

CELSI Discussion Paper No. 1

ACTING ON THE EDGE OF PUBLIC SECTOR: HOSPITAL CORPORATIZATION AND COLLECTIVE BARGAINING IN HUNGARY AND SLOVAKIA

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ABSTRACT

**Acting on the Edge of Public Sector:
Hospital Corporatization and Collective Bargaining in Hungary and
Slovakia***

Effective public sector management became central to economic and political debates across Europe in the last decade. One of the most affected domains is public healthcare that is often subject to ambiguous reforms combining private and public sector “best practices”. This paper attempts to extend our theoretical and empirical knowledge on healthcare reforms and their effect on employment relations in Hungary and Slovakia. A particularly salient feature of healthcare reforms in both countries is hospital corporatization, defined as a process in which public hospitals become subject to regulations applicable to private sector companies, formally entailing the possibility of bankruptcy. We argue that effects of corporatization on employment relations are more complex than the available literature in organizational change and public sector management suggests. Corporatization contributed to stability in bargaining patterns, while produced diversity in bargaining outcomes in Hungary and Slovakia. Particular effect of corporatization have been channelled through the interests and responses of involved actors. Despite market-oriented reforms of the institutional environment, we found remarkable similarities in how actors responded to hospital reorganization; and in the stability of bargaining institutions due to actors’ commitment or inability to bring forth institutional change in bargaining patterns.

Keywords: public healthcare reform, hospital corporatization, collective bargaining, working conditions, Central and Eastern Europe

JEL Classification: I18, J51, J52, J81, L32, P26

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* This paper is part of the FP7 project GUSTO.

1. Introduction

Effective public sector management became central to economic and political debates across Europe in the last decade. Fiscal austerity called forth reform measures that further intensified with the economic crisis after 2008. These reforms exposed the formerly sheltered public sector to organizational change in need for more efficiency and market-like provision of public services. This new phenomenon of exposure raises relevant questions about the effects of organizational change on public sector governance in general and public sector employment and industrial relations in particular.

Reform processes continuously impact on diverse parts of the public sector. One of the most affected domains is public healthcare that is often subject to ambiguous reforms combining private and public sector “best practices” (c.f. Avgar and Givan 2011, Harding and Preker 2000). States all over Europe remain committed to safeguarding the public goods character of core healthcare services while striving to make these services more market-like (Grimshaw et al. 2007: 609). Despite the economic, political and societal importance of public healthcare reforms, political economy literature lacks a systematic analytical and empirical account of these processes. For example, we lack a conceptualization of reforms combining state and market-based healthcare provision, and an account on reform effects on employment and collective bargaining across diverse institutional settings. Moreover, the available but limited empirical account on public service and healthcare reforms centres on “old” EU members (Bordogna 2008, Galetto, Marginson and Spieser 2011, Grimshaw et al. 2007, Schulten, Brandt and Herman 2008, Duncan 2001, Brandt and Schulten 2007), leaving healthcare reforms and their effects in the “new” EU members unexplored.

This paper attempts to extend our theoretical and empirical knowledge and fill the above gap in the literature by studying particular features of healthcare reforms and their effect on employment relations in Hungary and Slovakia, two postsocialist EU member states in Central and Eastern Europe (CEE). In the course of 1990s and 2000s, both countries underwent wide-ranging reforms in all spheres of economic and political life. Reform efforts, among others in public healthcare, have further intensified since mid-2000s. In Hungary, between 2006 and 2008, a pro-market ministry introduced radical reforms intending to facilitate a shift to a system based on efficient hospital operation based on market competition. In Slovakia, reforms aimed at market-oriented healthcare provision with hospitals acting like efficient private corporations. Although a full reform of public healthcare was never achieved due to changes in government structure, a particular feature of healthcare reforms remained central in both countries. This is *hospital corporatization*, defined as a process in which public hospitals become subject to regulations applicable to private sector companies, formally entailing the possibility of bankruptcy. For corporatized hospitals this means remaining in public ownership while enjoying greater management autonomy as the state no longer takes responsibility for hospital financial performance. Due to saliency of corporatization in both countries, we aim at analytical and empirical understanding of the effects that corporatization produced on

employment relations, in particular, on collective bargaining patterns and outcomes. Bargaining patterns refer to processes through which employment issues are governed, e.g., bargaining levels, structures and coverage, salience and regularity in bargaining, and the enforcement of collective agreements. Bargaining outcomes refer to the kind of collective agreements concluded, their provisions and relevance, and hospital employment conditions.

Despite remarkable similarity of corporatization efforts in both countries' healthcare systems, Hungary and Slovakia are characterized by great differences in their industrial relations systems. Hungary's industrial relations are characterized by a high number of actors (especially trade unions), many of which emerged after 1989, a decentralized bargaining structure with predominantly establishment-level bargaining, and national-level coordination mainly in the public sector (Berki 2006). In contrast, Slovakia maintained its coordinated industrial relations system with predominance of sector-level bargaining both in the public and private sectors; and complementarity between the sector and establishment level bargaining especially in large firms (Czíria 2010). These differences frame our motivation to investigate how hospital corporatization influenced bargaining patterns and outcomes in a coordinated bargaining system (Slovakia) in contrast to a decentralized bargaining system (Hungary).

Informed by the available literature on recombinant property (Stark 1996) and organizational change in the public sector (e.g., Barzelay 2001, Bordogna 2008, Grimshaw et al. 2007, Pollitt and Bouckaert 2004, Schulten et al. 2007) we propose that corporatization can produce a break with established bargaining patterns in the direction of bargaining decentralization and declining bargaining coverage especially if enforcement of collective labour regulation is weak. Next, corporatization as an effort to make public hospitals operate like private actors may produce deterioration in hospital employment conditions and fuel emergence of a two-tier workforce with cleavages between employees in corporatized and non-corporatized hospitals.

Taking these propositions as a starting point for our empirical inquiry, our findings show that corporatization's effects differ from the above expectations. First, the effect on bargaining patterns remained marginal in both countries. Established bargaining patterns¹ not only survived corporatization, but independent bargaining has in fact been strengthened through a shift of bargaining responsibilities from the broader public sector to sector-level actors in healthcare.² In result, neither in Hungary nor in Slovakia did corporatization produce a break with established bargaining patterns. Second, in exploring the impact of corporatization on bargaining outcomes, we find that collective agreements in both countries continue to reproduce earlier provisions from public sector agreements. The role of healthcare collective agreements is declining in Hungary, as their ability to provide stipulations beyond the statutory minimum is decreasing, while Slovak sector-level agreements maintained their central role in governing employment conditions. Next, the Slovak evidence shows that corporatization produced a growing gap in employment conditions between hospitals

¹ National and company level bargaining in Hungary; and sectoral and company level bargaining in Slovakia

² Actors refer to trade unions, hospital employers' organizations, hospitals and the state

corporatized earlier in the reform process (smaller public hospitals) and large university hospitals whose corporatization has been recently blocked by strong trade union opposition. The emergence of a two-tier workforce has been less prominent in Hungary, because working conditions deteriorated in non-corporatized hospitals as well. In sum, we argue that corporatization's effects are not uniform across bargaining patterns and outcomes and across the studied countries, but comprise elements of stability and change across all domains.

The paper is based on an international research project on the governance of employment conditions in public healthcare, using coordinated qualitative comparative research methods. In order to contend with the variety of healthcare organizations in each country, the study is limited to the hospital subsector and hospital healthcare personnel.³ Our analysis covers the period between 2001 and 2011 when corporatization has been implemented. Evidence has been collected from various data sources in Hungary and Slovakia in 2010 and 2011. We consulted relevant legal documents, national and sectoral collective agreements and their amendments (particularly in Slovakia), reports and press releases. In Hungary we consulted the database of collective agreements, the State Audit Office's Report on the Monitoring of Outsourced Hospital Activities and a survey commissioned by the former Ministry of Social Affairs and Labour. We also conducted interviews with key informants in each country's healthcare sector.⁴

The paper is structured as follows. The second section offers a literature review related to public sector reform, organizational change and recombinant property. Based on selected concepts from this literature, in the third section we propose how corporatization influences bargaining patterns and outcomes. The fourth section offers an account of corporatization and its main effects on bargaining patterns and outcomes in Hungary and Slovakia. We point out the complexity in effects of policy changes and formulate our argument that corporatization did not produce the expected changes because of being channelled through actors' interests and responses within established economic and institutional structures. The paper concludes with a summary of our arguments and a discussion on the viability and stability of reform policies and their role for governing employment conditions (not only) in postsocialist countries.

2. Conceptualizing corporatization: insights from the available literature

Corporatization is an organizational change where hospitals in public ownership become subject to regulations applicable to private sector companies. This contains more independence and less financial assistance from the state, and the possibility of going bankrupt. Due to its interface position between the *public* and the *private*, it is a

³ Doctors, nurses, midwives and other healthcare personnel

⁴ In Hungary, five interviews were conducted by Tibor Meszmann, one interview was conducted by Imre Szabo and 2 interviews were conducted jointly. Interview partners included industrial relations experts, representatives of trade unions, hospital associations, the Hungarian Medical Chamber and other professional organizations. In Slovakia, 9 interviews took place with trade unions, sector-level hospital associations, national tripartite social partners, the Healthcare Surveillance Authority and professional chambers of doctors and nurses. The interviews were transcribed.

challenging endeavour to conceptualize corporatization's effects on bargaining patterns and outcomes. The first obvious choice for grounding our endeavour is the new public management literature (NPM) on government reform measures (Pollit and Bouckaert 2004, Barzelay 2001, Bach and Kessler 2008). Public management reform is defined as "*deliberate changes to the structures and processes of public sector organizations with the objective of getting them [...] to run better*" (Pollit and Bouckaert 2004: 8). Reform efforts target those government services where wholesale privatization is not an option but where constant pressures exist to limit costs and make provision more efficient. In other words, reforms aim at "*mimic[king] the structure and efficiency of private corporations while assuring that social objectives are still emphasized through public ownership*" (Harding and Preker 2000: 15). In this sense, healthcare reforms in general and hospital corporatization in particular represent a deliberate "*systemic organizational change*" (Barzelay 2001: 48) and can therefore be conceptualized as part of public management reform. However, the NPM literature falls short of providing relevant analytical tools for elaborating *how* reforms produce outcomes, e.g., in employment issues. According to Bordogna (2008: 382) "*the NPM approach tends to neglect the specificity of public sector employer as a political institution and displays an excessive [...] concern with moral hazard and agency costs problems.*"

Acknowledging this shortcoming, two other literature streams seem more suitable to facilitate our endeavour. First, the literature on organizational change in public healthcare addresses the effects of privatization and outsourcing on industrial relations (Grimshaw et al. 2007, Schulten, Brandt and Herman 2008, Duncan 2001, Brandt and Schulten 2007). Although corporatization is not equivalent to privatization or outsourcing, its effects on employment conditions can be similar. Findings suggest the main effect of privatization on hospital employment to be *the emergence of a two-tier workforce* consisting of insiders in relatively stable public employment, and outsiders losing their public servant status and experiencing deterioration in working conditions. Bargaining decentralization happens simultaneously. Recently the gap between insiders and outsiders widened in Germany, while in the UK recentralization took place after detrimental effects of decentralization and outsourcing (Grimshaw et al. 2007: 605).⁵

The second useful source is Stark's (1996) notion of *recombinant property*, a hybrid form of private and public ownership, in post-socialist transition economies, as it provides analytical insights for propositions concerning corporatization effects on bargaining patterns and outcomes. "*Recombinant property is a form of organizational hedging in which actors respond to uncertainty by diversifying assets, redefining and recombining resources*" (Stark 1996: 993). During recombination, "*actors ... redeploy available resources in response to their immediate practical dilemmas*" (Stark 1996: 995). Stark concentrates on property relations; and although hospital corporatization does not aim at ownership change, recombination can also mean a purely organizational shift. First, even if corporatization does not entail diversification

⁵ Organizational pressures differ in conditions of stable public ownership (UK, Scandinavia) and widespread privatization (Germany). The emergence of a two-tier workforce has been most acute where "real privatization" happened during the last few years, namely in Germany. The literature does not explicitly address why organizational change operated in particular directions in particular countries.

in property assets, it certainly means redeploying and regrouping organizational resources, which we expect to bear consequences for bargaining patterns and outcomes. Next, we stretch Stark's argument to examine how his assumption on a *trade-off between increasing adaptability and decreasing accountability* in firms with recombinant property translates into hospital corporatization. Stark contends that the emergence of recombinant property made economic actors more adaptive to external challenges while weakening their accountability. Blurring the line between the public and the private helped firms to survive, while it created an accountability problem because firms were subject to too many accountability standards (Stark 1994: 37). Stark (1994: 21) understood *accountability* as a set of standards on the basis of which the value of a company can be assessed; or management compliance with certain general standards of operation. For this paper's purpose, the latter understanding is feasible. *Adaptability* is applicable to corporatization's conceptualization, especially if related to *uncertainty* (c.f. Beckert 1996, Dosi and Egidi 1991, Crouch 2009): hospital owners (employers) perceive corporatization from the perspective of their manoeuvring space in uncertain conditions. Uncertainty in this case refers to a post-reform situation in which employers [*cannot anticipate the outcome of certain decisions, cannot assign probabilities to the outcome, [...] or cannot anticipate other actors' behaviour*] (Beckert 1996: 804). Substantive uncertainty refers to a lack of knowledge in order to make decisions or predict their outcomes (Dosi and Egidi 1991, Kahancova 2010: 22). Hospitals may also face procedural uncertainty, referring to a competence gap to pursue desired interests (c.f. Dosi and Egidi 1991). In particular, hospitals as employers and industrial relations actors seek their most suitable strategy in the post-corporatization business of industrial relations, which has [*shifted to being a series of deals and conflicts over how, and by whom, the burdens of economic uncertainty should be distributed, and through what forms of employment contracts and their terms and conditions.*] (Crouch 2009: 5). In sum, although recombinant property focuses on the role of owners and managers in privatization, we find this notion useful for the paper's aim because offering concepts that facilitate an analytical underpinning of corporatization effects on bargaining patterns and outcomes. We borrow the concepts of *adaptability*, *accountability* and *uncertainty* to develop our analytical framework in section three.

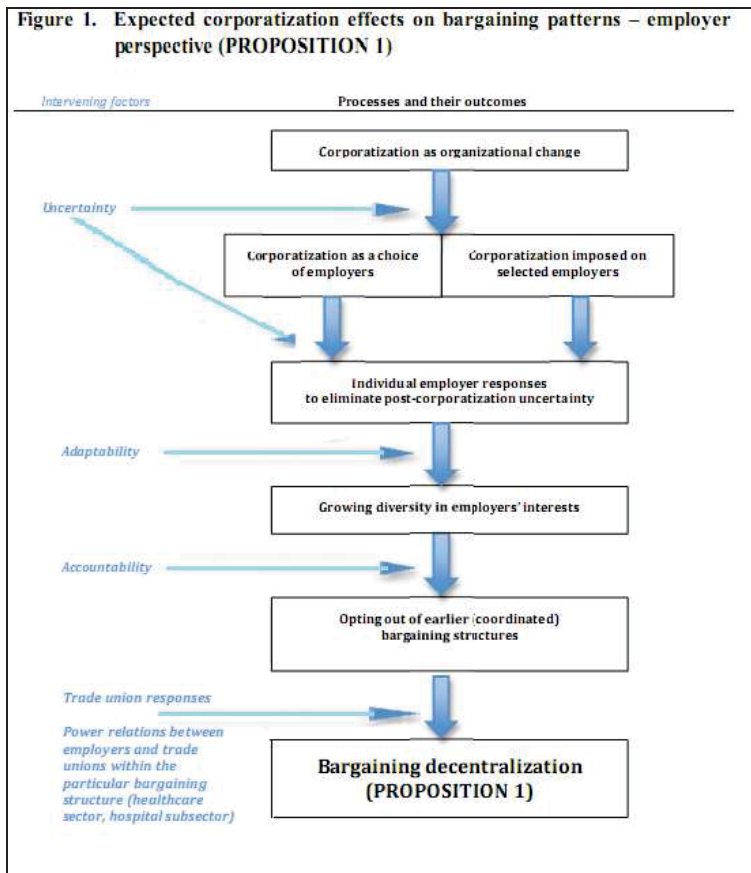
Finally, since corporatization and collective bargaining is about reshuffling actors' power relations and interactions to produce certain outcomes, we argue that an actor-oriented perspective on corporatization effects is a viable addition to the above concepts. Actors' interests, behaviour and efforts at adaptability to decrease post-reform uncertainty are central to the relationship between corporatization and bargaining patterns and outcomes. In other words, the effects of policy processes (corporatization) in Hungarian and Slovak political, economic and institutional contexts are channelled through responses of trade unions, hospitals, and hospital associations, their adopted strategies, and structural power relations (c.f., Hattam 1992, Pontusson 1995, Hall 1997, Scharpf 1997, Levitsky-Murillo 2011). The role of actors is underspecified in the NPM as well as in the organizational change literature perceiving reforms as a top-down state-supervised process. Actors independent of the state enter the model only to react to state-induced processes. An exemption is the study by Schulten, Brandt and Hermann (2008) distinguishing forms (or phases) of

trade union responses to privatization. In the first phase unions can launch political campaigns aimed at preventing privatization. When privatization was already carried out, unions can call for more regulation to “*defend jobs, pay and working conditions, as well as employees’ participation rights.*” (second phase.) In the third phase “*they can try to promote alternative policies to strengthen the public sector, including the return of certain privatised activities to public ownership.*” (Schulden, Brandt and Hermann 2008: 305-306). This argument offers relevant insights for expected trade union responses in steering corporatization effects on bargaining patterns and outcomes.

3. Expected corporatization effects: an analytical framework

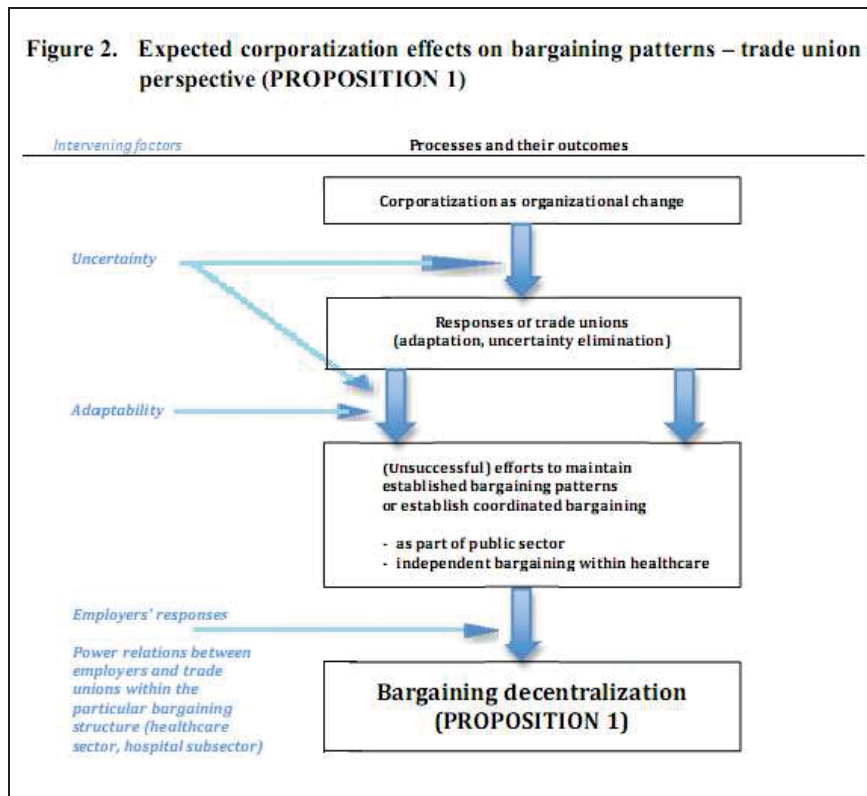
Pulling together the presented concepts, Figures 1 and 2 offer an actor-oriented perspective on the mechanism how corporatization affects bargaining patterns. The starting point of our framework is corporatization as organizational change from state budgetary organizations to state-owned corporations. Corporatization is either the employer’s choice or part of centrally implemented healthcare reforms. In both cases, employers seek to eliminate uncertainty in post-reform conditions through promoting certain processes and outcomes aligning with their individual interests.⁶ Through voluntary interest in corporatization, employers can enhance flexibility in management practices while remaining publicly financed. Even if corporatization is not voluntary but part of a central reform policy, hospital managers have an opportunity to liberate themselves from constraining practices, including collective bargaining. This opportunity aligns with the general proposition that management in recombinant organizations aims at getting around accountability standards (Stark 1996). Decreasing accountability can mean that corporatized hospitals cut their earlier ties to the public sector and no longer follow regulations (including collective agreements) that applied to them prior to corporatization.

⁶ This proposition holds if procedural uncertainty, or a competence gap, as intervening variable on the side of employers (hospitals) is low. Due to limited empirical evidence, we refrain from considering procedural uncertainty in our framework.



Trade unions are expected to defend coordinated collective bargaining (see Figure 2). However, this task is arduous given CEE countries' hostile environment towards collective interest representation, collective bargaining, and any form of collective regulation other than the legal framework (Ost 2000). Despite their efforts, the weakness of trade unions in CEE accounts for the dominance of employers' and other actors' (i.e., the state and health insurance companies) influence on bargaining patterns, operating in the opposite direction to unions' efforts.

Derived from the above mechanisms, our first proposition is that corporatization shall produce **bargaining decentralization** among hospitals (PROPOSITION 1). Evidence to support this proposition needs to document, first, a move from national or sectoral bargaining levels towards establishment level bargaining; second, a declining role of collective agreements in governing employment conditions; and third, a replacement of collective agreements by unilateral management practices. This aligns with the trend of disappearing collective agreements in many private sector corporations in CEE (European Commission 2011: 36).

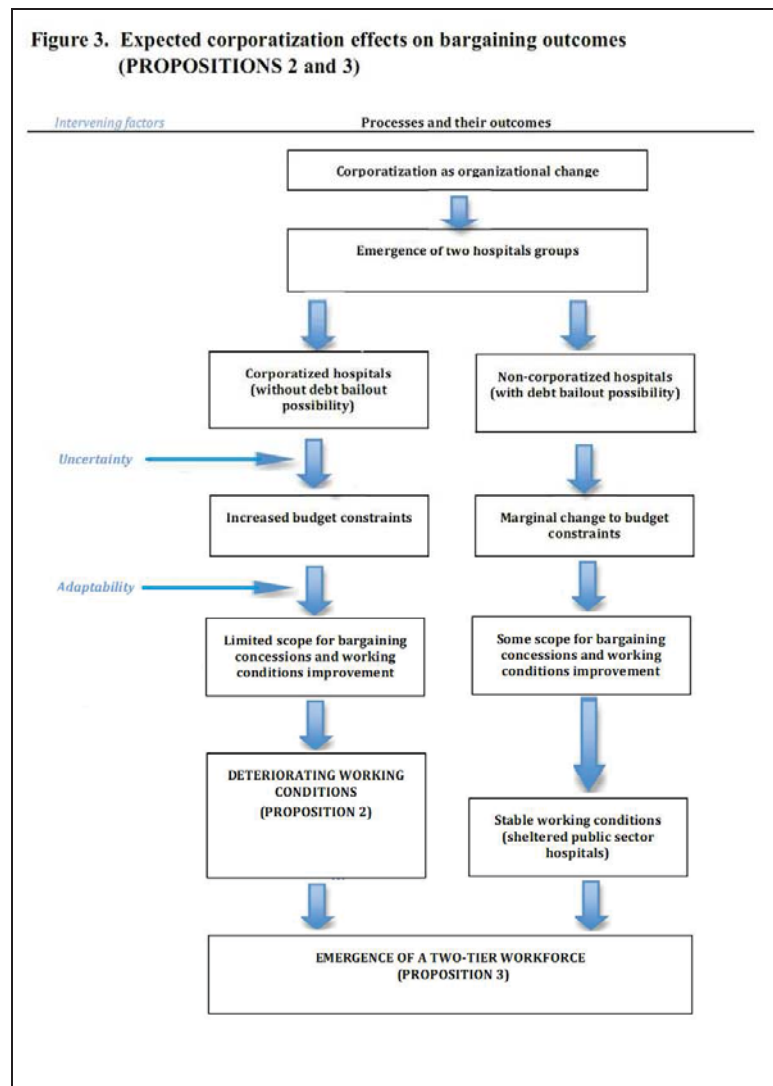


The mechanism through which corporatization affects bargaining patterns also considers intervening factors, e.g., pre-existing institutions and actors' power relations, which are possibly more enduring than the corporatization process itself. An important intervening factor is the pre-corporatization bargaining structure. In Hungary, bargaining has been decentralized prior to corporatization; in such conditions we expect proposition 1 to hold if evidence shows that employer independence has further grown through corporatization (e.g., cutting formal and informal ties to other bargaining benchmarks).

Bargaining outcomes should be subject to similar effects (see Figure 3): the presented literature suggest that corporatized hospitals face budget constraints and new uncertainties; and therefore have to recombine their organizational resources to adapt to the post-corporatization situation. Adaptation occurs through less bargaining concessions and reluctance to improve working conditions. Seeking a new accountability, hospitals should no longer follow regulations and collective agreements applicable before corporatization. Related to this is the change in agreements' contents in a bid to dismantle collective regulation of employment conditions. After successfully degrading or dismantling collective bargaining, management is likely to take advantage of newly earned discretion and introduce dispersed wages and greater employment flexibility (Schulten, Brandt and Hermann 2008), which supports the proposition that **working conditions deteriorate** (PROPOSITION 2). The intervening effect here is the pre-corporatization situation, namely, whether healthcare employees were covered by encompassing public sector bargaining or had their own bargaining institutions beforehand. In both countries,

healthcare has been part of public sector, therefore, we expect that an exclusion from public sector in the course of healthcare reforms fuelled the proposed deterioration in working conditions.

As Figure 3 shows, the reasoning behind proposition 2 can be extended to cover a further consequence of corporatization, namely the emergence of a **two-tier workforce** (PROPOSITION 3): insiders employed under relatively stable public employment terms, and outsiders losing public employment status upon corporatization (Schulten Brandt and Hermann 2008, Grimshaw et al. 2007).



Whether trade unions can counterbalance these processes depends on their strategic choices. Unions face a dilemma between reverting to coordinated bargaining, or utilizing the new conditions without a reversal attempt. The former is more political because requiring trade unions to target central-level decision makers to rewrite legislation and retake public control over hospitals. The latter requires more action at the local or workplace level. This distinction between state- and workplace-centred union strategies does not necessarily entail contradictions, as trade unions may pursue

both strategies simultaneously or in sequence depending on the context (c.f. Hattam 1992, Schulten et al. 2008). However, because of limited resources, they eventually face a dilemma where to focus their activities.

Similarly to proposition 1, we consider intervening factors – pre-existing institutions and actors’ interests and power relations – for propositions 2 and 3. To simplify, we adopt two assumptions: the only serious cleavage within the workforce is between employees in corporatized and non-corporatized hospitals; and employees in non-corporatized hospitals work under more stable and possibly better working conditions than their fellows in corporatized hospitals (see Figure 3).⁷

In sum, we expect corporatization to produce bargaining decentralization, deteriorating working conditions and a two-tier workforce in the hospital subsector. This trend can be reverted through successful trade union strategies at the central and workplace levels. The mechanism addressing how corporatization impacts on bargaining patterns and outcomes, leading to the above propositions, also considers the intervening effect of pre-existing bargaining institutions and interests and power relations between involved actors. We now turn to investigate these propositions in Hungary and Slovakia.

4. Departing the public sector: corporatization and its effects

In order to understand healthcare reforms in each country, we first briefly review the basic features of public healthcare provision in Hungary and Slovakia. In the Hungarian hospital system local governments own and operate most hospitals,⁸ while their financing remains centrally administered. Due to an enormous variation in local governments’ financial capacities, there is a large variation in healthcare workers’ working conditions. The Slovak hospital structure comprises a few larger university hospitals and a group of smaller public hospitals operated by local governments. Similar to Hungary, hospital financing is centrally administered. Cleavages exist between non-corporatized university hospitals and smaller public hospitals corporatized in mid 2000s due to better access to finances and more attractive working conditions in the former.

In Hungary, hospital reorganization has a long history and aligns with the “distortedly decentralized” healthcare system. Corporatization is a local-level process as local governments enjoy broad autonomy. However, the influence of central-level policies is extensive mostly through the framework for restructuring public sector institutions.⁹

⁷ Despite our simplifying assumptions, we acknowledge crosscutting cleavages as a basic tenet of political economy (Hall 1997). Corporatization, through increasing variation in employers’ interests creates cleavages between hospitals in better and worse performing regions or between university and municipality hospitals. The assumption on the working conditions’ gap between corporatized and non-corporatized hospitals is more empirical in nature; however, in an era of austerity, public sector is also under pressure (ETUC 2010). Therefore, the stylized distance between employment conditions in corporatized and non-corporatized hospitals might not be as substantial as the literature suggests.

⁸ Exception are university hospitals and state-run specialist institutions.

⁹ Centrally set rules for corporatization include the list of available legal forms, rules for hospital financing, and outcome (service) requirements. Moreover, government controls hospital resources and exerts influence over local hospitals also through the administration of the single, state-run, health insurance system (Hungarian State Audit Office 2009: 20).

The restructuring of core hospital services into business-like operations started in late 1990s as local level initiatives, partly with the aim to involve private capital in hospital operation (Hungarian State Audit Office 2009). Corporatization accelerated in the mid-2000s with radical governmental measures fostering commitment towards greater competition amongst hospitals. The idea of private capital involvement has again been promoted; and the role of private providers indeed strengthened significantly. Two providers (HospInvest and MediSyst) became major regional players integrating several hospitals. However, this trend has again been soon reverted when national-level reforms were frozen and private providers again almost completely disappeared from the local scene. Both HospInvest and MediSyst withdrew from the sector and returned hospital control to municipality-owned companies (National Institute for Strategic Health Research 2010: 80). In 2008, comprehensive structural reforms stopped but austerity continued. In result, corporatization also continued: local governments and hospital management chose new organizational forms and broadened their financial autonomy through flexible accounting, efficient debt management and a flexible employment relations system. The main healthcare union (EDDSZ) played a highly decisive role in shaping healthcare reforms because successfully fighting against hospital privatization but failing to prevent corporatization. EDDSZ was critical of both processes, but corporatization is a much wider and politically less conspicuous process, therefore harder to attack upfront. Until 2010, 30.9 percent of public sector hospitals voluntarily switched from their public institution status to a more independent legal status. (National Institute for Strategic Health Research 2009:81) Nevertheless, corporatization might come to a halt as a result of the current conservative government's measures. In a comprehensive move towards re-centralization, the government took control of all municipal hospitals from 2012. The fate of corporatized hospitals remains unclear, as the current Ministry of Healthcare prefers a return towards the regular budgetary institution form.¹⁰

In Slovakia, major healthcare reforms started after 2001, involving healthcare decentralization and hospital corporatization. Privatization has been a less attractive option due to the rigid financing structure through health insurance companies. Corporatization aimed at ensuring transparency in hospital financing and management under strong fiscal criteria, while granting corporatized hospitals freedom in profit creation. Corporatized hospitals were expected to compete for patients and profits. This transformation has been centrally designed and coordinated. First, the state founded the shareholder company *Veritel'* to bail out hospital debt. Second, the hospital structure underwent decentralization: between 2003 and 2006, control over 59 small and medium-sized public hospitals moved from the central government to local governments (i.e., cities, municipalities and regional administrative units). These hospitals underwent corporatization in mid-2000s, while large university hospitals and specialized medical institutes remained under direct state control without corporatization.

This first wave of corporatization fuelled a cleavage between corporatized and non-corporatized hospitals due to their different access to public finance. Non-

¹⁰ Source: Interview with Miklos Szocska, 13 October 2011, in: http://www.medicalonline.hu/cikk/szocska_megszunik_a_jatek_a_betukkel_es_a_szamokkal [Last accessed: 26/01/2012]

corporatized university hospitals continued to enjoy access to state aid in case of debts and received higher payments for their services, while corporatized hospitals were pushed to market-like behaviour under lower reimbursements of the same kind of healthcare services.¹¹ In consequence, local governments operating corporatized hospitals strictly opposed further corporatization because of their unfavourable position: while pushed to behave like private-sector corporations, their efforts remained unrecognized by health insurance companies, leaving corporatized hospitals with limited budgets.

Further reforms, including full marketization of public healthcare, failed due to immense political pressures. Strong public opposition caused that corporatization stopped in 2006 after electing a new social-democratic government. Non-corporatized hospitals again accumulated large debts and enjoyed a hidden preferential treatment by the state, better access to public finance, and lacking a market-oriented management approach that would prevent debt creation. From 2008, the hidden preferential treatment has been formalized after the government approved a preferential network of 34 non-corporatized healthcare providers, resulting in further discrimination of corporatized hospitals, deterioration in their services and strengthening of a two-tier public healthcare system.

The surprising change in the government to a right-wing coalition in 2010 again resuscitated earlier reform attempts. Preferential treatment of non-corporatized hospitals has been abolished; and the remaining university hospitals should have been corporatized in 2011.¹² However, corporatization again faced fierce public opposition and has finally been put on hold due to strong pressures by the doctor's trade union (Lekárske odborové združenie, LOZ). Coordinated trade union action has pushed the government against the wall, because a high number of doctors in university hospitals declared to quit their job if doctors' demands are not met. Stopping corporatization has been one of LOZ's demands. To avoid a critical shortage of hospital doctors, the government accepted union demands and the parliament endorsed the non-corporatization of university hospitals.

To sum up, corporatization involved distinct features in each country, deriving from the political situation, hospital structure, and coherence and coordination of healthcare reforms. In Slovakia, corporatization took the form of centrally administered hospital reorganization in two clear phases, fuelling a cleavage between university hospitals and smaller public hospitals operated by local governments. In Hungary, government policies supported corporatization, but did not intervene into actions taken by local

¹¹ The major reason why this discrepancy has been intensifying after corporatization is the rigid structure of healthcare financing, which lacked alignment with reforms stimulating market-oriented behaviour.

¹² The state was eager to corporatize the remaining hospitals in order to cut the direct ties between the state budget and hospital debts and stimulate efficiency in hospital organization. By 2010, university hospitals again accumulated a debt of almost 150 millions EUR. The main argument of actors opposing corporatization is the fact that indebted hospitals need to finance the corporatization process from their own funds (e.g., administrative change in asset management, change in the accounting system, fees for expert evaluations of assets, etc.), which leads to a further accumulation of debt instead of a more efficient market behaviour. Instead of more efficiency, corporatization may yield deepening of financial difficulties, rapid deterioration of healthcare services, potential bankruptcy and finally the necessity of privatization. Source: SME (2010) <http://ekonomika.sme.sk/c/5655308/na-akciove-spolocnosti-najskor-premenia-problemove-nemocnice.html> [accessed on 24 August 2011].

governments and municipalities as hospital owners. No clear cleavage emerged between different hospital groups.

At the same time, we found several relevant cross-country similarities in corporatization with potentially great impact on bargaining patterns and outcomes. First, hospitals with most severe financial difficulties or those chosen for privatization were corporatized first, while university hospitals were spared from corporatization in both countries. Second, employees in corporatized hospitals lost their public employee status;¹³ and public-sector rules and collective agreements formally no longer apply to their employment relationship. This crucial legal change may fuel the emergence of a two-tier workforce. Third, we note an important similarity in the character of involved actors, as well as a lack of real change in actors in both cases. First, not only the state but also other (possibly less powerful) actors were able to shape corporatization. Third, no new actors entered hospital management in Slovakia, while in Hungary they soon left the pitch after they met fierce resistance from virtually all sides. Therefore, we argue that public management reform in general and hospital corporatization in particular does not necessarily happen through change agents. In both Hungary and Slovakia established actors in public healthcare¹⁴ themselves actively influenced the reform process either by initiating reforms to broaden their manoeuvring space, or blocking reforms in order to maintain their privileged position. In turn, the continuity of actors influenced corporatization's effect on changes in the governance of employment conditions.

Impact of corporatization on bargaining patterns

Despite the relevance of corporatization and turbulences in its implementation, it did not substantially alter dominant bargaining patterns in Hungary and Slovakia. In Hungary, interest representation in the hospital sector is subject to interplay of national and local developments. At the national level, corporatization caused that “semi-formal” bargaining between public sector unions and the government no longer applies to employees in corporatized hospitals. Although formally separated, corporatized hospitals still consider public sector wage developments as benchmark. At the local level, corporatization strengthened the already established decentralized bargaining system: hospital employees are no longer public servants and their employment terms follow the Labour Code, which offers more autonomy to local-level bargaining¹⁵. However, actors did not really use this opportunity to “open up” local-level bargaining. The continuity in bargaining patterns through interplay at the central and the local level not only survived corporatization itself, but also the attempts of the main healthcare trade union EDDSZ to establish sector-wide bargaining. This effort failed due to employer resistance, and organizational and institutional weakness on the union side. Employers argue that sector-level agreements would decrease their capacity to flexibly use scarce resources.¹⁶

¹³ The loss of public employee status directly resulted from corporatization in Hungary. In Slovakia, all hospital employees, including those in non-corporatized hospitals, lost their public employee status during healthcare reforms.

¹⁴ Owners including the state, hospital management and trade unions.

¹⁵ Employees have more to bargain for because centrally guaranteed wage levels in the public sector no longer apply to corporatized hospitals.

¹⁶ Interview with Lajos Ari, president, Association of Managers in Healthcare, 7 June 2010.

Moreover, the absence of a potent sectoral employer association is a major institutional barrier. Stability in bargaining patterns after corporatization is manifested in the continuity of interest groups at local and national levels. EDDSZ lacks organizational and institutional capacities to overcome this established bargaining system without employers' and the government's cooperation.

Corporatization did not yield major changes in bargaining patterns in Slovakia either, because the coordinated sector-level bargaining system has not been defeated. In fact, corporatization as part of broader reform attempts strengthened sector-level bargaining. Two particular developments account for persistence in bargaining coordination. First, resulting from a central policy aiming at shifting responsibility for healthcare's agenda from the broader public sector onto particular sector-level social partners, healthcare was excluded from public sector bargaining structures and healthcare employees lost their public servant status after 2005.¹⁷ Second, sector-level bargaining in healthcare emerged because of organizational and bargaining capacities of involved actors, namely, the interest of sector-level unions and employers' associations in maintaining bargaining coordination next to single-employer bargaining. Corporatization increased tensions between non-corporatized university hospitals and smaller corporatized public hospitals within the single employers' association, and later caused a split in two organizations. the Association of Faculty Hospitals (AFN SR) representing university hospitals is more open towards bargaining concessions because non-corporatized hospitals face less budget constraints (e.g., partially covering costs for lifelong learning, more discipline in pay for overtime work, more wage increases). The Association of Hospitals of Slovakia (ANS), representing corporatized hospitals, also continued its engagement in coordinated bargaining despite stricter budget constraints and diversity in members' interests. Social partners' interests and commitment to coordinated bargaining therefore account for the development of independent two-tier bargaining in public healthcare from 2006. While substantive bargaining happens predominantly at the hospital level, sector-level bargaining plays a prominent role because coordinating the diversity of hospital-level agreements. Third, there are external pressures onto bargaining patterns, originating from frequent changes to the Labour Code, the government's reluctance to improve the financing of public healthcare, and attempts to legally limit trade union codetermination rights. Because of a strong interest representation structure in healthcare, unions and professional associations regularly voice their dissatisfaction with such trends.¹⁸ In sum, corporatization increased pressures for bargaining decentralization and at the same time created preconditions for strengthening sector-level bargaining. These opposite forces crystallized in the hands of involved actors: as social partners showed their commitment to bargaining coordination, sector-level bargaining has not been defeated but strengthened.

¹⁷ Unions maintain that healthcare has been excluded from public sector remuneration because of interest competition between healthcare and education. Limited public resources were channeled to boost education, while healthcare was left to bargain independently. Source: interview SOZZaSS deputy director, 14 April and 11 May 2010.

¹⁸ LOZ responded to the second wave of corporatization via coordinated job leave threats of several thousands of doctors in university hospitals. With support of trade unions and professional associations, the association of nurses and midwives organized a petition for better working conditions of nurses, leading to legislation on higher wages for nurses.

Coordinated bargaining in Slovak healthcare shows remarkable stability despite recurring tensions between unions and employers associations on wage increases. Although several bargaining rounds produced mediator-stipulated decisions instead of regular collective agreements (mainly between unions and ANS given corporatized hospitals' financial constraints), all involved actors respect the established bargaining structure and contribute to its persistence. Changes to bargaining patterns are unlikely from within the sector, although the main trade union SOZZaSS does strive to revert to public sector bargaining coverage in wages. Public sector wage scales continue to remain an important informal benchmark for healthcare bargaining; however, a formal reversal to the pre-2005 situation is unlikely. Sector-level bargaining is the strongest centralizing element, which bring stability into healthcare's two-tier bargaining structure.

When comparing bargaining patterns in Hungary and Slovakia, we argue that instead of straightforward decentralization (PROPOSITION 1), corporatization strengthened both countries' bargaining patterns and therefore did not yield major changes to established patterns. This effect of corporatization has been channelled through interests, capacities and abilities of actors. In Hungary, further decentralization to the already decentralized system did not happen. Next, employers' reluctance to organize and coordinate bargaining at the sector level, coupled with the dominant trade union's inability to impose coordinated bargaining onto employers, accounts for persistence of established bargaining patterns in the post-corporatization period. In Slovakia, organized employers' interests, and commitment of sector-level employers' associations and trade unions to coordinated bargaining despite decentralization pressures account for persisting sector-level bargaining coordination even after corporatization.

Developments in bargaining coverage and enforcement of collective agreements align with presented trends in bargaining patterns. In line with coordinated bargaining in Slovakia, corporatization did not produce a declining bargaining coverage. Coverage is 100% among employers' organization members (both corporatized and non-corporatized) and about 95% in public healthcare. In contrast, in the decentralized Hungarian bargaining, coverage rates between corporatized and non-corporatized hospitals differ: 95,4% employees in non-corporatized hospitals were covered in 2008, but coverage reached only 45% among corporatized and privatized hospitals in the same year. Interestingly, the 2011 data indicate a substantial increase in coverage rates in the corporatized sector.¹⁹ This might support claims that after an intermediate period, even corporatized hospitals reverted to collective bargaining.

Bargaining enforcement lacks institutional mechanisms in both countries. Enforcement derives from the actors' strength to enforce bargaining and compliance with collective agreements. Nevertheless, in both countries there are cases when

¹⁹ Source: Kisgyörgy et al. 2008: 6-9, in http://www.szmm.gov.hu/mkir/doksik/ksz/elemzes/egeszsseguy_ksz_elemzes.pdf. and Information System on Hungarian Labor Relations <http://www.szmm.gov.hu/mkir/lciinternet.php> Last accessed: 25/01/2012.

serious conflicts postponed the conclusion of an agreement, or its conclusion has been stipulated by an appointed mediator.²⁰

Bargaining outcomes

To recall, our understanding of bargaining outcomes refers to the kind of concluded agreements and their particular provisions, relevance for governing employment relations, and hospital employment conditions per se. In Hungary, relevant collective agreements are concluded at the hospital level. In Slovakia, collective agreements are signed at the sector and hospital levels. Slovak healthcare unions conclude sector-level agreements individually with ANS representing corporatized hospitals and AFN SR representing non-corporatized hospitals.

There is no comprehensive assessment of how corporatization, including actors' responses thereto, affected bargaining outcomes at the sector and hospital levels. However, our analysis yields that unlike inertia in bargaining patterns, corporatization produced divergence in bargaining outcomes. While in Slovakia this divergence clearly links to differing interests of corporatized and non-corporatized hospital groups, we did not find such a clear cleavage pattern in Hungary. Instead, some Hungarian hospital managements used corporatization as an opportunity to completely eliminate collective bargaining, while others opted for improvements in bargaining outcomes. Even in such a divergence in outcomes, public sector provisions and the public servant status continue to serve as the most important benchmark in both countries.²¹ Even in substantive outcomes with greatest divergences – most commonly wage stipulations - public sector wage scales are a relevant reference point for sectoral (Slovakia) and establishment-level (Hungary) collective agreements.

Taking a closer look at healthcare's collective wage stipulations, we argue that wages were more exposed to corporatization effects than other stipulations, because of different financing and management rules for corporatized and non-corporatized hospitals. Detailed public sector pay scales apply to non-corporatized sector hospitals only in Hungary. Corporatized Hungarian hospitals, as well as all Slovak hospitals (corporatized and non-corporatized) do not face legal constraints on wage setting. Furthermore, laws in public sector employment relations allow hospital-level collective agreements to depart from the public service pay scale in the positive direction; and non-corporatized hospitals in Slovakia can still benefit from state bailout in case of accumulated debts. These conditions, coupled with our propositions based on earlier evidence from Western Europe, suggest wage dispersion between corporatized and non-corporatized hospitals as an important element in the emergence of a two-tier workforce (PROPOSITION 3). However, our findings substantiate these expected effects only in Slovakia, but not in Hungary.

²⁰ In Slovakia, despite regular bargaining social partners in corporatized healthcare found the conclusion of collective agreements increasingly difficult. All recent bargaining rounds terminated in the hands of an appointed mediator. Nevertheless, during dispute settlement procedures, hospitals followed the previous collective agreement and did not attempt to scrap coordinated bargaining, which documents their commitment to bargaining coordination and sector-level agreements.

²¹ Source: interview EDDSZ head of the local branch in Veszprém (Hungary), 17 March 2011; interview SOZZaSS vice president (Slovakia), May 2010.

In Hungary, public sector wages have been constantly losing value; and centrally set wage supplements were withdrawn. With public sector wage scales serving as a benchmark, it is a commonly held belief amongst managers and workers that corporatized hospitals cannot possibly offer less than the severely depressed public sector wages. The main worry of EDDSZ regarding corporatization was that “outsourced” workers will not be eligible for the 13th month salary. (Tóth, Edelényi and Neumann 2009). Corporatized hospitals indeed did not receive funds needed to cover this benefit, but during 2009-2010, the 13th month salary was scrapped in non-corporatized hospitals, too. Some newly corporatized hospitals could introduce a perk system, taking advantage of more lax income tax regulations in the corporate sphere. In sum, corporatization did not produce pay deterioration and a growing gap between public servants working in non-corporatized hospitals and employees in corporatized hospitals whose wages are set according to market forces.

The situation has been different in Slovakia, where corporatization did contribute to an emergence of a two-tier workforce. After corporatization it became increasingly difficult to conclude wage agreements in corporatized hospitals. Bargaining outcomes between unions and ANS have in the past years been reached through a dispute settlement institution instead of a direct deal between social partners. Because of strict budget limitations, employers regularly turned down union proposals to wage increases despite labour shortages, deteriorating working conditions and migration of personnel to better paying hospitals (c.f. Kaminska and Kahancova 2011). In result, collective wage increases in non-corporatized hospitals amounted to some 10% between 2006 and 2008 and 5% after 2009, while in corporatized hospitals increases were only modest (about 7% in 2009 and 2010). In the 2011 bargaining round, ANS even proposed a wage decrease given the critical financial situation of corporatized hospitals. In sum, the growing gap in bargaining outcomes between corporatized and non-corporatized hospitals in Slovakia yielded major consequences on working conditions and contributed to the emergence of a two-tier workforce.

Other than on wages, corporatization had a limited effect on substantive bargaining outcomes. Working time regulation has been less exposed to corporatization effects than wage regulation. Constant problems with strict overtime regulation in the face of labour shortages and budgetary constraints are equally relevant in non-corporatized and corporatized hospitals in Hungary and Slovakia. Next, only 30.9% of employees in corporatized/privatized hospitals in Hungary are covered by collective agreements stipulating non-wage benefits, as opposed to 52.1% in non-corporatized hospitals.²² The value of non-wage benefits is constantly deteriorating in non-corporatized hospitals. This evidence supports our earlier argument that corporatization did neither contribute to a growing gap in bargaining outcomes between corporatized and non-corporatized hospitals nor to a two-tier workforce in the Hungarian hospital sector. In Slovakia, some broadening in the scope of bargaining outcomes is obvious after 2009. Novel provisions include equal access to training, learning, employment; creating conditions for work-life balance; supporting lifelong learning; and pay increases related to performance-related pay next to flat increases in base wages. Nevertheless,

²² Source: Information System on Hungarian Labor Relations. <http://www.szmm.gov.hu/mkir/lcinternet.php> [accessed: 02/02/2011]

novel provisions are more common in the non-corporatized subsector, while bargaining outcomes in corporatized hospitals continue to be limited to “basic” provisions, i.e., wages, working time, pension contributions, dismissal regulation and social fund maintenance. This finding supports our earlier argument that unlike in Hungary, corporatization did deepen the gap between corporatized and non-corporatized hospitals in bargaining outcomes and contributed to an emergence of a two-tier workforce.

In other employment conditions (e.g., employment stability and alternative employment), healthcare reforms in general and corporatization in particular did not yield major changes. Instead, these conditions are shaped by long-term labour shortages in both countries (c.f. Kaminska and Kahancova 2011). Shortages account for the fact that corporatized hospitals do not employ more part-time workers or agency workers than non-corporatized hospitals despite the legal possibilities to do so. Part-time employment in healthcare is marginal and agency-work is virtually non-existent.

To sum up, we argue that employers did not respond to corporatization according to the mechanism proposed in Figure 1. Employers have not chosen to face uncertainty and adapt to post-corporatization situation via utilizing the possibilities offered by more relaxed statutory regulations and escaping earlier ties to bargaining coordination or national-level benchmarks. Their behaviour, interacting with union choices and other intervening variables, then did not produce bargaining decentralization as expected (PROPOSITION 1). Instead, in both countries we found inertia in bargaining patterns, with public sector bargaining developments serving as benchmark also after corporatization. Although trade unions attempted to revert post-corporatization bargaining trends (especially in Hungary), as proposed in Figure 2, their efforts failed due to organizational and institutional factors on the side of employers and unions alike. Therefore, commitment to established bargaining patterns proved to be a rational solution of both employers and unions responding to post-corporatization uncertainty through adaptation and seeking for new accountability.

The most important formal consequence of healthcare reforms in both countries for employment conditions is the loss of healthcare workers’ public servant status. This shift created preconditions for deteriorating working conditions in corporatized hospitals (Figure 3, PROPOSITION 2). However, we found relatively little post-corporatization wage dispersion in Hungary, because austerity squeezed non-corporatized and corporatized hospitals equally and produced deterioration in working conditions in non-corporatized hospitals, too.²³ In Slovakia, wage dispersion clearly resembles a cleavage of interests between corporatized and non-corporatized hospitals. Non-corporatized hospitals in Slovakia could offer more bargaining concessions and better working conditions than the struggling corporatized hospitals. In light of these developments, we argue that corporatization widened the gap in working conditions between non-corporatized and corporatized hospitals; and fuelled an emergence of a two-tier workforce in Slovakia (Figure 3, PROPOSITION 3). In

²³ According to Erzsébet Berki, a Hungarian industrial relations expert, employment stability in public services is merely a myth. Interview 30 March 2011.

Hungary, we did not find evidence for the emergence of a two-tier workforce, but an overall deterioration in working conditions and wages in the entire healthcare sector.

5. Conclusions: how does corporatization matter for governance of employment conditions?

In this paper we argue that effects of healthcare reforms, exemplified through hospital corporatization, on the governance of employment relations are more complex than the available literature suggests. We explored this complexity, namely, particular mechanisms through which corporatization contributed to stability in bargaining patterns, while diversity in particular bargaining outcomes in Hungary and Slovakia has grown. Furthermore, we argued that particular effects of corporatization have been channelled through the interests and responses of involved actors. The main message of our case studies is that despite market-oriented reform of the institutional environment in the public sector, actors in the healthcare/hospital sector did not automatically start behaving individually in line with private sectors rules. Although we observed variation between the two countries in the effects of corporatization on employment relations, we also discovered remarkable similarities, especially in how actors reacted to hospital reorganization; and in the stability of bargaining institutions due to actors' commitment or inability to bring forth institutional change in bargaining patterns.

In Hungary, corporatization was part of the process in which employers broke the low-level equilibrium between employment security and low wages in the public sector. Deterioration in hospital working conditions can be ascribed to employer interests to bring down hospital costs and to governmental austerity policy. The main healthcare union pursued a state-centred strategy and forged political alliances to prevent full-scale privatization, but lacked a nation-wide strategy to face the challenge of corporatization as a semi-public solution to healthcare problems (c.f. Frege and Kelly 2003, Avdagic 2005). In contrast, trade union interests and capacities in Slovakia played a significant role in maintaining coordinated bargaining, but failed to prevent the emergence of a two-tier workforce directly growing out of interest cleavages after corporatization.

In contrast to our proposition that employers will seek adaptability to new conditions by utilizing them through escaping constraining practices like collective bargaining, we found that employers adapted to post-reform conditions through avoiding uncertainty deriving from the new situation. This kind of employer behaviour invokes at least informal commitment to benchmarks from pre-reform period, such as bargaining practices, wage levels and public sector collective agreements' provisions.

Although the main focus of this paper is on the effects of corporatization on the governance of employment issues, our final point of discussion concerns the stability, viability and future prospects of corporatization itself. Throughout our analysis we treated corporatization as an intermediary solution between the public and the private sector, as a compromise between public ownership and private-style management.

That is why we chose the literature on recombinant property as a main point of reference and that is why we focused on the question of whether and how industrial relations in corporatized hospitals became distinct from the state sector. However, the intermediary nature of corporatization brings up further issues about the viability of the whole process. We think that the long-term survival of corporatization depends on the balance of power between pro-state and pro-market actors and on state capacity to go on with the process despite pressures from both sides.

We argue that both pro- and anti-market forces find corporatization as a suboptimal situation and try to turn it into privatization or reverse it. Market actors push for a complete privatization of hospitals, while healthcare unions see corporatization as a first step in healthcare deterioration and will do everything to reinstall direct government control. To take the experience of recombinant property, it did not become a dominant form of ownership in any East European country, as private capital eventually came to see it as a burden instead of an opportunity. It was only a stage in the post-socialist transition process even in Hungary, where Stark (1996) discovered this phenomenon.

In the domain of hospital corporatization both the Hungarian and the Slovak example demonstrates that without strong actors corporatization does not slide into privatization. In fact, the strong opposition that comes from healthcare unions can lead to the halt or even the reversal of the process. The success of Slovak doctors in forcing the government to spare university hospitals from corporatization is a case in point. Recent corporatization attempts were blocked after severe protests and discontent of hospital owners but mainly the LOZ trade union. A change in the political environment can also undermine the survival chances of corporatization. Current developments in Hungary point to this direction. The conservative government in office since 2010 already took over ownership rights from local governments and considers a full return to the state-managed system.

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