overcome the barriers identified above by borrowing social movement mobilization tools. The industrial relations literature is showing increasing interest towards social movements theory, especially in the context of trade union renewal. The term social movement unionism is used to cover a wide range of strategies that help trade unions to move beyond the traditional model of “membership representation and wage bargaining”, including the framing of demands in social justice terms rather than in terms of narrow wage goals and building alliances with grassroots community organizations (Briskin, 2011; Greer, 2008: 605; Johnston, 1994; Tattersall, 2013).

This article revisits the conceptual building blocks of social movements theory as formulated by Tarrow: political opportunities, repertoire of contention, issue framing and social networks (Tarrow, 1994: 23). The latter three are the most relevant here as I already discussed economic and political opportunities as the starting point of the argument. The repertoire of contention refers to the forms of collective action, including the protest tools organizers rely on. Framing can be defined as the content of the communication through which protesting organizations justify their claims in a way that resonates with the broader public. Finally, social networks include alliances that make large-scale mobilization possible.

These concepts were developed as analytical dimensions that could cover various types of contention over a long period of time, including traditional trade union protest and identity-based, “new” types of protests. The contribution of this study lies in showing how professionals adjust their protest along these three conceptual dimensions to tackle the barriers of professionalism on collective action identified above. It argues that professionals will be stronger if they target the repertoire of contention away from mass strikes, if they frame around service quality and if they create and coordinate alliances across different skill groups working in healthcare.

First, targeting the repertoire of contention will have an impact on the legality of the protest and on its economic costs. As already mentioned, an untargeted, full-frontal use of the

strike weapon is not available for professionals as it would deplete (often anyways non-existing) strike funds and would pose ethical and legal challenges. A more targeted selection of protest tools can ensure that the protest meets legal requirements and that it does not drain fiscal and organizational resources. Furthermore, the more targeted the protest is, the easier it will be to reach a balance between being disruptive enough to attract public attention, but not so disruptive to threaten basic services to vulnerable patients.

Settling issues of resource management and visibility is only the first step in a confrontation with the government. As the conflict becomes a salient political issue, protest organizers will have a short window of opportunity to make their case. This is where the importance of framing lies. I argue that professionals can move beyond demands for fair wages and rely on a framing strategy of common concern with patients, which in practice means rallying around service quality (Tattersall, 2013). Framing is an area where the interpersonal, high responsibility work logic can serve as an advantage for protesting healthcare workers. Due to their close links to consumers and due to their detailed systemic knowledge on healthcare delivery, professional organizations can provide a credible alternative vision on service quality.

Framing around service quality is a proactive tool in the hands of employee organizations to incur political damage on governments. As mentioned previously, public sector strikes can do little economic damage to governments, but the political costs of mishandling a conflict can run high for them. Criticism coming from professional organizations can expose the government not only as an employer but also as a healthcare provider. A government that ends up on the losing side of a debate with professional organizations will also become more vulnerable to criticism from opposition parties and in the end may suffer electoral losses.

As a third, final element, this study narrows down the meaning of social networks to coordination across different employee groups. Even when not all employee groups participate in collective action, the relationship between them can turn out to be crucial in determining protest outcomes. Coordination can help a better use of resources and can also enhance the message that

the struggle is not fought to advance particularistic interests but to advance wider claims. The participation of non-professional or less skilled grades within healthcare can help fend off the accusations that the protesters only fight for privileges.

Figure 1 summarizes the theoretical argument, showing the process of contentious action by healthcare professionals. The blocks on the left-hand side show the starting points of organizational legacies and work logic. Conservative organizational legacies act as hindrances on effective mobilization in healthcare as they strip professionals of campaigning experience and strike funds. Interpersonal work logic leaves professionals with a dilemma of finding the right balance between being disruptive enough to be noticed in the public but not to cause too serious disruptions to patients. Finally, a high responsibility work logic leaves professional exposed to accusations of irresponsibility when they refuse to take up work.

Professionals could overcome these hurdles by adapting social movement tools to their own struggles (the three right-hand blocks of the figure). Targeting, framing and coordination are crucial aspects of any trade union campaign, but targeting the protest repertoire away from mass strikes, framing protest around service quality and coordinating with lower-skilled employee groups are specific features of successful protest by healthcare professionals. First, reshuffling the repertoire of contention by relying less on full-scale work stoppages and more on a mixed and targeted approach helps tackle the problem of meagre resources and find the right level of disruptiveness. Second, framing demands around service quality serves as an effective tool to fend off accusations of irresponsibility, to convince the public that the short-term disruption is necessary to achieve long-term common goals. Finally, coordination across employee groups with different skill levels and seniority helps counteract the accusations of irresponsibility but also enhances the impact of both targeting and framing.

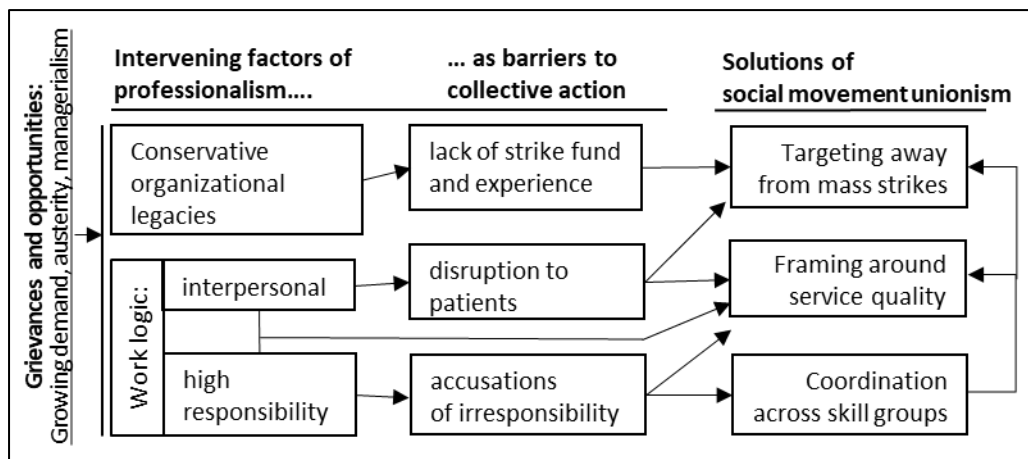


Figure 1: The process of collective action by healthcare professionals

The diagram also demonstrates that from the two broad aspects of professionalism, conservative organizational legacies place only hurdles on protest action, while work logic has an ambivalent impact: it erects barriers to traditional ways of collective action but it also creates opportunities for protesters to frame their demands around service quality. Finally, each of the three aspects of social movement unionism in healthcare must be activated by conscious decisions of campaign organizers. Tactical choices that organizations make during campaigns matter, which is the subject of following sections.

Comparative case study evidence from four healthcare campaigns across Europe

This study draws empirical evidence from four protest campaigns in healthcare in four EU countries between 1999 and 2012: the strike of Irish nurses in 1999, the strike of Danish nurses in 2008, the general healthcare strike in Estonia in 2012, and the resignation campaign of Hungarian junior doctors in 2011.¹

¹ Domestic and international media covered all four campaigns. I reviewed the English, Hungarian and partially the Danish language press reporting on the events. I ensured the reliability of information through cross-checking reports on one event from different news outlets as well as from international and national observatories of labour relations, such as the EurWork-European Industrial Relations Observatory, the archive of Irish Industrial Relations News and in the Danish cases the collections of FAOS - the Employment Relations Research Centre of the University of Copenhagen. Policy documents, press releases and published interviews with protest organizers proved to be useful primary sources. To complement documentary evidence, I conducted six semi-structured interviews with representatives of trade unions and employer associations.

All four protest campaigns led to eruptions of conflict in an environment of overall labour quiescence. In Ireland, nurses were the first large group to go on a nation-wide strike despite labour peace enshrined in Social Partnership agreements. The strike lasted for nine days with the participation of 29 000 nurses, and it is considered by the organizers to be the largest industrial dispute in the history of the Republic to that date (Sheehan, 1999), interview 1). In Estonia, a country which has been an extreme case of labour weakness, the resilience of protesters - the strike lasted for four weeks - surprised not only the public and the government but the organizers themselves (interview 2, interview 6). The 2008 conflict in Denmark was the longest such event ever recorded in the Danish public sector and the largest strike in the country after the general private sector strike in 1998 (Jørgensen, 2008). Finally, the resignation campaign of Hungarian junior doctors was the only nation-wide labour protest event in the country's public sector between 2010 and 2016 that required direct workplace-level involvement from employees (Altwickler-Hámory and Köllő, 2013). The outcomes of the campaigns however diverged, in terms of material gains achieved for employees and in terms of the power position of the organizing actors compared to the status quo.

The healthcare strike in Estonia in 2012 was the most successful from among the selected cases. The Estonian Medical Association (EAL) and Estonian Union of Healthcare Workers (ETK) called industrial action with a goal of concluding a new sectoral collective agreement that increases occupational minimum wages and reduces working hours. In the wake of the strike, the government agreed to wage increases between 11 and 23% and to a workload reduction of 15-20% for all the main groups working in healthcare (Lai et al., 2013: 156–157; Murphy, 2015). Furthermore, the strike strengthened the institutional position of the organizers, since the government acknowledged them as contractual partners.

The Irish Nurses Organisation (INO) ran its 1999 strike on a complex agenda, which on top of wage increases also aimed at the upgrading of the entire salary structure. These goals were not fully achieved, but they were reflected in the Labour Court recommendation that ended the

conflict. Nurses received a 2% salary increase and benefitted from the creation of new senior nurse posts (Labour Relations Commission, 2000: 8). The strike was considered successful, although there was some dissatisfaction among members because they were not compensated for lost wages during the strike (Irish Nurses Organisation, 2000: 4, 82).

In Hungary, the material goals of the protesters were largely achieved. The campaign focused on the improvement of wages and working conditions for resident physicians, but more general claims were also formulated, such as the long-term goal of increasing specialized medical consultants' salaries three times above the national average. To resolve the dispute, the government gave a one-off wage increase that in some categories reached 20%. (Szabó, 2014). The leaders of the Association of Resident Physicians (MRSZ) gained countrywide recognition in the wake of the events, but they were not able to oust the conservative leadership of traditional professional associations (interview 5).

The Danish nurses' strike in 2008 weakened the position of the nurses' union and did not produce the desired results in terms of wage increases either (Stallknecht, 2011, p. 26, interviews 3 and 4). In Denmark, health- and elderly care assistants (represented by the general service union FoA) initiated the wave of militancy during the 2008 bargaining round, but the Danish Nurses Organisation, DSR also decided to follow suit with its own campaign. FoA reached an agreement with the employers first, securing a 13.3% wage increase over three years. DSR was not satisfied with this and the conflict between them and the employer side dragged on for a total of 43 days but ended with the same result. DSR's strike fund was running critically low and lost members in the wake of the conflict (Scheuer et al., 2016: 378).

To sum up, from the four cases, the Estonian healthcare strike was the most successful, while Danish nurses achieved the least and their union suffered the most as the result of the conflict. The Irish nurses' strike and the Hungarian resident physicians' resignation campaign falls in between the Estonian and Danish cases. The cases leave us with a question: why was protest more successful in some cases than in others?

Healthcare employees benefited from a tight labour market in all cases, therefore economic opportunities in themselves cannot account for the differences in outcomes (Global Health Workforce Alliance, 2014). Moreover, the results also cut across organizational strength and institutional embeddedness of associations. The success of the Estonian strike and the Hungarian resignation campaign defies the low membership rate and the meagre financial resources of these organizations, as well as the hostile institutional environment that they were operating in. On the other hand, the Danish nurses' strike achieved disappointing results despite almost full membership coverage, institutional security and ample financial resources (Traxler, 2009).

The evidence to be presented in the following sections suggests that rather than economic opportunities or the strength of institutions and organizations, it is the tactical choices of targeting, framing and coordination that provide the most convincing explanation for the different outcomes in the four cases.

Targeting the protest repertoire away from the mass strike

To repeat, targeting means the shift away from a full-scale, frontal strike mobilization towards a more conscious and economical use of the strike weapon. The first strike organized by the Irish Nurses' Organization highlights the risks that a professional association faces when it embraces the protest tools of the labour movement without appropriately targeting them. The INO leadership decided to go for an all-out strike, putting 23 500 of its members on the picket line, despite several factors that made this move risky. First, due to its preceding aversion to industrial action, INO only had a small strike fund to rely on during the strike and this meant lost pay for member for the nine days of the action (Birchard 1999, Irish Nurses Organisation, 2000, p.4, p.19).

Second, the procedure of securing emergency services was not regulated neither by legislation nor by collective agreements during the 1999 strike. Instead, strike committees of nurses determined emergency cover on the spot, leaving patients in a potentially vulnerable

position (Irish Nurses Organisation, 2000, p. 4, p. 19). The absence of an agreement on minimum services presented not only a legal and reputational but also a further fiscal challenge for the organizers. Members on strike had to take up work when an emergency patient reached the picket line, but they still did not get paid as they were officially on strike (Brown et al., 2006).

In turn, the experience of the Danish nurses shows that in the absence of targeting, a conflict can even drain the resources of a professional association with a large strike fund and with a long experience of industrial conflict. DSR is a well-staffed organization that had called its first strike in 1973 and had started collecting a strike fund already before that event (Stallknecht, 2011: 21–23). In 2008, DSR opted for an all-out strike, withdrawing from work and paying strike compensation to all those members who did not provide emergency services (interview 4). Based on their experiences from previous strikes, leaders of DSR expected that the Danish parliament would break up the conflict by legislative intervention (Madsen and Due, 2008). The government however refrained from proposing an intervention, prolonging the conflict and thereby draining the nurses' unions strike funds further (interview 3).

As opposed to the Danish, Irish and Estonian healthcare workers, Hungarian junior doctors dropped the strike weapon altogether and relied on a resignation campaign instead. The term resignation campaign denotes the organized, simultaneous and publicized threat of mass termination of employment contracts by the employee side. Within labour disputes, resignation campaigns represent the closest example of what Albert O. Hirschman called the loyalist's threat of exit (Hirschman, 1970, p. 82). During resignation campaigns, employees deposit their resignation letters, specifying a future date when the resignation takes effect.

As resignations are outside the scope of strike regulations, no prior agreement on emergency services has to be reached with the government and the responsibility for organizing alternative provision remains on the government side (Granberg, 2015). This was an especially useful aspect of the resignation campaign in Hungary, where the governing majority amended the strike law in 2011, prohibiting strikes that were launched without a prior agreement with

employers or without a preliminary court ruling on minimum services (Rindt, 2012). In addition, the financial risk of the resignation lies with the individual participants and not with the organizing association. Individual medical doctors are however likely to take this risk as the chances of re-employment are high in a sector which suffers from serious labour shortages.

From all the reviewed events, the Estonian case was the most successful in resource management and in navigating through the legal problems of a strike. Similarly to the Hungarian professional association, Estonian unions were forced to economize on human and financial resources during the 2012 strike as they have lower membership density and a shorter history than counterparts in Western Europe (Traxler, 2009: 31). The combination of a piecemeal and gradually extended strike action with work-to-rule and slow-down minimized costs, and it also secured that patients notice the events while they are not immediately hurt by them:

“The strike started with first-time visits; those were cut down. And when [family doctors] participated in the strike, they followed the rules, they did not take so many patients. If it is 20 minutes for one person, it is only 20 minutes for one person. [...] Next stage: planned surgeries which could be postponed [...]. And the next plans if the strike would not have ended, the next step would have been not to accept more stationary patients in hospitals, except emergency.” (Interview 2).

The Irish and Danish case demonstrate that the exclusive reliance on the mass strike as an untargeted, full frontal weapon brings more costs than benefits to the organizers. By contrast, the experience of the junior doctors’ resignation campaign in Hungary suggests that an alternative form of protest may force the government to concede. No actual disruption is needed in healthcare to achieve the goals of campaigners if the threat of disruption is credible. Finally, the Estonian case highlights that a lean strike action supplemented with work-to-rule and slow-down serves the goal of targeting most efficiently.

Despite the differences in how much resources the organizers expended to achieve it, all four protest campaigns analysed here generated a fair degree of media attention. Then the next

question is how protest organizers exploited this window of opportunity and what kind of message they sent to the public.

Framing around service quality

Framing is the sum of the narratives that protesters invoke to justify their demands in front of the public. Framing is a key element of protest because it increases the political costs that a government bears during a conflict, which in turn may force it to concede. The main demand of the analysed protest events was wage increase. This is problematic from the perspective of social movement unionism, as it is a narrow goal that potentially inhibits public sympathy and coalition-building capacities with other unions and social movements. All four campaigns were aware of this problem as they linked wage demands to broader issues of fairness, but they were not equally successful in embedding their claims in a broader vision of improved healthcare provision for patients.

The common and most evident justification scheme in all these cases was intersectoral fairness of wages. Organizers claimed that the wages of public sector healthcare professionals should be brought in line with those in the private sector. In the Danish and Irish cases, the main argument was that healthcare sector workers were left behind in times of economic boom, when private sector wages were shooting up. One of my informants from Ireland claimed that “nurses would be drawn away” into private sector technology jobs because they had expertise in medical technology (Interview 1). The private sector offered higher wages for jobs requiring less responsibility, which was also perceived as unfair.

The grievances were slightly different during the Hungarian and Estonian protest campaigns, as both took place after the financial crash of 2008. Apart from the need to catch-up with the private sector, protest organizers also called for the reversal of austerity-related public sector wage cuts (Vaughan-Whitehead, 2013). Furthermore, in the two Eastern European countries, the injustices of cross-national wage differences were also on the agenda, as both events happened parallel to the peaking of emigration.

Finally, the gender pay gap featured prominently in the communication of the Danish and Irish strike organizers. They demanded a higher increase than what was enshrined in national-level collective agreements to allow for a catch-up of salaries in the mostly female profession of nursing (interview 1). However, while Irish nurses had their first nationwide strike in 1999, Danish nurses initiated a conflict for the third time in 15 years with the same agenda.

In three out of four cases, discursive struggles between the government and protest organizers were fought around the question of responsibility. Protest organizers in Estonia, Hungary and Ireland had to deal with a government communication that portrayed them as irresponsible actors, violating professional standards and representing particularistic interests. The Estonian minister of finance called the leaders of the Medical Association terrorists (Interview 2). In Hungary, the health secretary appealed to the professional ethics of protesters and condemned the resignation campaign as a senseless activity (Szócska, 2011). In Ireland, even the head of the government, Bertie Ahern got involved in the discussions, but his admonition of the strike organizers did not concern professional irresponsibility, but rather was made in defence of Social Partnership against “special interest groups” (Industrial Relations News, 1999a).

In response to these government claims, healthcare professionals in Estonia and Hungary, and to some extent in Ireland channelled their demands into health policy debates, demonstrating that they are responsible actors who are concerned about broad issues of service quality. It was only in the Danish case where I did not find a link between the wage conflict and broader health policy issues. In Hungary, the representatives of junior doctors consciously grouped their media messages around two issues: the enhancement of patient safety and the fight against informal payments (interview 5). Deterioration of patient safety was the end-result of a long chain starting with low salaries, leading to emigration and understaffing, then to excessive working hours and exhaustion of the remaining staff.

MRSZ is also one of the most outspoken critics of the wide-spread practice of out-of-pocket informal payments in Hungarian healthcare. This is a soft form of medical corruption –

patients usually pay after the treatment “to express their gratitude”. MRSZ stood up for stricter sanctions against these payments, but they always added that sanctions could only work in conjunction with a comprehensive salary increase (interview 5).

The organizers of the Estonian healthcare strike made efforts to highlight the dangers that emigration and the resulting understaffing poses to patients, and were able to frame their strike as a general struggle against austerity and a step towards the improvement of service quality. For example, their demands included the increase of healthcare spending within the GDP (European Junior Doctors Permanent Working Group, 2012). Organizers also insisted that the government invite them to negotiations on healthcare policy reforms (Lai et al. 2013 pp. 156–7; Murphy 2015).

In Ireland, the nurses’ pay campaign was linked to the long-term rethinking of their role in the health system as professionals. The main selling point of the Labour Court’s final offer that resolved the conflict was the creation of 2500 senior staff nurse posts. The new posts could only be filled by nurses with at least 15 years of experience, who also went through additional training (Industrial Relations News, 1999b). By accepting this deal, nurses demonstrated that they achieved pay progression based on professional merit and not purely through militancy.

It is difficult to assess the impact of these framing strategies on public opinion and patient groups, due to the scarcity of survey data and due to the silence of patient advocacy groups during these conflicts with the exception of Denmark. In Ireland, 70% of respondents in an MRBI (IPSOS) poll blamed the government for the strike (Marks, 1999). In Denmark, public support for strikers hovered between 65 and 75%, but polls did not disaggregate across the different employee groups that were on strike: nurses, healthcare assistants and kindergarten teachers. However, there are signs that the public increasingly saw DSR losing control of the situation as the strike progressed. The chairman of the organization Danish Patients warned that the strike among nurses could have fatal consequences if it continued and called for its conclusion (*nyheder.tv2.dk*, 2008).

There is no opinion poll data available on the campaigns in Estonia and Hungary. However, Hungarian junior doctors received favourable coverage from different sides of an otherwise deeply divided media landscape (Interview 5). Based on a quick review of its articles during that period, even the staunchly pro-government newspaper, Magyar Nemzet offered a balanced coverage of the events. In Estonia, one of the leaders of the organizers stressed that they gathered supporting statements from 20 organizations, including patients groups, and recalled the personal experience of hospital receptionists and nurses who received flowers and candies as an expression of solidarity from patients (Interview 3). Across the four cases there is a link between the outcomes of protest on the one hand and framing on the other. The most successful Estonian and Hungarian cases were those that relied on a service quality framing, while in the least successful Danish case there was no sign of such a framing.

Coordination across skill groups

The question of coordination across different employee groups in healthcare is the final element that accounts for the different outcomes of the protest campaigns presented here. Coordination is linked to participation: from the diverse employee groups working in healthcare, who takes part in the campaign and who does not. If more than one group participates, then the question of how to coordinate their actions arises.

The broadest participation and the tightest coordination was present in the Estonian case. Except the Chamber of Nurses, all employee organizations participated. The protest extended to all levels of healthcare provision, including primary care. Employees of all skills and qualifications participated, from medical doctors to healthcare assistants. All stages of the campaign were coordinated, from the formulation of demands, through the planning of the conflict up to the signing the collective agreement with employer representatives.

Strike demands also reflected solidarity amongst groups with different skill and salary levels. The organizers asked for the largest pay rise (23%) for healthcare assistants, the second

largest (17.5%) for nurses, and the lowest for the relatively best paid group of medical doctors (11%). This sent a clear message to the public that the strike is about more than just narrow interest-group politics. Coordination also enabled the efficient targeting of the strike mentioned above.

In Denmark and Ireland, coordination was absent. In Ireland, nurses went alone, as neither less qualified healthcare grades nor doctors took part in the strike. The fact that nurse strike committees decided on the admission of emergency cases was a source of conflict between them and medical consultants (Birchard, 1999).

In Denmark, medical doctors continued to work as normal during the nurses' strike, but as already mentioned health- and elderly care assistants walked out. According to the leader of FoA, the representative union of these groups, coordination between them and nurses could have alleviated the pressure on the latter's strike fund, but DSR rejected the offer (interview 3). DSR going alone also meant that Danish Regions could provide alternative arrangements for care more easily, relying on medical doctors (Interview 4).

The campaign in Hungary had the narrowest reach in terms of participating employee groups, as it only focused on junior doctors. At the same time, the Federation of Hungarian Physicians (MOSZ) called upon its members to refuse overtime in case the demands of MRSZ were not met (origo.hu 2011). This call increased the credibility of the resignation threat as senior consultants would have had to substitute junior doctors through a compulsory overtime scheme set out in the emergency plans of the government in case of a mass resignation (origo.hu, 2011). The main nurses' union's leadership on the other hand remained hostile to the organizers of the junior doctors' campaign (Interview 5).

Table 1: Targeting, framing and coordination. Evidence from four campaigns

	<i>Targeting the repertoire away from the mass strike</i>	<i>Framing around service quality</i>	<i>Coordination across skill groups</i>
Estonia 2012	Yes	Yes	Yes
Hungary 2011	Yes	Yes	Partly yes
Ireland 1999	No	Partly yes	No
Denmark 2008	No	No	No

Table 1 summarizes the main findings from the comparison of the four cases, ordering them from the most successful (Estonia) to the least successful one (Denmark). Estonian healthcare workers met all three conditions of targeting the protest repertoire away from the mass strike, framing demands around service quality and coordinating across all skill groups of workers. In Hungary, the innovative protest tool of the resignation campaign and framing around service quality compensated for the only partial engagement of the medical establishment. Irish nurses targeted resources poorly during the strike and could not rely on help from other employee groups. Compared to the Hungarian and Estonian case, Irish nurses in 1999 also connected their wage claims less directly to service quality. However, there was an implicit link between professional upgrade and quality improvement of the health services for patients.

Finally, Danish nurses took up an all-out fight and chose not to coordinate with healthcare assistants, factors that led to the depletion of their strike funds. Furthermore, this campaign was the third time in fifteen years that they fought under the same banner of gender pay equality and this did not generate the sufficient level of public sympathy, while healthcare assistants, who used this agenda for the first time, fared better.

Conclusion

How are public service professionals able to win bargaining conflicts in an era that is otherwise characterized by a decline of labour protest? Many industrial relations scholars explain the rise of labour unrest in public services with changing economic pressures and opportunities (Kaminska and Kahancová, 2011; Silver, 2003; Vaughan-Whitehead, 2013). While these processes may indeed account for the eruption of labour conflicts on the long-run, this study argued that the outcome of the conflicts depends on the tactical choices that professional associations make on the short-run. In this sense, the argument presented here puts more emphasis on agency in industrial relations research.

To advance the claim that choices matter, this study has taken the social movement unionism literature, but it has advanced it in two important respects. First, the reviewed works on “social movement unionism” assume that the (semi-)professional status of protesters only facilitates protest, while this study claimed that the professional background of healthcare employees could equally be a hindrance to collective action. Second, it went back to the building blocks of social movements theory as formulated by Tarrow and identified three dimensions of social movements that are relevant in a professional setting: targeting, framing and coordination. Case study evidence from four protest campaigns in healthcare in four European countries (Denmark, Estonia, Hungary and Ireland), over the period 1999-2012 revealed how each of these elements work out in a professional setting.

First, targeting means that rather than calling a mass strike, protest organizers are better off with gradual strike action, complemented or substituted with alternative forms of protest, such as work-to-rules, slow-downs or resignation campaigns. The evidence suggests that from among the possible framing strategies, those are the most likely to achieve success that prove to the public that the protest is not about defending privileges but about the improvement of healthcare services for all (Tattersall, 2013). While other narrative frames – such as the demand for gender pay equality – may also achieve success, evidence is less solid in that regard. Finally, coordination across different

professional and non-professional groups working in healthcare simultaneously facilitates targeting and framing. The success of the Hungarian and Estonian campaign suggests that effective targeting, framing and coordination can compensate for a small membership base, modest financial resources and weak institutional embeddedness.

These findings shed new light on the power resources of labour in the service economy. Scholarly work on traditional industries tends to focus on organizational and institutional power resources of trade unions such as membership density and involvement in collective bargaining institutions (Wagner and Refslund, 2016). However, this study lends support to a broader conception of power resources, in which discursive power - as the basis of successful framing - plays an equally important role (Lévesque and Murray, 2010). Discursive power resources are sometimes only acknowledged as a backup option that trade unions turn to after their organizational and institutional resources have depleted (Wagner and Refslund, 2016: 347). Estonian and Hungarian healthcare workers compensated for their low institutional and organizational power by relying on discursive power, while the Danish case suggests that even a high degree of institutional and organizational power cannot substitute for the lack of discursive power. The outcome of a public sector conflict is a matter of discourse and actors can maximize their discursive power through linking their own claims to issues of common concern with service users.

Healthcare is a leading branch of the economy in the 21st century, and therefore it has also become an important arena for labour unrest. In healthcare, labour intensity, professional standards and an ever-increasing public demand clash with austerity and managerialism, producing an environment where open workplace-level confrontation between employers and employees are more likely than ever. However, these conflicts are of a different kind than what they used to be in the industrial age. This study has made one step in understanding these differences and showed how professional organizations that adjust the tools of the labour movement to their own struggles are more likely to achieve success than those that do not.

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List of interviews

- Interview 1: Dublin, December 18, 2014
 Interview 2: Tallinn, May 14, 2014
 Interview 3: Copenhagen, October 22, 2015
 Interview 4: Copenhagen, October 22, 2015
 Interview 5: Budapest, June 10, 2015
 Interview 6: Tallinn, May 13, 2014

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