Health worker mobility and employment relations responses in Romania

Steve Shelley

University of Hertfordshire Business School Working Paper (2012)

Health worker mobility and employment relations responses in Romania

Steve Shelley

The Business School, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB, UK

Hertfordshire Business School Working Paper 2012

Abstract

The public sector in Romania is undergoing dramatic change as the state continues to come to terms with the post-Communist era, liberalisation encouraged further by accession to the European Union in 2007, and the impact of austerity measures implemented as a result of IMF loans in 2010. In this context Romania may be thought of as predominantly a 'sender' country of migrant health workers to Western Europe. Although this is undoubtedly the case, this paper shows how the situation regarding mobility of health workers in Romania is complex, involving multiple patterns of mobility - public to private, rural to urban, outward migration and circular migration. These are influenced by a potent mix of contributory factors, including the economic austerity measures (a public sector salary cut of 25 per cent, a recruitment freeze, and a limit on hospitals' staff budgets); centralised and decentralised aspects of financial and employment controls (within which there are differing forms of hospital governance and funding); poor working conditions; and that this mobility is variable according to skill specialism. Further, the paper finds that whilst there is some creativity in management and trade union responses to these problems at local level, largely the employment relations system is struggling to cope with these challenges.

Context of the study

Since the end of the communist regime in 1989, Romania has become established as a democratic republic and has moved to a liberal market economy (Vladescu and Olsavsky, 2009), further enabled through 2007 EU accession and free movement of goods, services and labour. However, the political system is characterised by a turmoil based on personal politics and widespread accusations of corruption (Gallagher, 2005; BBC, 2012b) and the economy has fluctuated wildly in recent years (Eurostat, 2012), with high levels of poverty (CMAJ, 2010). Financial deficits required an IMF financial aid package of 20 million Euros in 2009, but this was conditional upon the government introducing austerity measures, including a 25 per cent pay cut for public sector workers and a five per cent increase in VAT to 24 per cent (BBC, 2012a, Pidd, 2012) in 2010. In early 2012, street protests were a manifestation of discontent with the government's austerity measures and lack of consultation (BBC, 2012b; and primary sources), leading to formation of a new coalition government in May 2012 (BBC, 2012c).

Turning to the health sector specifically, the overall picture for Romania is one of a poor and worsening crisis (BBC, 2010b). The country has an increasing mortality rate, with average life expectancy six years shorter than the EU average and infant and maternal mortality among the highest in Europe (Vladescu et al, 2008). It has one of the lowest densities of health professionals to population in Europe (Vladescu and Olsavsky, 2009; CMAJ, 2010) and low government spend on health compared to other European countries (Ovidiu et al, 2008). Despite recording the biggest

increase in health care expenditure of all EU states, increasing by 171 per cent over the period 2003 to 2007/08 (Eurofound, 2011), this represents an increase from a very low starting base and Romania remains second lowest EU state on health expenditure per capita (Eurofound, 2011), even before the effects of the economic downturn and austerity measures have been recorded.

The demand for health care is increasing because of an ageing population (Cismas and Maghear, 2010) and this problem is compounded by an overall population decline of 5 per cent between 1992 and 2006 (Vladescu et al, 2008), caused by a declining birth rate and an out-migration of the 18-50 year old age group (Cismas and Maghear, 2010), thus reducing the capacity to provide health care.

The health care system has moved from a centralised 'Semashko' system (Baba et al, 2008; Vladescu et al, 2008) under the communist regime, to a decentralised insurance-based system (Baba et al, 2008; Ovidiu, et al, 2008; Vladescu et al, 2008) with the mandatory health insurance scheme covering the whole of the population (Vladescu et al, 2008). Nevertheless, the system has evolved only slowly and retains a relatively high inpatient admission rate because there is little in the way of a developed care system outside of hospitals and "many patients are hospitalised for social rather than health reasons" (Vladescu et al, 2008, p.xix), putting further strain on the system.

There is a mixed system of governance of hospitals controlled at national, county and municipal levels (Vladescu et al, 2008). Only 58 major clinical hospitals are under the direct control of the Ministry of Health where, for all intents and purposes, the Ministry is the employer. Other hospitals are run by county councils, and others are run by municipal town councils; for which there is no unified employers' organisation (meeting 2).

However, centralised control also remains (Ovidiu et al, 2008) so that currently the Ministry of Health regulations apply across all types of hospital governances, particularly the 25 per cent pay cut and recruitment freeze, adherence to national staff pay scales and a limitation on all hospitals to spend no more than 70 per cent of their budget on staff salaries (meetings 2, 6, 12). These are enforced by close Ministry of Health inspection of budgets. Aside from these requirements, hospitals of any type can raise money from other sources, either from their own governing boards at county or municipal levels, or from private fees (meetings 2 and 12; Vladescu et al, 2008).

Research approach

The study was undertaken as part of a larger research project examining health worker mobility across Europe (see end note). Starting assumptions were guided by the project tender and by the wider literature on labour migration both working from the basis that Romania is likely to be predominantly a 'sender' country of health workers to other European countries and that this flow is influenced largely by inter-country income differentials (Galan et al, 2011). EU accession had the potential to be a growing problem for Romania (Eurofound, 2007; Morley, 2007) and indeed net outflow has become stronger since then, with the total number of Romanian citizens in other EU member states estimated to be between 2.5 and 2.7 million (OECD, 2010), equivalent to ten per cent of the total population. For health care staff in particular, the assumption of Romania as a sender country is based on an increasing flow from EU New Member States (NMS) to western European states as ageing populations and increased demands for health care combine with increasing concerns about, and restrictions on, the recruitment of non-EU workers (especially in the case of the UK) (Bach, 2010).

In this context, a further starting assumption is of poor employment relations, management and trade union responses as Morley (2007) typified EU NMS having underdeveloped industrial relations systems with low trade union membership, a limited collective bargaining focus only at company rather than sector level, an absence of European Works Councils, and weak social partner organisations (albeit some tripartite discussions involving social partners and government). The paper aims to examine these assumptions for Romania, as most studies of migration and industrial relations have tended to focus on the 2004 A8 NMS but have not considered Romania and Bulgaria who joined in 2007; and the paper also aims to redress the dearth of literature on public sector industrial relations in EU NMS, in particular in the health sector.

Documentary and literature research was completed during the period December 2011 to March 2012, and a study visit was made in January 2012 to undertake primary research. The visit was enabled by the European Federation of Public Service Unions (EPSU) office in Bucharest and was hosted by the largest trade union representing health workers, Federatia Sanitas. The aim was to clarify the scale and flows of doctors, nurses and other health workers' migration and to discover more about causes of migration and potential employment relations solutions. Insights into the latter were provided by collecting qualitative information in semi-structured interviews. The interviews were held in meeting situations, involving more than one respondent. In all, 17 meetings were held involving 24 respondents including government officials, trade union officers, hospital managers and working doctors and nurses in three cities in different parts of the country (see appendix one).

The services of an interpreter were used throughout. This being the case, hand-written notes were taken of both verbatim quotes and interpreter summaries. These were summarised and stated back to the respondents at the end of each meeting and were also subject to ongoing verification with the interpreter and trade union hosts between meetings and at the end of the visit.

From here the paper is organised into three sections of findings, before concluding with a discussion section. The first section reveals the complexity of worker mobility patterns, the second explores the reasons for these mobilities, and the third, the employment relations responses. Each section is an analysis of both literature and interview sources, with quotes coded and meetings identified by their chronological order one to seventeen.

Migration and other mobility

Migration numbers and destinations

Prior to Romania's accession to the EU in 2007, cross-EU mobility of Romanian workers was restricted by work permit requirements and other controls, although substantial numbers did move to take up employment often under bilateral agreements (Ministry of Labour information, 2012). However, Romania's membership of the EU provided free movement for Romanian workers to sixteen member states, with the remainder currently operating some restrictions until the completion of transition arrangements in 2014 at the latest. So, for example, the United Kingdom Border Agency (UKBA) restrictions require work permits on the basis of employers demonstrating inability to recruit from the 'home' labour market (Bach, 2010).

Establishing exact numbers of emigrants and other forms of mobility is difficult. As Galan (2006) and Galan et al (2011) identified, data on migration of Romanian health workers is scarce and of poor quality; and this research project found that the information is partial and contradictory. The Ministry of Health keep data on the numbers of health workers who request certificates of verification for their qualifications within the EU, however, these do not necessarily mean that the worker does actually emigrate. Vladescu and Olsavsky (2009) obtained this Ministry of Health data for Nurses in 2007 to 2008, however, subsequent data has not been published. The Ministry of Labour has data on the numbers of workers only who migrate on pre-arranged work contracts that the Ministry itself mediates under the EURES European job search system, or who leave using recruitment agencies, but the information provided by them is incomplete and covers only the period 2006 to 2009.

The professional bodies the Nurses' Order (OAMMR) and the Doctors' Federation (The Romanian College of Physicians) operate a mandatory national registry of those licensed to practice (Galan, 2006). Continuation on the register is dependent on completion of annual Continuing Professional Development training courses but is not necessarily an indication that the person is still in the country or indeed whether they are currently in employment in their profession (meeting 10). At the hospital employer level there is no complete information about migration and measurement of mobility is further complicated by the national health sector employment contract that gives all employees the legal right to request up to two years unpaid leave of absence without obligation to divulge destination.

Although not able to produce published figures, the Ministry of Health were able to say that in the last four years 20,000 certificates of recognition of qualifications have been requested – and that from all health staff and of certificates of recognition issued, typically 60-70 per cent actually leave the country (Ministry of Health, meeting 2). The Ministry of Labour data shows 1358 health workers leaving the country between 2006 and 2009 (46 doctors and 1312 nurses), but this is limited to those that it directly mediates through recruitment agency figures. Both sources seems low when compared to other information that follows and the OECD report a continued underestimate of actual emigration given that many workers do not use official channels to move (OECD, 2010).

Considering doctors specifically, according to CMAJ, 2010) the Romanian College of Physicians (Doctors' Federation) reported that more than 4000 Doctors have emigrated since 2007, representing almost ten per cent of the Doctors in the country. However, this looks to be an over-estimate as both Vladescu and Olsavsky (2009) and Galan et al (2011) give a ten per cent 'intending to leave the country' figure, with only three per cent (but nonetheless 1421 doctors) leaving in 2007 (Galan et al, 2011), albeit with applications for certificate verification more recently increasing to an average of 300 per month in 2010 (Galan et al, 2011). Galan (2006) charts a trend in doctors' migration, with a shift from a variety of destination countries in the 1990s, to a predominance of North America and subsequent to EU accession Germany, France and some Nordic nations (CMAJ, 2010). More recently the UK is now the largest destination country for doctors (uncorroborated source, taken from Tjobs.ro website during meeting 1).

For nurses, Vladescu and Olsavsky (2009) report the Ministry of Health figures of 4608 requests for certificates of recognition of their qualifications for the period 1st January 2007 to 31st December 2008, representing 3.8 per cent of the total nursing workforce. Of these 3525 received the

certificate and “the others were either not compliant or dropped their request” (Vladescu and Olsavsky, 2009, p.15). Commenting on similar official figures, Galan et al (2011) believe these to be a substantial under-estimate of the real number leaving. From their own survey data, Vladescu and Olsavsky (2009) also report that 21 per cent of nurses expressed a desire to work abroad and 39 per cent said they knew more than 10 others who were thinking of working abroad. “Lots leave” (Medical Director, meeting 7); 120 nurses left this hospital last year (out of 500+) (meeting 5);

> “most would like to leave, but perhaps 5-10 per cent do leave from all departments. In one ward 2 left out of 20” (Nurse, meeting 8).

Italy has traditionally been the largest single destination country for migrant nurses (Ministry of Labour information), Romanians comprising the largest group of immigrant nurses in Italy (Paleses, et al, 2008), with 25 per cent of all foreign nurses registered in Italy from Romania in 2008 (Galan et al, 2011). This is due to Romania having strong cultural links and language similarities with Italy. It is still said that nurses migrate mostly to Italy and France, and to a lesser extent to Spain (meetings 3, 5, 7, 10), but since joining the EU more are now going to the UK and to Scandinavian countries (meetings 5 and 14), or at least that is where they are saying they want to go. For the UK this requires employers’ demonstration of skills shortage, and for workers to be able to become ‘culturally embedded’ (Bach, 2010, p.260), but this is increasingly enabled by an emphasis on learning English at school rather than the traditional emphasis on ‘romance’ languages (meeting 5).The hospital manager in meeting 14 also suggests that there has been a reduction in demand in Italy and Spain now due to the poor economy in those countries.

Specialist occupations and skills

Migration for doctors, dentists and nurses appears easier and more common for staff with specialisms staff such as anaesthetics, radiology, obstetrics, gynaecology, other intensive care and surgery expertise, family medicine and psychiatry (Galan et al, 2011; Meetings 5, 6 and 14). Even with requirements for work permits remaining in the UK, specialist nurses appear able to go straight into fully qualified nursing jobs in the UK (meeting 14) on the basis of employers demonstrating skill shortage (Bach, 2010). By contrast there was reportedly very little problem with out-migration of staff from a small municipal hospital, and this would appear related to the generalist nature of the health care provision there (it being unlikely for generalist nurses to get work permits for the UK, for example (Bach, 2010), plus also governance and funding issues discussed later. From the large city clinical hospital it is felt that the prime destination of these specialist staff is Italy, the UK and Ireland (meetings 5 and 7) and, also for doctors, France (meeting 7).

However, some staff have different opinions about the value of specialist skills abroad, saying that even qualified nurses mainly only get work as health care assistants in nursing homes for the elderly in Italy (meeting 10), whilst others say it is only nurses who are less specialist who have gone into these roles in Italy (meeting 5), the latter implying perhaps that nurses qualified to the higher level are now able to get ‘proper’ nursing jobs there. For example, staff with Accident and Emergency experience can go straight into Nursing jobs (meeting 10), as can those with specialist gynaecology and obstetrics experience (meeting 14) whereas, for a lot of generalist staff,

> “a lot apply for the UK, but they end up on low (pay) rates, because they need to supplement their education – the Romanian Diploma doesn’t yet qualify them. They are

> accepted onto lower grades, looking after adult patients, working in elderly care homes, and looking after adults with learning difficulties" (meeting 10).

For lower grade workers in Romania, Health Care Assistants, there are different stories, with "little out-migration of these staff" (Medical Director, meeting 7) at the Large Clinical Hospital, yet this being,

> "a big problem, with them leaving mainly to Italy and to the private sector, as personal carers in domestic homes" (Hospital Manager, meeting 14).

In this hospital, the same is true for other support staff at the lower level of Auxiliaries (cleaners), where only 50 of 100 posts are currently filled (Hospital Manager, meeting 14).

Regional variations

There are reportedly regional variations in the extent and destinations of migration. Rural and deprived areas have been persistently under-staffed, attributed by Galan (2006) to lack of incentives to work there. 98 villages are without a health professional and a third of the country is lacking 30 per cent of the medical specialisms found elsewhere in the country (Vladescu and Olsavsky, 2009). For example, Vladescu and Olsavsky (2009) comment that in the North East, the poorest area, 'migration seems to be more intense'. Galan et al (2011) also found the majority of requests for certificate verifications coming from Iasi in this north-eastern region.

There is also some rural to urban migration, which is allied to moves from public to private sector work, especially in specialist branches of health care (meeting 1). However, the research study found differing views from a more rural county, where it is felt there is not much internal migration within Romania, because of family and property ties (meeting 10). In addition, although (CMAJ, 2010) suggest migration of doctors could be compounding the depletion of the numbers of rural doctors, this may be conflating an issue with doctors simply not choosing to base themselves in rural areas, perceived to be unattractive for a variety of social and economic reasons.

Age and gender

There are age and gender dimensions to migration. It is predominantly younger staff who leave, both for the private sector and abroad (meeting 10), a pattern found by Galan (2006) who identified that over half of Doctors who emigrate are in the 30-39 age group. A frequently cited example is of younger doctors who migrate out on completion of their internships at the end of their medical training (Hospital Manager, meeting 14). One estimate is that 35 per cent of interns leave to go abroad (Head of HR, meeting 6; Medical Director, meeting 7). As well as young, the nurse workforce in Romania is predominantly female (Vladescu and Olsavsky, 2009). Although Palese et al (2008) assert that it is much easier for males to migrate, evidence in the next section suggests females often take the lead in moving and this is part of a bigger picture of growth in younger female migration within the EU (Eurofound, 2007).

Circulatory and return migration

There is mixed evidence here. For nurses, there is an opinion that,

> "they all come back eventually" (County President of the Nurses Order, meeting 10).

Most nurses only migrate when they have a definite employment contract to go to, often arranged through a recruitment agency, and in some cases through friends, family, and those who have already migrated, taking an initial fixed term contract. At the end of the contract they often return 'home' to Romania, usually for a break, not often to return to work in Romania. They typically then arrange their next contract, often with their previous employer abroad (independently, without the involvement of the agency, so without the employer paying an agent's fee), or with another employer they have networked with whilst abroad. In this way agencies are really only used for first placements. After their initial contract, nurses may work abroad for anything between one and five years on a succession of fixed term contracts, returning when they've got money (meetings 9, 10 and 14). One nurse is looking for a total of five years abroad (Nurse, meeting 9). This will more than pay off her investment in the three year post-high school Diploma, and allow investment in a house. She is likely then to return to Romania, although not sure to what job, public or private. She has another colleague nurse who is aged 50, who wants to leave to support her child financially.

Friends and family are often a reason to go - and to return, and there is a gendered aspect to nursing mobility. Spouses' employment is an important consideration, both enabling migration in cases where the spouse also migrates, or mitigating against it. This also extends to wider family networks. For nurses, as a female-dominated profession,

> "it is the women who leave, the wives….. If the husband can't get a job, often the woman returns" (meeting 1)

> "Many would like to leave, but don't; or come back; because of their families here, or are afraid of living in another country" (Nurse, meeting 9)

> "Very few come back….. (especially) if both the husband and wife work in health….. (and/or)….. the other spouse comes to live there." (meeting 1)

One nurse's husband is a welder, in construction, so she is hopeful he will get work with her abroad too (meeting 9). She has a friend who went to Italy, initially through an agency, then by herself. However, she has not returned because she has met and married a Romanian already in Italy. One nurse in meeting 16 plans for her husband and family (two children aged 12 and 2) to move with her to the UK. Her husband is a policeman and thinks he can get a security job. The other nurse in this meeting wants to go to Italy where her sister has been as a nurse for six years.

Indeed, Romania is still seen very much as their home, with very few nurses planning on leaving the country for good. Of the Romanian nurses he visited in Italy, the President of the Nurses Order says they do return on a five-year cycle,

> "they will come home, because of family, their own culture, their home country…." (President of the Nurses Order, meeting 3).

This is confirmed by Palese et al's (2008) study where Romanian nurses in Italy intended to stay for a maximum of five years. These reasons for return correspond to the more general barriers to mobility identified by the 2005 Eurobarometer survey, particularly citing lack of contact and support from family and friends and the challenges involved in learning a new language (Eurofound, 2007) which for nursing can place a restriction on career progression in the host country (Bach, 2010).

Some return because,

> "it's hard being abroad without relatives" (Nurse, meeting 9),

others because they,

> " can't adjust to the pace of the work (abroad)" (Nurse, meeting 8),

and others because they end up in lower grade care assistant work which they say is beneath their nursing qualifications (because these are not always deemed comparable) (meeting 8).

Another factor influencing circulatory and return migration is the need to return for mandatory professional updating training, of 30 credits, typically two weeks per year, organised by the nurses' professional body as a requirement to retain their registration licence to practice in Romania. Migrants do this when they take leave from their contracts, or when between contracts (meeting 5).

However, other opinions are expressed,

> "very few – the exceptions – come back" (Nurse, meeting 8), and
>
> "about 20 per cent of nurses come back to same hospital at the end of a contractual period of unpaid leave" (Head of HR, meeting 6),

although this doesn't mean that they don't come back to Romania to a different hospital or to the private sector – the private sector is often the ultimate destination on return for specialist nurses (meeting 12) as discussed in the next section of this paper.

The general opinion is that far fewer doctors return or circulate compared to nurses. Trainees who leave at the end of internships, or on a scholarship abroad, "generally don't come back" (Head of HR, meeting 6). Although this needs a more national-level view, this is also corroborated by the County Head of the Doctors' Federation (meeting 11). A small number come back, especially those who left to continue to develop a particular field of specialism to bring back, and to keep up with technology (Medical Director, meeting 7).

By contrast there is generally very little in-migration, although some doctors arrive from Moldova where Romanian is spoken, and the move is enabled if they hold dual citizenship and/or have trained and qualified as a doctor in Romania and there are isolated examples of workers from other countries on the basis of studying in Romania and/or family links. For many of these, their stay in Romania is not long, regarding Romania as a transit country on their way to other EU states (Hospital Manager, meeting 14).

Movement to the private sector

In addition to migration, there would appear to be increasingly movement of staff from the public to the private sector. Under the privatisation bill introduced in December 2011, it is proposed that hospitals will be free to set up as Foundation hospitals, free from some government Ministry of Health controls and able to raise money in different ways. This would seem to be the culmination of a plan noted by Eurofound (2011) when citing Romania as a particular example of a country intending to decentralise health care structures. The Bill proposes increasing the size of the private

sector to up to 15 per cent of the health care system, whilst retaining at least one state hospital in each county in order to provide basic essential services (Sanitas, meeting 17).

It is difficult to gauge the current size of the private sector. On the one hand the private hospital and surgical sector is said to be small (Sanitas VP, meeting 1) and 4.5 per cent of the national system (meeting 17), on the other CMAJ (2010) states there has been a "significant growth in a parallel, private system" (p.655), which is increasing rapidly (Vladescu and Olsavsky, 2009). All these sources agree that this private sector is largely city-based, consisting largely of corporately-sponsored clinic chains, typically specialising in gynaecology, dermatology and some surgeries which are seen to be more profitable (CMAJ, 2010; Hospital Manager meeting 14) and being small and mono-speciality (Sanitas VP, meeting 1).

Those who leave the public sector mainly join such private clinics - this applies particularly to nurses with specialist experience (Medical Director, meeting 7) such as the example of gynaecology (Hospital Manager, meeting 14) where in the first few weeks of 2012 six had left to join the private sector compared to four migrating abroad (meeting 16).

By 2006 almost all dentists, pharmacists and family doctors worked exclusively privately (Galan, 2006). In a further measure of private sector increase, Eurofound (2011) names Romania as having one of the largest proportions of health care expenditure (over 30 per cent of total health care spend) coming from private, out-of-pocket payments and with a growing trend for those who can afford it to go abroad for surgery (Eurofound, 2011).

Outside of the medical and surgical system there would appear to be very little in the way of private care homes, with care of adults with learning disabilities and care of the elderly almost entirely provided by the family within the home. According to one source, the small number of privately run care homes that do exist are staffed by nurses who have left the public sector, not by immigrant workers (meeting 5).

Causes of the migration

There are multiple causes of migration. These are pay and income, the recruitment freeze, staff shortages causing worsening conditions in the form of work overload, perceived lack of autonomy and respect for nurses, nurse training and qualification equivalence, over-supply of labour and the lack of workforce planning, the right to two year's absence, to gain further education, to have the opportunity to use new equipment and procedures, the activity of recruitment agencies, and unofficial payments and the impact of media and public perception on health workers. In some respects these findings are not surprising - they correspond to the two most frequently cited reasons for labour migration from EU NMS shown in the 2005 Eurobarometer survey, as being higher household income and better working conditions (Eurofound, 2007). However, it is the way in which the particular Romanian political and economic context has exacerbated these that is significant here; together with some other factors that are more particular to the health worker professions.

Pay and income

Financial reasons are given as the main reason for leaving public sector employment, both to migrate and to join the private sector (e.g. meeting 1, 8, 14, 16, Palese et al, 2008; CMAJ, 2010).

> "It's because of money – no other reasons" (Hospital Manager, meeting 14).

Nurse wages in the Romanian public sector have a normal maximum of 300 Euros per month (Vladescu and Olsavsky, 2009; Sanitas, meeting 14). How this compares to other countries depends on specialism and experience, but examples of perceived relativities include the nurse in meeting 13 who says he can go to France for 1000 Euros per month and a nurse who has worked already in the UK (meeting 16) who says she can earn £12 per hour in the UK compared to £1.50 per hour in Romania. Ministry of Labour information details nurses moving to jobs paying in the range 680 Euros per month (Cyprus) to 1200 Euros in Spain and 1600 Euros in Germany and Italy.

The national pay scale for the Romanian health sector is seen as offering little opportunity to increase earnings. It is a unitary scale, stipulated by national law (Medical Director, meeting 7), recognising only one pay band for nurses and one for doctors without differentiating according to specialism, experience or performance. The ministry of health monitors hospitals very closely on their adherence to this. Scope for differential pay was further reduced by the 2010 austerity measures which reduced the maximum of the pay scale, so halving the difference between maximum and minimum (meetings 5, 14). In addition, weekend payments have been cut (Sanitas meetings 5 and 17). Hospital managements do have discretion about where to pay staff on the scale and this can lead to variations in actual pay which have a regional effect, not because of the geography per se, but according to relative wealth of the locality in which the hospital operates and draws its budget, and by local negotiation to move specialist staff to top of scale (there being more specialist jobs in some of the major cities). The corollary of this is that for the majority of staff there is very slow progression in the pay scale (meetings 1 and 5) and so, whilst the contribution of such local innovations are further discussed later in the paper, overall they appear to do little to address the problem of the overall wage cap and the differentials between the public sector and the salaries offered by the private sector and other countries.

> "There are no incentives, no bonuses, no more money" (Head of Human Resources, meeting 6).

The recruitment freeze and work overload

Since the 2010 austerity measures were introduced, there has been a recruitment freeze in the public health sector. The specialist county hospital reports that it has only 200 nurses employed out of 400 posts (meeting 14). With staff leaving, those staff who remain have considerably higher workloads and difficult working conditions. A report from one hospital indicates a night shift ratio of one nurse for a ward of 30-50 patients, and also on the night shift in the large clinical hospital, nursing cover had gone down from 4 to 2 nurses for 76 patients in a post-op surgery ward. One striking story which hit the media and had a particularly demoralising effect on health workers is told of a children's' ward where only one nurse was on duty at night, and when she had to go out to the toilet a fire had begun, resulting in loss of life (meeting 5). Although the day shifts tend to be more fully staffed, the staff-to-patient ratios were perceived to be significantly worse than those in western Europe (meetings 5 and 9). Such concerns of over-workload are also reported by the Romanian health unions in Eurofound (2011).

In addition to shortages in numbers of staff, staff turnover has led to loss of experienced staff, particularly in specialist areas, which also has demoralising effects as well as severe impact on

service provision, so that surgical wards cannot always operate due to lack of staff. For example, in the large clinical hospital the loss of specialist doctors has hit Intensive Care provision particularly hard, with only four IC doctors remaining for the whole hospital (Meeting 7).

> "3 anaesthetists remain for eleven operating theatres. We especially suffer in this type of emergency hospital" (Head of Human Resources, meeting 6).

At a nearby hospital, surgery had been particularly badly hit because of a shortage of anaesthetists, reduced from 7 to 3 and according to a union official in meeting 1, there are stories of rural hospitals which have had to close to all surgical work.

Perceived lack of autonomy and respect for nurses

A general view is that nurses are seen as doctors' assistants and are not allowed autonomy (Vladescu and Olsavsky, 2009), suffering from lack of esteem and empowerment to use their skills (meeting 5). This is a reflection of how things used to be, when nurses were trained in vocational schools prior to the establishment of higher Diploma qualifications in University Colleges. Even though they are now trained to higher levels, they are not allowed to use the skills that current training provides (meeting 5; Vladescu and Olsavsky, 2009); level of qualification not being a differentiator of roles and tasks nurses can carry out (meeting 5). This is attributed to continuing cultural attitudes between doctors and nurses.

> "Nurses are completely subordinated to the medical doctor. (They) have no sense of autonomy, weak teamwork skills and there is little understanding that nursing and medicine require complementary skills" (Galan, 2006, p.48).

Nurse training and qualification equivalence

Whilst attitudes to nurses and their autonomy may not have changed in the workplace, the nursing education system has been reformed, thus raising nurses' expectations of their jobs and enabling the acceleration of out-migration through greater EU-equivalence. Before 1990 nurses were trained only in vocational high schools, but since 2003 they are now trained to higher levels in Nursing University Colleges for four years - to a Diploma (General Medical Nurse Diploma – Nurse, meeting 9; Galan, 2006) standard that is perceived by Romanian nurses as,

> "being trained in the western (European) system" (meeting 5).

This is seen as aligned to EU requirements and in compliance with Romania's EU accession arrangement (Vladescu and Olsavsky, 2009), although there is some confusion here, from the Ministry of Health,

> "training here is very good…… but it's not what the EU wants" (meeting 2),

and it is the case that the Romania nursing Diploma does not qualify them automatically for a nursing job in all other EU countries, because there are still problems with lack of equivalence (meeting 10); and for the UK requirements for work permits a specialism is usually required to justify employment.

Nevertheless, in addition to newly qualified nurses, as many as 90 per cent of older nurses who originally qualified at the lower level have now completed training at this higher, Diploma level at university or college (meeting 5). They have to pay for this, conversion taking up three years at 2000 Lei (c. £400) per year. It would seem that a decision to personally invest in the higher qualification is a decision to leave the Romanian public sector, in order to re-coup the costs.

Over-supply and the lack of workforce planning

Funding and student numbers are controlled in the public Nursing University Colleges, but in recently-founded private nursing schools numbers of nursing students are not controlled nor counted (Vladescu and Olsavsky, 2009). In total Vladescu and Olsavsky (2009) imply that there is large over-supply of trained nurses coming out of the colleges, although the supply and demand numbers and the causes from this are not clear from their text (page 14).

Local information gives some more detail,

> "There is an over-supply of nurses in Romania. In (this) county, 500 nurses graduate in the County each year, whereas only 120 are needed to fill jobs here" (County Head of Nurses Order, meeting 10).

This is explained by a lack of overall health workforce planning, identified by Galan (2006) and by the current research project. Whereas previously under the centralised system and beyond, there had been three-year predictions about demand required in Romania, this is not now being done (County President of Nurses Order, meeting 10). A reflection on this situation suggests it is not clear on what basis Romanian 'demand' figures are set, given that there is currently a recruitment freeze. There would presumably be much greater domestic demand if the recruitment freeze was lifted and it may be the case that supply training has kept going at pre-freeze levels and as a result the new private schools entering the market may in effect currently be training nurses for foreign supply outside of the state system. Indeed, it has previously been the case that private schools in Romania were training nurses and many were going directly to fill a demand in Belgium. As the Belgian supply has now exceeded demand, Belgium is now asking for three years' experience, so this route is now less direct (meeting 10).

The right to two years' absence

Mobility is enabled by a contractual right for public sector health workers to request up to two years' unpaid leave of absence. This enables staff to be circumspect about their intentions without divulging what they are doing, to try out the options of working abroad, to take short overseas contracts, and ultimately to resign if they find a successful longer term job abroad (Head of HR, meeting 6; Hospital Manager, meeting 14). It makes tracking reasons for staff turnover difficult. So,

> "they don't come here saying they are going abroad to Spain or Ireland, they ask for the suspension of their labour contract….. maybe just saying that they have to solve some family problems, …… maybe because they're not sure that they can adapt themselves. They send their resignations when they've found work" (Head of HR, meeting 6).

This can also enable workers to 'try out' the private sector too. This is the case of a nurse in meeting 16, who has just taken one year unpaid leave of absence to move to the private sector initially, although wants to move on to Italy.

The leave of absence has to be agreed with the employer, the hospital management and there is an incentive for hospital managers to encourage staff to take their leave of absence, rather than resign, as the recruitment freeze applies to permanent contracts and leave of absence will allow their replacement albeit it on a temporary basis, whereas staff who resign outright cannot be replaced (Hospital Manager, meeting 14). This leaves the way open for hospitals to employ staff on fixed term contacts, against posts which are temporarily vacant due to granting of unpaid leave of absence; and assuming this does not exceed 70 per cent of their budget on staff costs. Indeed the hospital manager in meeting 14 implies he will apply pressure on them to take the leave rather than resign. This is confirmed by one nurse who wanted to leave, but has taken one year unpaid leave of absence because her manager told her,

> "it would be better so he can recruit a temp, otherwise the post will be blocked" (nurse, meeting 16).

Nevertheless, those who leave take a lot of experience and skill with them, and are usually only replaced by inexperienced short-term replacements (meeting 14).

Unofficial payments and the impact of media and public perception on health workers

> "All the doctors take black money" (Sanitas, meeting 12).

Various stories collected during the study told of how staff find ways to supplement their income, taking additional unofficial payments and gifts. Galan (2006) recognised this pattern of "under-the-table and untaxed payments from patients" (p.47). Indeed, what are noted as 'informal payments' in CMAJ (2010) are actually measured and are said to account for 0.3% of Romania's GDP in 2008 (Centre for Urban and Regional Sociology; in CMAJ, 2010).

By example, as a patient, and telling of friends who are patients, the interpreter tells how it is universally expected that patients and their families 'pay' health staff, GPs and hospital workers, and that staff expect this. Payments depend on level of worker and what the patient can afford, whether that is envelopes of money under the desk (she gave her surgeon an extra 200 Euros), or a gift (she always takes chocolates to her GP). She has to give something to all the staff who look after her, no matter how small, and as an in-patient gave something to each nurse in her ward, at the appropriate time. She describes this as "grubby" and says people don't like it, but she says it's not done in the expectation that it will lead to better or worse medical care,

> "just that it might smooth things round the edges, like comfort and how you're looked after….".

Galan (2006) shows that this is not a new thing, and the interpreter describes it as long term, cultural and traditional. Nevertheless it is highly likely that the culture of unofficial payments is more important than ever, as an income supplement against the background of austerity cuts and as such may go some way to prevent higher levels of turnover and migration. Paradoxically, the culture is also portraying health workers in a bad light with,

"negative advertising against the staff on TV" (meeting 12),

leading to staff discontent and low morale (meeting 12). Indeed, Galan (2006) comments that doctors' inertia to wider reform of the health system has been attributed to this unofficial payments culture, and may have fuelled the unfavourable public image of health workers over a longer period. In addressing the issue to raise staff morale, the hospital director in meeting 12 "believes it is not the case in this hospital", describing how she takes a strong line against such payments,

"constraining the staff, to stop them taking bribes",

and she personally takes patient satisfaction questionnaires round to patients.

Employment relations responses

The national level: unions and arrangements for social dialogue

In Romania four unions represent workers in the health care sector, all of which are health sector-specific unions, and all are involved in collective bargaining (Eurofound, 2011). Federatia Sanitas is the largest union, formed immediately at the time of the revolution in 1989, and represents doctors, nurses, midwives and other health staff, with 120,000 members (meeting 17). In the large clinical hospital, according to the Branch President, Sanitas is by far the biggest union, with about 50 per cent density (meeting 5); and in the small municipal hospital, 98 per cent of staff are Sanitas members (meeting 12). Sanitas has affiliates in all 42 counties (the other unions do not), plus one other affiliated branch – the hospital drivers branch.

There are three other smaller unions, all representing staff from across the range of health occupations but with limited locational coverage - Hippocrat; the Camera Federative of Medics; and a new union, formed in the last five years, the Central National Trade Union of Health and Social Care *(Centrala Nationala Sindicala din Sanatate si Asistenta Sociala)* (Eurofound, 2011). Eurofound (2011) puts the creation of such new unions down to dissatisfaction with the current ones, although is not specific about the reasons behind the creation of this new Romanian union.

Eurofound (2011) does not find it relevant to highlight specifically high or low levels of cooperation or competition and rivalry between the four Romanian unions. However, Sanitas officials describe two of the other unions as

"'yellow' trade unions …. in the government's pocket" (President of Sanitas, meeting 17),

with the issue being that they have equal national bargaining rights as Sanitas despite being much smaller and are given this recognition in return for blocking Sanitas' moves (President of Sanitas, meeting 17).

In addition to the trade unions there are the professional bodies. OAMMR – Ordinul Asistentilor Mdedicali Generalisti Moaselor si Asistentilor Medicali din Romania (The Nurses Order) and the Doctors' Order/Federation. Membership of these is compulsory for license to practice. Staff will therefore join and pay subscriptions to the two organisations – a trade union and their professional body. There appears to be some conflict between the professional body and the trade union over who provides continual professional updating training.

In keeping with industrial relations across the Romanian public sector, there are centralised and unitary terms and conditions (EIRO, 2008), with one national contract for doctors and one for nurses, defining pay and hours. 100 per cent of workers in the sector are covered by the collective agreement, although it is implemented by the one sector-specific employers' organisation - the Ministry of Health (Eurofound, 2011). Even though this is the employer only for the 58 nationally-run hospitals, the contract also covers employment in the county and municipal level hospitals which are not represented by an employers' association and in other respects are outside the formal collective bargaining process. Thus, not only is there an absence of formal local bargaining, there is what may be seen as a contract unilaterally-imposed on these employers and workplaces, thus limited the room for local bargaining. By contrast, there are three employers' organisations for private sector health (Eurofound, 2011), with which there are structures for a decentralised form of collective bargaining.

There have been relatively high levels of industrial action in the Romanian health sector and public sector generally, with wage disputes having caused over two-thirds of strikes in Romania between 2005 and 2009 (Eurofound, 2011). However, because the health sector is legally defined as an essential service in Romania, there are restrictions on strike action and union leaders are legally required to ensure that at least a third of normal duties are carried out during strikes (Eurofound, 2011).

On a broader range of consultative processes than collective bargaining, 'social dialogue' (Eurofound, 2011) for the public health sector in Romania is regulated by the 'Bismark Law' (meeting 1), a tripartite arrangement between employers, trade unions and government (Eurofound, 2011). However, there are contrasting views about this, with one view,

> "trade unions are a partner of the Ministry of Health" (Ministry of Health, meeting 2),

whilst another,

> "trade union proposals are not taken into account ever" (Sanitas, meeting 1).

The trade union fears being further side-lined if the draft Privatisation Bill (December 2011) is enacted, as this has only a brief one sentence acknowledgement of trade unions; and because the bargaining and social dialogue context will fragment to multiple employers (meeting 1).

Other than noting that Romania is one of the countries which has particular issues arising from labour mobility, the Eurofound (2011) does not identify any examples where collective bargaining and social dialogue have made a contribution to the challenges facing the health care sector in Romania, unlike quite numerous examples from across other EU states on such matters as improvements in wages and terms and conditions, improvement of gender equality, improvement of access to career development and lifelong learning; as well as on specific measures dealing with migration and labour mobility.

The Sanitas union voices general agreement that workers are wanted to stay, but says,

> "we can't block them leaving" (meeting 1).

Indeed this is a typical response of employer and trade union,

> "it's the EU; they're free to leave…..we can't detain them" (Ministry of Health, meeting 2),

and at local level,

> "they just need to go and earn the money – they need the money" (Sanitas County official, meeting 15).

With what appears to be very little room for manoeuvre, Sanitas say that many will return because of problems they experience in receiver countries and that as a trade union they have relationships with unions in other countries to help them to return when their contracts run out (meeting 17). Otherwise,

> "it is difficult to have a strategy on migrant workers when pay is being cut, weekend payments are cut, etc. These are a much greater priority" (President of Sanitas, meeting 17).

There was some suggestion from the Ministry of Health (meeting 2) that staff moving from the public sector to private sector hospitals may get better wages and that this may be enough to keep them in the country, although the trade union in meeting 1 felt that the Bill did not give a strong rationale of increasing pay through privatisation and were concerned to ensure minimum wages would not be reduced through privatisation.

In meeting 2 and subsequent correspondence, neither the government Ministries of Health or Labour appeared to know of the WHO (2008) or HOSPEEM (2008) codes of conduct on the ethical recruitment of health workers which the trade union side were keen to see implemented. This would seem to be an indication of the lack of action, ability and will of government, employers and unions to be able to address migration, and perhaps symptomatic of the attitude of government and the powerlessness and concerns expressed by unions.

> **Workplace level employment relations. Exceptions to a universal migration problem – stories from two hospitals**

Earlier, this paper documented a move to a partially decentralised system of health provision, albeit with national state controls on budget, wage levels and permanent staff recruitment. On the basis of the three hospitals visited in this study, there are varying extents of local hospital manager autonomy and ways of involving trade unions in local level employment relations processes. At the workplace level seeing migration as one big problem is an over-simplification. Variations would appear related to size, governance and function of the hospital and to degree of specialism, but there are also influences of agency, innovation and willingness to work cooperatively associated with local managers and trade union officials. Key players in all three hospitals described union-management relations as good, and in all three hospital cases there are examples of constructive involvement with trade unions to find pragmatic solutions to the problems, although there is no evidence about how far this may be replicated across the sector.

It has already been noted that some specialist staff may be migrating more than generalist or lesser experienced staff, and that this affects particularly large hospitals with specialist functions. The large clinical hospital is an example of this, providing specialist care and governed at national level by the Ministry of Health. Here the Head of Human Resources and the Sanitas Branch President do seem to have a good working relationship – having agreed to use maxima on pay scales in the face of what

they saw as retention being a problem common to them both. At local level, at each hospital, Sanitas say they have been active in negotiating to get employers to use the full maxima of the pay scales, in order to give as many staff as high pay as possible to aid retention, and have been successful in some places (Sanitas Branch President, meeting 5). But is in the other two hospitals that more in-depth stories were revealed.

The small municipal hospital operates at city level, as opposed to county or national; and provides largely less-specialist and out-patient functions. Although migration is generally seen as a problem in the region and county (meetings 10 and 12), it is not a problem in any large scale from this hospital (meeting 12). The reason for this is attributed to less specialisms, but also to a range of other factors – local governance and relative wealth of the local area, income diversification, investment and local management. Although the national restrictions on salary levels and on the proportion of revenue from the national insurance house to be spent on the staff salary bill still apply here, the governing board is at city level, at City Hall, including the major and locally elected politicians. They are able to make non-staff investment into the hospital. This is enabled by the relative wealth of the region, where local revenues have enabled funding of equipment such as imaging equipment and sufficient medicines and training for this (meeting 12). The provision of protective equipment and uniforms for doctors and nurses is promoted as a positive example (meeting 12), although seems rather limited in the whole range of potential collective bargaining outcomes.

The hospital is also diversifying income sources, for example, by undertaking contracts for private clinics, charging for driving licence medical tests, and for pathology work. The hospital Director is young, less than two years into her appointment, and seems to be a driving force for change. She describes how she has increased available budget by driving down the cost of providers' contracts – maintenance contracts and food contracts,

> "the chicken was twice as expensive!" (Hospital Director, meeting 12),

and now has money to re-invest. The meeting describes how staff turnover has been reduced because equipment and medicines enable staff to do their jobs well; and staff salaries have been supplemented by non-salary benefits, principally food vouchers.

The Hospital Director appears to be taking an investment approach, arguably of innovative local management but with some severe limitations in service outcomes. Although there may be a relatively low level of staff turnover, the national-level recruitment freeze applies. This has meant that the range of specialist functions in this hospital has become more narrow as staff have left, with oncology, neurology and intensive care no longer provided (even though a specialism was until recently oncology), because they rely on a small number of specialist staff and because they are too expensive (meeting 12).

> "Emergency and intensive care are too expensive. …. They are here on the structure, on paper only. They are vacancies" (meeting 12), saying that "it becomes not my problem. Patients go to one of the county hospitals instead" (Hospital Director, meeting 12).

Although this approach is reportedly supported by the governing board and the Mayor, it would seem that overall medical capacity in the region is reduced, potentially lengthening waiting lists elsewhere in the county.

In the specialist county hospital, manager and union official together describe their working relationship as 'permanently good' (meeting 14). The Sanitas union is a member of the hospital board of administration, as observer, where there are also representatives from the County Council, the national Ministry and the Nurses' Order and Doctors' Federation. The hospital has local governance, this time at County council level. Unlike the small municipal hospital however, it does not receive the local funding it should.

> "I should get County money for buildings, maintenance, equipment, ultrasound, etc; but I've not received a single Leu – not even for heating" says the hospital Manager (meeting 14).

However, he says he finds a way round this, playing down any suggestion of budget problems, by raising money in other ways,

> "we raise our own fees, for example through abortions, other out-patient services in all situations where patients do not come with a referral note from their GP; and by offering other fee-paying facilities such as husbands able to pay for an additional room for themselves when they come to visit their wife" (Hospital manager, meeting 14).

There is a staff turnover problem here, but one that is as much due to moves to the private sector as it is to migration. The hospital manager assesses that 70 per cent of nurses who leave go to the Romanian private sector, compared to 30 per cent migrating abroad. This is due to the specialist gynaecology and obstetrical skills of many of the staff, as they leave to better paid work in small private sector gynaecology clinics; and a lack of demand for midwives in other countries.

> "Each week one wants to leave" Hospital manager (meeting 14),

although he feels he knows that they often regret moving to the private sector because it may be for more pay but this is often for longer hours and for many more different types of work all included.

> "They have to do all sorts of work in the private sector - unlike here" Hospital manager (meeting 14).

When they regret their decision and want to return, they cannot because of the recruitment freeze (Hospital Manager, meeting 14).

For doctors, again there is a difference compared to other hospitals. Here, very few of the established experienced doctors leave (Hospital Manager, meeting 14). This is because they have the equipment they need to do 'good' work here; but also because they mainly all operate privately at the same time as working within the state system, through a number of private gynaecology clinics. They are thus able to supplement their income (Hospital Manager, meeting 14). From this hospital it is the young doctors at the end of their internships who leave – to migrate predominantly to France – and to leave to join the private sector outright as their main employer (Hospital Manager, meeting 14).

The hospital manager has various creative ways of dealing with staff turnover, including persuading leavers to take the two years leave of absence so that he can replace them with temporary staff (as noted previously), and creativity in the use of pay scales as far as they relate to responsibilities, with the hospital manager being able to pay additional allowances per number of beds and for additional

inventory responsibilities. These would seem to be the result of local negotiation, but none-the-less are restricted by the relatively small number of in-patient beds in what is largely an out-patient and short-stay hospital; and restricted within the 70 per cent national salary budget cap (Hospital Manager, meeting 14).

The manager also has a longer term plan to get around the recruitment freeze if it's not unblocked, by outsourcing work to service providers – he proposes sub-contracted cleaning companies and employing self-employed freelance nurses – thus getting posts and employees off his staff budget (Hospital manager, meeting 14). It would appear that the national constraints on recruitment might be driving hospital managers to consider such alternative working arrangements. He describes this as already happening in one other local hospital, where IT support, laundry and catering posts have been ceased and the work outsourced, thus enabling the budget and posts to focus on the employment of medical staff within the overall staff budget cap.

Conclusion

At the beginning of this paper, one initial assumption was of Romania as a 'sender' country of health workers to Western Europe. Findings suggest this is the case, although there is lack of clarity about numbers and flows. Obtaining accurate data is highly problematic, although a realistic estimate is that three per cent of doctors and somewhere between 5 and 10 per cent of nurses leave the country each year; and they tend to be the younger workers and those who have acquired valuable specialist skills. Although migration to traditional destinations of Italy and France is still strong, this is being over-taken by the popularity of the UK and Nordic countries as destinations.

Further, the situation regarding mobility of health workers in Romania is complex, involving different patterns of mobility - public to private, rural to urban, outward migration and circular migration. Different regions and hospitals with different purposes and governance structures, experience different circumstances. Out migration is more likely to be a problem from large urban areas and from specialist and surgical fields. Some specialisms also face staff loss to the private sector. General work, and smaller municipal and county hospitals may face less of a problem of staff loss, but this depends on the affluence of their region or city and how they may be able to leverage additional funding. There are great problems with lack of health staff in rural and deprived areas, partly attributable to regional or national migration and also to lack of incentives and good working conditions and infrastructure. Nurses are likely to return to employment in Romania, perhaps after three to five years away, and bring back valuable additional skills, although they may return to the private rather than the public sector. Doctors also leave to acquire greater expertise, but would appear to seldom return. Other influencing factors appear to be gendered, and family and friendship, social and cultural related.

There are multiple causes of mobility, primarily driven by income disparity, but influenced by chronic under-investment, contributory factors of economic austerity measures and centralised employment controls, yet also a decentralisation that has meant the cessation of national coordination and workforce planning.

The second starting assumption suggested likely poor employment relations, management and trade union responses, in the context of the EU NMS being typified as having underdeveloped industrial relations systems (Morley, 2007). However, in contrast to EU NMS union density more generally, the

public health sector in Romania has relatively high union membership. In addition, at workplace level there are examples of hospital managers working creatively to solve staffing problems, and there are examples of constructive involvement with trade unions to find pragmatic solutions. With different governance structures managers are able to use funding and employment contracts more constructively (although these cause longer term problems for the range of service provision and for employment security), in contrast to social dialogue at national level which appears largely to have broken down.

Within the mobility theme, there appears to be trend towards a fixed term contract culture, with staff moving between countries and between sectors (public to private) on a succession of temporary contracts. For workers in specialisms and with skills that are in demand, this appears to be workers moving on their own terms (Palse et al, 2008) country to country and employer to employer with the opportunity to earn more when they have acquired further skills, or to move to a location within a host country where the cost of living is cheaper. Such movement is primarily for individuals' calculated financial reasons, to invest in their future (house) or futures of others (their children). However, growth in the temporary contract culture raises serious concerns about the sustainability of staffing capability and skill acquisition across the range of medical service provision at regional and national workforce level; at the moment sustained only in part by professional body mandatory training, and hindered by a lack of effective employment relations responses.

References

Baba, C., Brinzaniuc, A., Chereches, R. and Rus, D. (2008) 'Assessment of the reform of the Romanian health care system', *Transylvanian Review of Administrative Sciences*, 24/E, 15-25.

Bach, S. (2010) 'Managed migration? Nurse recruitment and the consequences of state policy', *Industrial Relations Journal*, 41, 3, 249-266.

BBC News (2010a) 'Thousands protest over Romania austerity measures'. 19th May 2010. (www.bbc.co.uk/news/10127366 accessed 13/1/12)

BBC News (2010b) 'Romanian healthcare on verge of collapse'. 12th August 2010. (www.bbc.co.uk/news/world-europe-10914678 accessed 20/3/12)

BBC News (2012a) 'Country profile: Romania'. (www.bbc.co.uk/news accessed 24/2/12)

BBC News (2012b) ' Romania braced for more demos over austerity measures'. 20th January 2012. (www.bbc.co.uk/news accessed 24/2/12)

BBC News (2012c) 'Romania's PM-designate Victor Ponta unveils new cabinet'. 1st May 2012. (www.bbc.co.uk/news/world-europe-17918410 accessed 2nd May 2012)

Cismas, L. and Maghear, D. (2010) 'The Ageing of the population of Romania in the European context'. *Annals of Faculty of Economics.* (http://anale.steconomiceuoradea.ro/volume/2010/n1/027.pdf accessed 16/2/12)

CMAJ (2010) 'Health care in Romania: fighting collapse', *Canadian Medical Association Journal,* 182, 7, 654-655.

The Economist (2011) 'Romania's economy: buckle up', The Economist 10th December 2011 (www.economist.com/node/21541402 accessed 13/1/12)

EIRO (2008) 'Industrial relations in the public sector – Romania', European Industrial Relations Observatory On-line (EIROnline), 11th December 2008. (www.eurofound.europa.eu/eiro/studies/tn0611028s/ro061102 accessed 13/1/12)

Eurofound (2007) *Mobility in Europe: the way forward.* Foundation findings. European Foundation for the Improvement of Living and working Conditions: Dublin.

Eurofound (2011) *Employment and Industrial Relations in the Health Care Sector.* European Foundation for the Improvement of Living and Working Conditions: Dublin.

Eurostat (2012) *Assessment of the 2012 national reform programme and convergence programme for Romania.* Commission Staff Working Paper SWD (2012) 325 final. European Commission: Brussels. (www.ec.europa.eu/europe2020/pdf/nd/swd2012_romania_en.pdf accessed 13/6/12)

Galan, A. (2006) 'Health worker migration in selected CEE countries – Romania'; in Wiskow, C. (Ed) *Health Worker Migration Flows in Europe: overview and case studies in selected CEE countries – Romania, Czech Republic, Serbia and Croatia.* ILO Working Paper 245. International Labour Office: Geneva.

Galan, A., Olsavszsky, V. and Vladescu, C. (2011) 'Emerging challenges after EU accession: Romania', Euro Observer: The health policy bulletin of the European observatory on health systems and policies, 13, 2, 10-11.

Gallagher, T. (2005) *Theft of a Nation. Romania since communism.* Hurst & Co: London.

HOSPEEM (2008) Code of Conduct on Ethical Cross-border recruitment and retention. Jointly signed between HOSPEEM (European Hospital and Healthcare Employers' Association) and EPSU (European Federation of Public Service Unions). (www.epsu.eu.org accessed 2/2/12)

Morley, J. (2007) 'Labour market developments in the new EU member states', *Industrial relations Journal*, 38, 6, 458-479.

OECD (2010) 'Recent changes in migration movements and policies (country notes), International Migration Outlook: Sopemi 2010, Organisation for Economic Cooperation and Development: Paris. (www.oecd.org/documents accessed 2/2/12)

Ovidiu, C., Brinzaniuc, A., Chereches, R. and Rus, D. (2008) 'Assessment of the reform of the Romanian health care system', *Transylvanian Review of Administrative Sciences,* 24E, 15-25.

Palese, A., Barba, M. and Mesaglio, M. (2008) 'The career paths of a group of Romanian nurses in Italy: a 3-year follow-up study', *International Nursing Review,* 55, 2, 234-239.

Pidd, H. (2012) 'Romanian prime minister and cabinet quit en masse', *The Guardian,* 7th February 2012, 20.

Sanitas (2011) Press Release 14th April 2011. SANITAS Federation of Romania. (www.federatiasanitas.ro accessed 4/1/12)

Tjobs.ro (2012) www.tjobs.ro/resurce/communicate/en/jobs (accessed 2/2/12)

Vladescu, C., Scintee, G., Olsavsky, V., Allin, S. and Mladovsky, P. (2008) 'Romania: health system review', *Health Systems in Transition,*10, 3, 1-172.

Vladescu, C. and Olsavsky, V. (2009) 'Migration of nurses: the case of Romania', Human Resources Management: Management in Health 4/2009. SNSPMS (National School of Public Health and Sanitary Management). (www.fondulglobal.ro/...national-school-of-public-health-and-sanitary-management accessed 2/2/12)

WHO (2008) Global code of practice on the international recruitment of health personnel. World Health Organisation. (www.who.int/hrh/migration/code/practice/en accessed 16/2/12)

Appendix One. Study visit meetings

Meeting	Date	Venue	Participants
1	16/1/12	Federatia Sanitas head office, Bucharest	National President and two Vice Presidents of Sanitas, EPSU sub-regional secretary
2	16/1/12	Ministry of Health, Bucharest	Deputy Minister of Health, Head of Human Resources, National President of the Nurses' Order, EPSU sub-regional secretary, Sanitas National membership secretary
3	16/1/12	Ministry of Health, Bucharest	National President of the Nurses' Order
4	16/1/12	EPSU Regional Office, Bucharest	EPSU sub-regional secretary
5	17/1/12	Large city clinical hospital	Nurse/Sanitas Branch President
6	17/1/12	Large city clinical hospital	Head of Human Resources
7	17/1/12	Large city clinical hospital	Medical Director
8	17/1/12	Large city clinical hospital	Nurse/Sanitas Vice Branch President
9	17/1/12	Large city clinical hospital	Post-operative nurse
10	18/1/12	Nurses' Order regional head office, county level	County President of the Nurses' Order, County President of the Sanitas, County Official of the Ministry of Health, Sanitas legal adviser, Sanitas National membership secretary
11	18/1/12	Nurses' Order regional head office, county level	County President of the Doctors' Federation
12	18/1/12	Small municipal hospital	Hospital Director, County President of Sanitas, County Official of the Ministry of Health, Sanitas legal adviser, Sanitas National membership secretary
13	18/1/12	Small municipal hospital	Nurse/hygiene assistant

14	19/1/12	Specialist county hospital	Hospital General Manager, County Vice President of Sanitas
15	19/1/12	Specialist county hospital	County Vice President of Sanitas, Sanitas National membership secretary
16	19/1/12	Specialist county hospital	Two nurses
17	20/1/12	Federatia Sanitas head office, Bucharest	National President and Vice President of Sanitas

Note 1 – Full research project overview

OPPORTUNITIES AND CHALLENGES RELATED TO THE CROSS-BORDER MOBILITY AND RECRUITMENT OF THE HEALTH CARE WORKFORCE IN EUROPE

European Federation of Public Service Unions (EPSU) and the University of Hertfordshire

September 2011 – June 2012

The work is part of a project supported by the European Commission in the framework of improving understanding of the operation of the European Union and Europe 2020 Strategy in the health and social services sector, the broader project being about Europeanisation of health policies and health care systems incorporating the single EU market in health care systems; the EU financing of health care; as well as migration and mobility of health care workers in the European labour market.

The work considers current and future challenges and policy options to improve recruitment and retention, professional qualifications, the quality of jobs and employment, pay and working conditions and the effective management and sustainable financing of health care systems for all European countries, for a broad range of health care professionals including nurses, midwives, doctors, social workers and care workers. It seeks to identify strategy and policy options for employers, government agencies and trade unions within social dialogue and collective bargaining at different levels to address common challenges for the health care workforce for the next 5 to 10 years. The research comprises desk-based research plus a questionnaire to all EPSU affiliates in the health care sectors, together with six in-depth country case studies, of which Romania is one.

Acknowledgments

The author wishes to thank the other members of the EPSU project team, Jane Hardy and Moira Calveley (University of Hertfordshire, UK), Rebecca Zahn (University of Stirling, UK) and Julia Kubisa (University of Warsaw); and the EPSU staff particularly Mathias Maucher and Marina Irimie; for their assistance and advice. In addition, special thanks go to all the trade union officials, hospital managers and staff in Romania who gave their time so freely and without whom this research would not have been possible.