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# Is migration from Central and Eastern Europe an opportunity for trade unions to demand higher wages? Evidence from the Romanian health sector

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## Abstract

Industrial relations scholars have argued that east-west labour migration may benefit trade unions in Central and Eastern Europe. By focusing on the distributional aspect of wage policies adopted by two competing Romanian trade unions in the health care sector, this article challenges the assumption of a virtuous link between migration, labour shortages and collective wage increases. We show that migration may also displace collective and egalitarian wage policies in favour of individual and marketized ones that put workers in competition with one another. Thus, the question is not so much whether migration leads to wage increases in sending countries, but whether trade unions' wage demands in response to outward migration consolidate collective solidarity and coordination in wage policy-making, or support its individualization and commodification.

**Keywords:** Collective bargaining, migration, wage distribution, health care, Romania, wage equality, trade unions

## Introduction

Industrial relations scholars have seen east-west labour migration in the enlarged EU as a cause of labour shortages in sending countries (Hardy and Fitzgerald, 2010; Hardy et al., 2014; Meardi, 2007, 2012; Trif, 2008), providing an opportunity for unions to win higher wages (Kaminska and Kahancová, 2011). By focusing on the distributional aspect of wage policies, we challenge the assumption of a virtuous circle between migration, labour shortages and collective wage increases.

The key question of union responses to migration in Central and Eastern European (CEE) is not so much whether they lead to wage increases, but rather whether their demands contribute to consolidating or, on the contrary, destabilizing coordination and solidarity in wage policy. The decentralization and the commodification of wage-setting arrangements in CEE not only reflect the introduction of the new European economic governance regime (Erne, 2015; Marginson 2015), but also herald a transformation of national labour markets. This brings unions face to face with the crucial dilemma of either pursuing egalitarian wage policies both across and inside sectors or engaging in the neoliberal promotion of wage competition among workers as a tool of 'equal opportunity' (Schulten, 2002).

We assess this dilemma by means of a longitudinal comparison of the contrasting wage bargaining policies adopted by two Romanian healthcare unions. We aim to explain why one union continued to use the migration argument to justify egalitarian wage increases, whereas the other used it to justify a shift in favour of performance-related pay. This comparison in a country and sector in which national-level collective bargaining remains a central feature of the wage-setting system provides a critical case of unions' strategic choices in relation to migration and collective wage bargaining.

The choice of these two unions is particularly apt, because they have not lost their capacity to act strategically in the area of wage bargaining at national level, in contrast to most unions in other sectors or CEE countries (Greskovits, 2015). Whereas harsh government and IMF/EU interventions triggered a rapid decline in Romanian collective bargaining coverage between 2008 and 2011, national bargaining remains a very important feature in the health care sector. In fact, unions can only effectively use the migration argument to strengthen their own capacity for action if they are confronted with high levels of outward migration *and* retain the capacity to act strategically, including in the area of collective bargaining (Hyman, 2007, Lévesque and Murray, 2010).

The choice of the healthcare sector is also relevant because this involves both public service and reproductive work. It is in these two areas that resistance to commodification of labour has traditionally been strong (Lethbridge, 2011). CEE countries in general, and Romania in particular, also offer a particularly interesting vantage point since they were, only a quarter century ago, firmly rooted in socialist egalitarian wage policies. Finally, our comparative analysis across time also allows us to assess the relationship between migration and wage developments during both boom and austerity periods, which permits us to evaluate the validity of competing explanations from an additional comparative perspective. We adopt an analytical approach that sees healthcare worker migration and neoliberal healthcare reform as co-constitutive of the sector's capitalist integration. We thus link union responses to migration to their responses to neoliberal reforms and more particularly to their larger visions of inequalities in wages and access to services produced by these reforms.

In sum, we have adopted a comparative research design that is complementary to classical country-by-country approaches. The more sub-national disparities and transnational interdependence of EU member states are growing, the more important are alternative approaches that do not risk being overdetermined by stylized national accounts (Erne, 2008: 5). By keeping national and sectoral variables constant, our paired comparison of two unions across time allows us to uncover neglected sub- and transnational dynamics. Finally, classical country-by-country research designs are hardly appropriate in our case, not only because of their methodological nationalism but also because the number of relevant 'national cases' is very limited in the first place. Unions can only use the migration argument as a power resource given high levels of outward migration. For this reason, the relation between migration, wage bargaining and union action can hardly be studied in CEE states with relatively low emigration rates, such as Hungary, the Czech Republic or Slovenia (Kahancová, 2015: 346). Unions must also be able to negotiate wages collectively in the first place. For example, Polish health sector unions used the migration argument in their contentious mobilizations for higher wages, but they still failed to gain 'bargaining recognition from the government' (Kahancová, 2015: 346).

The article is based on a systematic analysis of union and government documents, newspaper articles, as well as 20 expert interviews with unionists and other stakeholders in the healthcare system, conducted in 2014 in Bucharest and Cluj. It is also informed by a long-term engagement with sociological and anthropological research on post-socialist transformations in Romania and its healthcare sector (Stan 2012, 2015; Stan and Erne, 2014). First, we outline our approach to union action and migration and the case for the selection of the two Romanian healthcare unions. Then, we compare the 2000–09 and 2009–14 periods in terms of developments in industrial relations, healthcare reforms and migration on the one hand, and unions' use of the migration argument in wage bargaining on the other. We conclude by highlighting the implications of our approach for the study of union responses to migration in CEE.

## **A holistic, historical perspective on trade union action and migration**

We consider migration to be constitutive of global capitalism (Hardy et al., 2014; Sassen, 1988; Stan and Erne, 2014), and east-west migration as constitutive of the EU enlargement project (Meardi, 2007, 2012). This means that in order to account comparatively for union strategies on migration we need to adopt an approach that concentrates on the process of capitalist integration and on the theoretically and empirically significant links we can establish between this process, migration and union action across time.

The integration of CEE healthcare sectors into global capitalism has been conducted through a series of neoliberal reforms that have accompanied the region's integration into the EU. As part of a

larger privatizing drive, the aim has been to increase the involvement of private actors and interests in the provision and funding of healthcare services by attempting to disengage states from healthcare provision and funding, introducing business-like models in the form of ‘new public management’ (NPM), or directly privatizing healthcare provision and spending by encouraging the rise of private healthcare units and funding. These measures led to an increase in inequalities of access to services and in the segmentation of the labour market in the sector, triggering in turn an increase in healthcare worker out-migration. Given their common imbrication in global capitalism, migration and neoliberal healthcare reforms should thus be treated not as two discrete variables --- as implied by the treatment of union responses to migration and NPM reforms by Kaminska and Kahancová (2011) and Kahancová and Szabó (2015) --- but as combined factors that play together on union strategies.

The response of CEE unions to migration has been mainly seen in terms of whether they utilize the opportunity offered by migration-induced labour shortages to increase workers’ wages (Hardy et al., 2014; Kaminska and Kahancová, 2011; Meardi, 2007, 2012). A historical approach looking at concrete processes of capitalist integration recognises the importance of socially mediated meanings (Ragin and Zaret, 1983) for the way these processes are defined and experienced by those whom they affect. Such an approach obviously demands a deeper knowledge of local social realities than usually afforded by variables-driven quasi-experimental approaches. It therefore leads to a methodological imperative to study fewer cases coupled with an obligation to know the local languages and to a long-term engagement with local situations.

This approach permits us to overcome the individualist assumptions behind the view that there is a virtuous cycle between migration, labour shortages and union bargaining power. This view treats the ‘labour market’ in a supply-and-demand perspective consonant with neoclassical paradigms. It is doubtful, however, that migration automatically leads to labour shortages in the healthcare sector, as governments’ commitment to neoliberal reforms not only leads them to enforce caps on employment but also precludes them from recognising reduced numbers of healthcare worker as ‘labour shortages’ to which they have to respond. Moreover, it is also doubtful that unions’ bargaining power is automatically reinforced by out-migration (Hardy et al., 2014), as eastward EU enlargement led to decreased union power and ‘voice’ (Meardi, 2007, 2012). Yet this did not preclude unions from actively using migration as an argument in the promotion of their interests (Hardy et al., 2014).

We seek to historicize further the possible links between union strategies, out-migration and wage increases in CEE by proposing three theoretical and methodological moves. First, we argue that we should place union responses in a historical perspective sensitive to the changing capitalist integration of various countries and sectors. In CEE, a temporal frame significant in this respect spans the 2000–08 boom (when EU accession led to the intensification of their capitalist integration) and the austerity following the 2008 financial crisis (which offered the occasion for an even deeper capitalist integration). Thus, by looking at Romanian unions’ responses to healthcare migration both before and after the 2008 crisis, we provide a longitudinal in-country comparison of union responses to migration and to neoliberal healthcare reforms.

Second, we situate union strategies in the larger configuration of changing power relations among the various actors in the healthcare sector. Drawing on Bourdieu’s view of the state as a bureaucratic field (Bourdieu et al., 1994), we examine healthcare as a social field of power relations where actors are differently positioned in relation to various types of capital (or what labour relations scholars call ‘power resources’). Actors struggle both over the distribution of these resources among themselves and in society at large, and over the legitimate criteria regulating this distribution in the first place. This perspective allows us to see unions not so much as responding to predefined reforms, but as being engaged in shaping these reforms and, through them, power configurations in society.

Given that power struggles are fought over the distribution of power resources, we consider, third, that union demands for wage increases are embedded in larger struggles over what counts at a particular point in time and in particular sectors and societies as legitimate criteria of wage distribution. This allows us to pose the crucial question regarding the implications of union wage policies for labour solidarity. It also means we have to see unions’ strategies not as discrete variables, but as part of larger, even if contradictory and sometimes loosely integrated, visions of ‘fairness’ (Schulten, 2002) in the distribution of power resources. In healthcare, these larger views link the issue of wage distribution among healthcare workers to that of the distribution of access to healthcare services in society. Unions’ responses to migration and inequalities of access may therefore extend from the embrace of the

neoliberal agenda of competitive wage restraint and inequality of access to services that fuelled migration in the first place, at one extreme, to the rejection of this agenda through the pursuit of egalitarian wage policies and opposition to healthcare privatization, at the other.

### *Case selection: Sectional craft versus encompassing industrial unionism*

‘While evidence directly related to union action concerning migration is not available from other CEE countries’, Kahancová recently reported that union mobilizations in Romania and Estonia led to wage rises and improved healthcare budgets (2015: 247). Yet our selection of two competing Romanian unions was not informed by her indication of Romania as an allegedly positive test case for the thesis that migration facilitates wage increases and union capacity-building. Rather the rationale for the case selection derives from the collective wage bargaining literature.

According to Schulten (2002), behind the adoption of egalitarian wage policies rests the division between craft and industrial unions, their ability to coordinate sectorally, the unions’ political power of persuasion and the level of wage determination. In this article, we take into account, as an indication of how various unions are situated on the (sectional) craft and (encompassing) industrial unionism continuum, the changing composition of their membership, as well as the way in which their leaderships perceive this configuration. Is the promotion of members’ interests in harmony with or contrary to the interests of other categories and/or unions? We also take into account unions’ various degrees of commitment to sectoral and cross-sectoral wage coordination, as well as their political power and their political leanings and alliances.

While also considering the strategies of the state as regulator and employer in the healthcare sector, we focus on two competing union federations that played a leading role in last decade’s disputes over wages in the sector: *Federatia Sanitas din Romania* (Sanitas) and *Federatia Solidaritatea Sanitara din Romania* (FSSR). Although both unions claim to represent the entire spectrum of healthcare workers (doctors and nurses), their membership composition is very different. The two unions also differ in terms of their programmatic orientation and in their methods of collective representation and action.

Whereas Sanitas is a ‘social democratic’ union, FSSR can be qualified as a ‘liberal technocratic’ one. Sanitas, created at the beginning of the 1990s, is affiliated to the *Fratia* (Brotherhood) union confederation. It has tried to build the image of a militant union and a respected social partner at national level, notably through its long-term alliance with the *Partidul Social Democrat* (PSD) and its membership in the European Federation of Public Service Unions (EPSU). This ‘social-democratic’ union legitimizes its actions (including claims on migration) through collective representation. Its strategies include the promotion of sectoral collective agreements, requesting changes in laws regulating wages in the healthcare sector to the advantage of workers and recourse to industrial action in the street and workplace as a means to coerce the government to agree with its demands. Sanitas is generally perceived as predominately a nurses’ union. Although its membership declined from 109,000 in 2007 (Traxler, 2009: 28) to 94,157 in 2012, it retains the highest membership and geographical spread in the healthcare sector, covering all 42 counties. Given its large membership, and the fact that it shared its leader with *Fratia* up to 2010, Sanitas is seen as one of the most active unions in Romania.

FSSR, formed in 2002, is part of the *Cartel Alfa* confederation. Though *Cartel Alfa* is a member of the European Trade Union Confederation and its other healthcare affiliates are members of EPSU, FSSR has joined the ‘Christian-democratic’ European Federation of Public Service Employees (Eurofedop). It promotes itself as a ‘modern’ union, seeking to become the preferred social partner in negotiations with the government. Although since 2005 it has been one of the signatories of sectoral collective agreements in healthcare, this ‘liberal-technocratic’ union has focused its strategy on the ‘pressure of arguments’ based on ‘scientific proofs’ (Amos News, 2013) provided by in-house studies and reports. Its membership in the first years was concentrated among elite healthcare units such as university and county hospitals, clinical institutes and county Public Health Directorates, and probably included proportionally more doctors than nurses (relative to doctors’ share of total healthcare employment). Its membership has grown rapidly in the last few years, from a documented 4619

members in 2012 to ---according to a union representative --- 15,000 in 2014, covering 22 of the 42 Romanian counties.

### **Industrial relations, healthcare and migration in the boom years (2000--08)**

The 2000s saw a gradual, but steady privatizing process in Romanian healthcare. The system was transformed from a tax- to an insurance-based system, while the status of doctors in primary and secondary care was liberalized. In 2006, a new healthcare law opened opportunities for private providers to contract for services with the National Health Fund, and other measures permitted the externalization of ancillary services in hospitals. This led to a rise in the number of private laboratories as well as private clinics and hospitals. By 2007, 45 percent of general practice or family medicine surgeries, and 92 percent of polyclinics were private (INS, 2013: 258). As a result, the share of employees in the private healthcare sector rose to 19 percent of the total in 2008 (our calculations based on Tempo Online, 2014).

During the 2000-08 economic boom, and despite Romania's turn to a neoliberal pathway of development (Bohle and Greskovits, 2012; Stan and Erne, 2014), unions still benefitted from the neo-corporatist industrial relations institutions built in the 1990s (Trif, 2013). Even if union density decreased from 90 percent at the beginning of the 1990s to around 30 percent in 2006 (Trif, 2008: 470), collective bargaining coverage was still 70 percent in 2008 (Visser, 2013). This meant that unions managed to obtain a 120 percent growth of real earnings in aggregate between 2000 and 2008 (see Table 1).

[Table 1 about here]

In healthcare, the 100 percent collective bargaining coverage (Adascalitei and Munteanu, 2014: 6) also meant that unions could raise monthly average gross wages in the sector to around €460 in 2008 while also bridging the gap with the national average. In the final years before the crisis, they also maintained a specific wage scheme in the healthcare sector that added a number of allowances on top of the basic salary (Chivu, 2011). Working conditions also improved, even if partially and unequally across the system, as a result of investment in healthcare infrastructure resulting from increased healthcare expenditure, which rose from 4.3 percent of GDP in 2000 to 5.6 percent in 2008 (WHO, 2015).

Yet the wage increases during the boom years barely offset the substantial real wage losses that occurred during the 1990s. The real earnings of healthcare and social workers only reached the equivalent of their 1990 level in 2007. The same applies also for their wages by comparison to the national average. In addition, Romania's turn to a neoliberal development trajectory and the increasing privatization of its healthcare sector led to a general rise in outmigration (Stan and Erne, 2014), and healthcare workers started to occupy lower-paid and more precarious positions in formal and informal healthcare sectors in the EU-15. After Romania's 2007 EU accession allowed for the recognition of Romanian professional qualifications in the EU, migration accelerated. Thus in 2007, almost 5,000 doctors (10 percent of the total) requested certificates needed for the recognition of professional qualifications in the EU (Galan et al., 2011: 452), while the number of nurses and midwives doing so rose to almost 3,000 (3.4 percent of the total) in 2007 and almost 2,000 in 2008 (Galan et al., 2011: 455). During the years of economic boom, Romania's healthcare sector experienced both out-migration and wage increases. Were these increases a result of union responses to outmigration?

### ***Trade unions' use of the migration argument during the boom years***

The issue of migration was from the start strongly connected in public discourse, including pronouncements by government and representatives of unions and professional associations, with that of wages and working conditions in the Romanian public healthcare system. This link was reinforced after 2007, when EU membership facilitated healthcare worker migration from Romania to other EU countries. Analysts of industrial relations in Romania have thus estimated that 'the general tenor of unions' demands is that the loss of personnel through migration to other labour markets leads to the

overburdening, in terms of workload and working time, of the remaining medical staff' (Chivu, 2011). However, different unions have embraced the migration argument with different intensities and on different scales.

Sanitas was highly vocal on the impact of migration on working conditions and has repeatedly used the migration argument when advancing demands for increased wages and better working conditions. It did this mainly through frequent releases on its web page, official letters and documents submitted to the Ministry of Health, but also through the sustained presence of its leaders in the media. For example, when interest in the topic of healthcare worker migration rose after 2007, Sanitas warned that the Romanian healthcare system was haunted by the prospect of being left with healthcare workers 'without experience or elderly' (Adevarul, 2007).

By 2009, Sanitas drew on the migration argument in its main strategy in respect to wage differentials, namely that of influencing the terms of the announced unitary wage scheme for public sector employees. Sanitas presented its proposal to increase the value of coefficients for the healthcare sector as a means to improve the wages of healthcare workers and thus 'stop the exodus of doctors and nurses' (Timpolis, 2009). It also proposed, together with the main union confederations, to reduce from 1:15 to 1:12 the difference between the lowest and the highest income coefficients in the scheme (rNews, 2009).

Although the government agreed to the reduction in coefficient differentials, at the same time it also planned to reduce wages in the public sector by between 20 and 25 percent (Ziare.com, 2009). In response the Public Employee Alliance, of which Sanitas was an important member, organized a big protest demonstration and general strike (Ursu 2009). However, these initiatives were largely unsuccessful. The unique public sector wage scheme was adopted as law at the end of the year and capped aggregate extra payments --- which form an important part of public employees' income --- at 30 percent of the basic salary (Chivu, 2011). Moreover, even after its adoption and revision (in 2010) the law has not been comprehensively applied, thereby leading to more confusion and disparities in public sector wages (Petre, 2013). While the failure of union strategies in regard to the unique wage scheme marked another crack in Romania's neo-corporatist industrial relations, it also shows that, even as the Balkan Tiger was crumbling, Sanitas stuck to its 'social-democratic' mode of legitimation and used the migration argument to foster its 'solidaristic' approach to wage differentials.

During the boom years, FSSR also drew vocally on the migration argument. It did so, in contrast, by adopting a more 'liberal-technocratic' approach, based on intensive production of, and recourse to, expert research and reports. In this initial period in the evolution of the federation, its approach to migration and wage differentials was also rather general, with still little to demarcate it from the position of Sanitas. Illustrating its technocratic approach, between 2006 and 2014, the federation produced, through the activity of its leader and, since 2010, of its research centre, more than 20 sociological studies and almost 20 reports (CCDSS, 2014), three of which focused on healthcare migration. But the first two studies on the topic of healthcare worker migration (Rotila, 2006, 2007) used migration solely to highlight the insufficient funding and low wages of professionals in Romania's healthcare system with no mention of an alternative vision to address these problems. While these areas of concern were still very general, they shared a common ground with those of Sanitas, and thus point to the fact that, at this stage, FSSR had not yet defined a distinctive stance towards migration and wage differentials.

During the economic boom years, while FSSR was still finding its own voice, Sanitas tried to use the migration argument to press the government to concede both wage increases and a 'solidaristic' wage policy. Hence this context appears favourable to the situation described by Kaminska and Kahancová (2011), whereby migration offers an opportunity for unions to advance their claims for wage increases. This situation was bound to change, as we will see, during the austerity years.

## **Industrial relations, healthcare and migration under austerity (2009--14)**

In 2009, the right-wing government signed a stand-by agreement with the IMF (GR, 2009a) and subsequently engaged in a drastic austerity programme (Trif, 2013), even though the Romanian public debt to GDP ratio was always far below the Maastricht 60 percent threshold. Thus, already in 2009 the 2008--14 tripartite agreement on the national minimum wage was suspended (Ciutacu, 2013) and the

filling of vacancies in the public sector was limited to a maximum of '1 in 7' positions (GR, 2009b). This was also applied to public healthcare units and led to increased workloads together with demands from management to engage in unpaid overtime (Trif, 2013).

Despite wide-ranging protests organized by unions, in 2010 the government unilaterally reduced wages in the public sector by 25 percent (Ciutacu, 2013). Following its Memorandum of Understanding with the IMF and the EU, the government intimidated critical union leaders (Varga, 2015) and radically altered the 2003 Labour Code --- as elsewhere by executive order 'to prevent unwelcome legislative amendments by labor-friendly parliamentary majorities' (Erne, 2015: 11) --- and curtailed collective bargaining legislation. The new law on social dialogue undermined fundamental trade union rights (Varga, 2015) and made it more difficult to negotiate collective agreements at all levels and limited their maximum duration to 24 months (Barbuceanu, 2014: 6). In consequence, the coverage rate slumped from 70 to 20 percent between 2008 and 2011 (Visser, 2013).

The 2008--10 sectoral agreement in healthcare was effectively suspended by the end of 2009, as the government adopted legislation to reduce wage expenditure in public services by 15.5 percent (Sanitas, 2009). The two following healthcare agreements signed in 2011 and 2012 covered only the group of units under the Ministry of Health, thereby ostensibly leaving the growing number of private healthcare units without coverage (Ciutacu, 2013). In addition, the 2011 agreement also withdrew provisions regarding annual leave, paid overtime, precarious conditions and food vouchers (Trif, 2013). When nominal wages started to grow again after 2011, they compensated only the 2010 nominal losses which did not keep up with inflation (see Table 1). In the same manner, while the '1 in 7' rule was revoked in 2012, this only affected positions vacated during the current year, and not the backlog accumulated since 2009.

Austerity also underscored the government's renewed attempts at privatizing public healthcare, and most notably its last bastion, public hospitals. These attempts included a sweeping proposal in 2011 to replace the National Health Fund with competing private insurers, as well as proposals for hospital corporatization, closure of local hospitals, the introduction of co-payments and private beds, tighter financial discipline and the turn from inpatient to outpatient care in financing healthcare services. Union protests and street demonstrations in January 2012 achieved some success, and the government subsequently reversed or diluted these measures. However, while the healthcare reform law was withdrawn, two governments fell and ultimately the centre-left PSD won the December 2012 elections, the various Ministers of Health that followed continued to pursue a privatizing strategy.

The dire employment and working conditions in Romania's public healthcare sector during the austerity period caused continued outmigration of large numbers of healthcare workers. While the yearly number of certificates provided to doctors enabling them to practise elsewhere in the EU dropped after the initial accession backlog in 2007, they more than doubled after 2010, rising to almost 3,000 in 2010--13 (CMR, 2014). More than 14,000 certificates were issued between 2008 and 2013, amounting to a potential annual loss of around 5 percent of Romania's medical employment (our calculations based on INS, 2013).

Thus, during the austerity period, unions had to challenge a new industrial relations environment, rising outmigration and radical attempts to privatize the sector. Their responses to these common challenges came, as we will see, increasingly to diverge.

### *Trade union use of the migration argument under austerity*

Austerity brought a clear division between the positions of the two federations. By 2010 FSSR had institutionalised its technocratic approach with the constitution of its research centre, *Centrul de Cercetare și Dezvoltare Socială 'Solidaritatea'*. The following year it also produced, through the centre, a follow-up study on the topic of healthcare worker migration (Rotila, 2011), with detailed conclusions and policy recommendations. These included the promotion of employment relations based on collaboration and competitiveness, of limiting access to the basic healthcare package offered by the National Health Fund by excluding 'non-contributors' (i.e. those without formal employment) and of a competitive system by presenting the private healthcare services as outperforming the public ones. Thus, FSSR managed to define an 'individualistic' strategy of promoting both a more discriminatory



competitive wage scheme and more discriminatory access to healthcare services through privatization, commercialization and limitations of access to services.

By contrast, Sanitas continuously opposed several government attempts at further privatization after 2011, seeing them as leading to more restrictive access to public healthcare services (Dulf, 2011) and, like migration, to a further weakening of the system (Ciocan, 2013). This was apparent also when, at the beginning of 2013, the Ministry of Health announced its intention to introduce an individualistic ‘performance-based wage scheme’ in the healthcare sector, which would have allowed doctors working in public hospitals to increase their income by working on a private basis after their normal duties. The proposed measure would have threatened both wage distribution in Romania’s public hospitals and their public character. In response, during the summer of the same year, Sanitas joined forces with the Romanian College of Physicians (CMR), the Physicians’ Union Federation *Cantacuzino* and several professional organizations to form the Coalition of Healthcare Professionals (Ciocan, 2013). The coalition put forward six requests and a plan of protest actions, most of which materialized in autumn 2013. Actions included picketing the Ministry of Health, a work-to-rule, a ‘Silence March’ and a warning strike.

During the protests, Sanitas repeated its earlier criticism of the project on doctors’ wages, arguing that this would provide increases for only a few hundred doctors, as more than 90 percent of the medical personnel would have been left with existing wages (Alexa, 2013). In addition, Sanitas continued to defend the continuation of the public character of the healthcare system as well as a more equitable wage distribution inside it (Ciocan, 2013). To the Ministry of Health proposal, Sanitas responded with demands for a unitary wage scheme specific to the healthcare sector, the adoption of a sectoral collective agreement and the implementation of the law on the unitary wage scheme for public employees. The latter, as we have seen, had not been comprehensively implemented, but Sanitas believed that better coefficients for healthcare workers would accrue upon its implementation.

Migration figured centrally in the dispute between the government and the Coalition of Health Professionals. The Ministry of Health presented its scheme as a means of increasing doctors’ incomes and thereby reducing ‘the exodus’ of doctors (Alexa, 2013). In response, the coalition presented their demands as necessary for reducing outmigration. Indeed, during the ‘Silence March’, demonstrators allegedly shouted ‘We want doctors in the country, not expats outside’ (Infoinsider, 2013). Moreover, Sanitas argued that a specific wage scheme for health personnel was necessary ‘if we take into consideration the great exodus of specialist personnel, of doctors and nurses to other countries in the European space’ (Ciocan, 2013).

While formally supporting its demands, FSSR did not become part of the coalition. Moreover, the federation also tried, in parallel meetings with the Minister of Health, to undermine the coalition’s institutional and symbolic power by attacking the organizational prerogatives of one of its main members, the CMR. It also pressed on its own take on a performance-based wage scheme. Indeed, while critical of the Ministry of Health’s proposal, it also criticised the Sanitas view of a fair wage distribution being achieved through the seniority and qualification criteria present in the unitary wage scheme for public employees. During the protests, FSSR denounced the latter as ‘burying the performance-based wage scheme’. In its place, the federation proposed to use collective agreements to introduce wage differentials based on the individual evaluation of healthcare personnel. For FSSR, ‘objective’ performance evaluation should be the basis for wage increases, since this would result in ‘more performing personnel at a competitive level’, a position also later formalized in its study on a performance-based wage scheme in the healthcare sector (Rotila, 2013).

In November 2013, the Ministry of Health gave in at the prospect of a warning strike and signed with Sanitas and the other unions a sectoral collective agreement. While the general impression left after the coalition’s protest actions was that they had mainly achieved the CMR objectives of a wage rise for junior doctors, while failing to obtain significant gains for the other healthcare workers, Sanitas may have obtained more than this (Adascalitei and Munteanu, 2014). Indeed, the significance of signing an encompassing sectoral collective agreement is better understood if one considers that the only other national collective agreements signed in 2013 were three agreements at the level of ‘groups of units’ (MM, 2014). In the same year, only two other sector-level agreements (in higher and pre-university education) were in force at national level (Barbuceanu, 2014).

However, given that the November 2013 collective agreement was signed only by the Ministry of Health and unions --- and not by employer organizations representing private healthcare units --- and

that the type of units listed in the agreement included only those under the Ministry of Health or local authorities, the encompassing character of the sectoral agreement became dependent on its publication in the official journal of the Romanian state. This did not happen immediately following its signing and has been indefinitely postponed until a later date.

In 2014, while continuously drawing on the migration argument, Sanitas also continued to oppose various Ministry of Health plans for further privatization, as well as requesting a 10 percent increase in wages, the publication in Romania's official journal of the 2013 sectoral collective agreement and the unfreezing of recruitment in the sector. By threatening, and then commencing protest actions, Sanitas compelled the Ministry of Health to make some concessions towards its demands. Thus, over the summer of 2014, the Ministry made efforts to bring employer organizations to negotiate with unions the extension of the 2013 collective agreement, albeit with no concrete results. Later, the Ministry announced that it had removed all restrictions on filling new positions and approved 1,500 additional ones (MS, 2014). The Ministry also conceded, starting in 2015, an increase in monthly wages of around 17 percent of the average nominal gross wage in the sector for those on the minimum wage and 5 percent for those earning above the minimum wage (Agerpres, 2014; INS, 2015).

In 2014, FSSR also continued to draw on the migration argument. But while the federation tried to mirror Sanitas in organizing (significantly more modest) street protests and demanding (significantly more considerable, and probably unrealistic) wage increases (of 40 percent), now it also started to try to define itself as a broader, more encompassing union. FSSR thus tried to position itself as a defender of the interests of nurses, and even, occasionally, of less qualified nurses with post-secondary school degrees. This possibly reflects its changing membership, which evolved, in the last three years, from a relative concentration on elite healthcare units and doctors, towards a greater diversity of healthcare units and employees. However, FSSR continued, at the same time, to state its commitment to doctors' interests and to a performance-based wage scheme. The federation reaffirmed its individualistic view of 'fairness' by stressing 'the principle of equal opportunities' and 'wage discrimination' rather than the principle of equal wages and wage equality. And it also restated its commitment to privatizing measures, such as the introduction of a 'complementary (private) insurance' that would increase inequalities of access to healthcare services. Thus, despite its recent attempts to broaden the scope of its claims to 'equity', FSSR continues to defend an 'individualistic' view of competitive wages and access to services.

During the austerity years, while Romanian governments have followed the IMF and EU injunctions to dismantle 'solidaristic' collective bargaining, unions have increasingly diverged in their wage policies. While Sanitas continued to use the migration argument to resist wage cuts, to support collective pay restoration claims, and to defend 'solidaristic' wage bargaining, FSSR used it to justify its support for individual, performance-related pay.

## Conclusions

Unions are only able to utilize the migration argument to strengthen their own capacity for action if they are confronted with high levels of outward migration *and* retain the capacity to act strategically in a coordinated manner in the area of collective bargaining, which is no longer the case in a majority of CEE countries. For this reason, we have examined whether east-west labour migration really supports unions in fighting for higher wages in a country and sector in which unions have retained the capacity to mobilize and conclude national wage agreements even in very harsh times. This particular research design, which kept national and sectoral factors constant and assessed different unions' wage policies across time, has made it possible to demonstrate that there is no automatic virtuous link between migration, labour shortages and collectively agreed wage increases.

The two Romanian health care unions that are at the centre of our paired comparison both used the migration argument to further their wage claims, both during Romania's boom (2000--08) and its austerity period (2009-14). East-west labour migration is in fact not simply a result of the austerity measures, which certainly increased the pressures on Romanian health care workers, but also a consequence of the preceding integration of Romania into the European economy (Stan and Erne, 2014), which caused both the boom of the 2000s and the neoliberal restructuring of the Romanian healthcare system.

And yet, although both unions were operating in the same national, sectoral, socio-economic and political context, Sanitas and FSSR legitimized their actions and used the migration argument in very different ways, not least reflecting distinct approaches to the distribution of wages and access to services. The ‘social-democratic’ Sanitas, the larger and more encompassing industrial union that predominantly represents nurses, used the migration argument to support its ‘solidaristic’ wage policy approach. It insisted on collective representation as the basis for the legitimacy of its actions, and tried to pursue the classical methods of collective bargaining and legal enactment to reduce wage differentials and to resist the exacerbation of inequalities of access through further healthcare privatization. By contrast, the ‘liberal-technocratic’ FSSR, which predominantly represents doctors and elite health care units, increasingly used the migration argument to justify its ‘individualistic’ wage policy approach; it mainly avoided the autumn 2013 collective mobilizations and used its ‘expert’ knowledge to legitimize its migration related wage policy claims.

Still, the findings that relate to the boom period (2000–08) seem broadly in line with the contention of Kaminska and Kahancová (2011) that east-west migration represents an opportunity for CEE unions. During this period, which was marked by the implementation of privatizing reforms and the rise in outmigration, Sanitas dominated union wage policies in the Romanian health sector. Yet the relatively high wage increases obtained during this period arguably reflect the relatively high collective bargaining coverage and union density in the sector, rather than the use of the migration argument as a justification for wage claims.

Under the conditions of austerity, the migration argument indeed lost much of its value as a factor for union power in CEE and led to a variety of union responses (Hardy et al., 2014). In Romania, austerity brought renewed attempts by governments to privatize healthcare, continued outmigration and an attack on collective bargaining institutions (Trif, 2013). In this changed context, the government not only succeeded in weakening the capacity of Sanitas to act as a successful bargaining agent, notwithstanding the relatively successful protest movement of health care workers it initiated together with other professional organizations in autumn 2013. The declining ability of Sanitas to enforce binding sectoral wage norms also facilitated the rise of FSSR, which did not participate in the 2013 protests and which argues for individual, performance related pay systems in response to individual workers’ ‘exit threats’ (Meardi 2007, 2012).

As the current austerity policies accentuate the trend towards neoliberal industrial relations regimes in CEE, the adoption of individual, performance-related wage policies is likely to become a more prevalent response to increased east-west labour migration than general, collective wage rises; notably among unions that represent professions and grades particularly affected by east-west labour migration. In a larger macro-historical perspective, it may thus not only be true that decreased overall union power leads to higher wage inequalities (Mosher, 2007), but also that some unions actively contribute to legitimate, if not directly accelerate, this trend.

Whereas unions that represent higher grades and professions have never been strong advocates of solidaristic wage policies (Schulten, 2002), our study has shown that the increased exit options of some CEE workers further undermine support for the latter. Hence, migration may well contribute to the expansion of union capacities, as shown by the membership gains of FSSR during the austerity period. Yet our evidence also suggests that the unions that gain most from workers’ exit threats are hardly those that prioritize unions’ function as a ‘sword of justice’ (Flanders, 1970).

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**Table 1. Real earnings and wages in healthcare and social work, 2000–12**

	<b>2000</b>	<b>2002</b>	<b>2004</b>	<b>2006</b>	<b>2008</b>	<b>2010</b>	<b>2012</b>
Real earnings index (1990 = 100 )	59	64	78	97	130	124	123
Consumer prices indices, yearly variation (%)	45.7	22.5	11.9	6.6	7.8	4.2	3.3
Gross nominal average wages in healthcare and social work, yearly variation (%)	-	22	25	25	35	-8	9
Average healthcare and social work wages as % of national average wages	81	82	85	95	97	87	87

Source: INS, various years.