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# NEW CHALLENGES FOR PUBLIC SERVICES SOCIAL DIALOGUE: INTEGRATING SERVICE USERS AND WORKFORCE INVOLVEMENT IN SLOVAKIA

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# Introduction

Slovakia underwent important economic, political and societal changes after the regime change in 1989. Facing the challenges of democratization and marketization, all sectors of the economy, including the public sector, underwent important structural changes during the transition period in the 1990s. The period of 2000s brought rapid economic growth, but also intensified reform efforts along the principles of new public management (NPM). NPM reforms aim at "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). Besides decentralization, privatization and the transfer of private-sector management principles into the public sector, strengthening citizen participation in the governance of public sector institutions is a fundamental aspect of NPM (Kjaer 2004).

Within the context of the above developments, the aim of this report is to analyse the formation and practice of citizen participation in shaping the quality of public services in Slovakia. Besides focusing on the quality of public service provision, particular attention is paid to the interaction between service user participation and workforce involvement through institutionalized forms of social dialogue in the public services sector.

The report focuses on public education and healthcare to illustrate cases of user involvement at the sectoral and organizational levels. Within education, the analysis covers secondary education, which equals level 3 in the International Standard Classification of Education (ISCED). Within public healthcare, we focus on hospitals, which comprise a key share of public healthcare provision and at the same time underwent important reforms in line with NPM principles since early 2000s.

# Data and methods

Evidence for this project is based on a variety of written materials, including legal documents, studies and reports, annual reports and internal evaluations of relevant organizations, minutes from governmental meetings, press releases and media coverage on recent developments in healthcare and education. This evidence is further substantiated by 25 semi-structured interviews with representatives of users (patients' organizations and various councils/boards in the education sector), trade unions, employer associations, government representatives and independent experts (see Annex). All interviews were conducted in person by the authors during 2014. The interviews differentiate between stakeholders at the national/sector level and the establishment level of our case study school and hospital. All interviews were conducted in person, recorded and transcribed upon consent of the respondent. If the respondent did not agree with recording the interview, notes taken by the authors during the interview provide for evidence.

The framework and methods for analysis derive from the framework set out in the international comparative project, of which this national report is part. A qualitative

comparative method and text analysis has been used to form conclusions from the conducted interviews. The authors raised the same sets of questions to stakeholders representing different interests, thereby controlling for a balance of various experiences and the validity of collected evidence. The interviews seeked to gather evidence on actors' views on and experiences with user involvement, their specific experience in user involvement pressures, as well as experiences and views on the interaction between user involvement pressures and social dialogue in shaping the quality of public service provision. Evidence has been compared vertically between the sector and establishment levels in healthcare and education, respective, as well as horizontally across both sectors.

# 1. Emergence of service user involvement: historic legacies and policy context

During state socialism prior to 1989, citizen participation and employee representation was strongly institutionalized across the economy through trade union membership. Moreover, the education sector has formally developed user involvement through various councils at the level of the sector, regions, and individual schools. The council of parents and friends of school (*Združenie rodičov a priateľov školy, ZRPŠ*) serves an example of established institution of user involvement across the country's schools, which channeled information from teachers to parents. Healthcare sector lacked similar institutions, as the regime avoided user involvement in its support of an asymmetric power relationship between state-operated healthcare providers and patients.

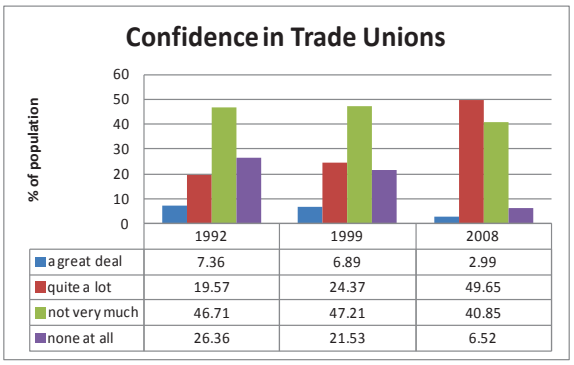
Despite formal structures in some sectors, including education, participation in the socialist times lacked political independence and served to legitimize political decisions of the ruling party rather than representing an independent voice of citizens. In result, as Slovakia embarked on building democracy after 1989, citizen participation as understood in democratic societies had to overcome its negative socialist legitimacy and start developing its functions almost from scratch. Trade unions as representatives of the interests of the working class faced a similar challenge. In order to establish themselves in the newly forming market economy, unions needed to dispose of their socialist legacy and develop new strategies of interest representation.

In the transition period in 1990s, the consequences of the previous regime yielded two important developments. First, as the new civil society was emerging, the term citizen participation penetrated the Slovak discourse and enjoyed increasing popularity among the new civil society organizations (c.f. Sičáková-Beblavá 2005). Second, as the public still associated participation with (often involuntary) practices of state socialism, membership and trust in existing civil society organizations, most notably trade unions, experienced significant decline. The development of participation, or user involvement, thus occurred on the one hand in conditions of great support and enthusiasms in building democracy, on the other hand in hostile conditions of individualization of the society and declining trust in community events and interest representation organizations. Figure 1 shows that the public's trust in trade unions has been gradually increasing from very low levels in early 1990s. The share of citizens not

trusting trade unions has also experienced a decline from 26.36% in 1992 to 6.52% in 2008.

During the transition and the reform periods of 1990s and 2000s, citizen participation and user involvement in the governance of public issues has been strengthening. The main motivators behind this trends are, first, a legislative underpinning of user involvement, and, second, the growing perception and confidence in the society to voice citizens' claims in shaping public services.

**Figure 1: Confidence in trade unions, Slovakia**




Source: Fabo et al. (2014) based on the European Values Study

### 1.1 Definition of citizen participation and user involvement

The concept of civic participation became the cornerstone for action of NGOs and civic initiatives, because it has transformed the perceived role of citizens from passive service recipients to actors with voice in shaping changes in public issues. Paulíniová (2005) defines civic participation in Slovakia as participation in public life, membership in organizations, participation in elections and in public events. More specifically, *participation is understood in relation to public decisions, or decisions with involvement of the public, with consequences for the public, and concerning public funds (ibid.)*. In this report, civic participation is limited to user involvement, which can be seen as a subgroup of civic participation. The above definition remains relevant because user involvement resembles the involvement of one group of the public (users of public services) in decisions that relate to the financing of public issues (transparency and efficiency), the services provided from public funds (character of services), and with consequences for the public (service quality).

For the purpose of this study we define end users of education as students and their parents (in case of underage students). Thus, when analyzing user involvement in education we aim to identify how students and their parents enter and influence social dialogue in the education sector. Similarly, by user involvement in healthcare we refer to patients and their engagement in shaping the quality of healthcare service provision through the adaptation of sectoral social dialogue at the sector level and in hospitals.

## 1.2 Legislative framework for citizen participation and user involvement

The right of citizen participation on the governance of public issues, either directly or indirectly through representatives, is recognized as one of fundamental rights in the Slovak Constitution (Article 30, section 1). Pirošík (2005) provides at least three interpretations of this article by the Slovak constitutional court:

- the governance of public issues shall be understood as the participation of the citizen on the political life of the state, state governance and governance of public issues at the levels of local government. (II. ÚS 9/00)
- participation in the governance of public issues shall not have a restrictive understanding (participation of citizens on the implementation of public power); instead, the Constitution guarantees citizens a right to engage in each for of public power (II. ÚS 31/97).
- Public issues relate to issues of public interest; and citizens have a right to participate in their governance via mechanisms established in the Constitution (I. ÚS 76/93).

Other provisions of the Slovak constitution are also relevant for user involvement in shaping public services. Sections 26 guarantees right to information, sections 27-29 guarantee the right to organize, and Section 2 stipulates that the state power comes from citizens, which participate either directly or indirectly through elected representatives (Pirošík 2005).

Next to the Constitution, several other legal Acts contain general stipulations on civic participation, which enable and offer a fundamental regulatory mechanism for user involvement in the public services. The Act No. 83/1990 Coll. on association of citizens, Act No. 84/1990 Coll. on right to association, and the Act No. 85/1990 Coll. on petition rights belong to such fundamental regulations. Other relevant legal acts include Act No. 152/1990 Coll. on complaints and Act No. 211/2000 Coll. on free access to information.

Evidence shows that service users have utilized their petition rights on various occasions in education and in healthcare. For example, in education, the year 2012 saw three petitions for the improvement of quality in the education system. The *Petition for Better Education*, organized by trade unions (New education trade unions - *Nové školské odbory, NŠO*), gained significant public support. The parents' *Initiative for good schools* with support of social partners, professional organizations and the public aimed at critical comments to legislative proposals on secondary education and financing of schools. Finally, a solidarity petition was organized by principals of vocational schools to support the legislative proposals of the Ministry of Education, Science, Research and Sports of the Slovak Republic (*Ministerstvo školstva, vedy, výskumu a športu Slovenskej republiky*)[1]. Petitions have also been often used in the healthcare sector, e.g., the 2011 petition for saving public healthcare and against corporatization of state hospitals, initiated by citizens with support of trade unions and patient organizations;[2] the 2011 petititon of nurses for wage increases;[3] or the 2014 petition against

[1] Source: SME in http://www.sme.sk/c/6407404/rodicia-sa-pre-caplovicove-zakony-obratili-aj-na-premiera.html and Hospodarske Noviny in http://hn.hnonline.sk/slovensko-119/rodicia-skolakov-tvrdia-ze-caplovic-nezvladol-svoje-zadanie-504238

[2] Source: http://www.slovenskypacient.sk/clanok/297/zdravie:-loz-privitalo-spustenie-peticie-proti-transformacii-nemocnic

[3] Source: Hospodarske Noviny, in http://hn.hnonline.sk/slovensko-119/zdravotne-sestry-bojuju-za-vyssie-platy-430063

wage decreases of nurses in the city hospital of Zlaté Moravce, organized by the Association of Nurses and Patients.[4]

Besides the general legal stipulations underpinning civic participation, other, sector-specific legal regulations set the scene for user involvement in the governance of public services. In the education sector, the most important legal acts include:

- Act No. 596/2003 Coll. on state administration in education and school self-government. This Act regulates the rights and responsibilities of governance of schools (see Sections 24, 25 and 26).
- Act No. 245/2008 Coll. on upbringing and education ("School Act", see Section 153 – School orders)
- Decree No. 291/2004 Coll. and Decree No. 230/2009 Coll. regulating the establishment, structure, organization and financing of of school self-government.

In healthcare, sector-specific regulations with impact on working conditions, quality of service provision and the structure user involvement closely relates to reform efforts in the 2000s. In this period, the right-wing-coalition reform government introduced a complex reform to the healthcare system, which was underpinned by the following legal acts:

- Act No. 313/2001 Coll. on public services (and its later amendments)
- Act No. 552/2003 Coll. on work in public interest
- Act. No. 553/2003 Coll. on remuneration of selected employees in public service and on amendment to several acts including Act No. 369/2004 Coll., Act No. 81/2005 Coll. and Act No. 131/2005 Coll. (all acts related to remuneration of public servants)
- Act No. 576/2004 Coll. on healthcare provision, services and healthcare service providers
- Act No. 577/2004 Coll. on the scope of healthcare provision funded from public health insurance and on payments for services related to healthcare provisions
- Act No. 578/2004 Coll. on healthcare providers, healthcare workers and professional organizations in healthcare
- Act No. 581/2004 Coll. on health insurance companies and healthcare surveillance

From the above, Acts No. 578/2004 Coll. and 581/2004 Coll. directly adopted stipulations on user involvement in shaping the quality of public healthcare. While Act No. 578/2004 Coll. defines the roles and structures of actors influencing the quality of services, Act No. 581/2004 Coll. stipulates the establishment of an independent Healthcare Surveillance Authority (*Úrad pre dohľad nad zdravotnou starostlivosťou, ÚDZS*, see below).

### 1.3 User involvement in healthcare: structure and milestones

In the healthcare sector, user involvement gained relevance only in the past 10 years. The main motivation for patient's involvement in shaping the healthcare quality is twofold. First, the state facilitated greater scope for user involvement in the course of implementation of healthcare reforms (c. f. HPI 2014). Second, motivation for user involvement evolved upon initiatives of various civil society organizations representing users, which can be related to the

[4] Source: http://www.peticie.com/protest_proti_zniovaniu_platov_sestier_v_zlatych_moravciach

overall growth of civil society in Slovakia after the 1989 regime change. More specifically, user organizations emerged hand-in-hand with the changing perception of the public to end the long-established power asymmetry between the doctor and the patient; and the recognition of the need to voice patients' claims and complaints and increase their awareness in order to receive better healthcare provision. The structure that has emerged during reforms comprises several user involvement channels at the sector and hospital levels.

The most important milestone in introducing user involvement upon government action was the establishment of the **Healthcare Surveillance Authority** *(Úrad pre dohľad nad zdravotnou starostlivosťou, ÚDZS)*, which started its operation in 2005.[5] The establishment of HCSA aimed at splitting the legislative and control functions in the healthcare system, which belonged to the Ministry of Health prior to 2004 (Szalay et al. 2011). ÚDZS shall serve as an independent authority with competences in supervision of health insurance companies' performance, and, more importantly, supervision over the quality of healthcare provision. In the latter, the ÚDZS acts on behalf of individual patients/clients who feel their rights were violated or think that the care they or their family members received was not adequate (ibid.). ÚDZS thus deals with direct initiatives and complaints of patients. With a final statement based on ÚDZS's investigation of the particular case, the citizen can engage in litigation. The ÚDZS also has power to impose sanctions on healthcare providers.

This form of user involvement in form of direct interaction between a sector-wide authority with individual users is not very common across other EU member states. While it resembles a strong and formally established institution with detailed regulation of its competences, at the same time the existence of user involvement through ÚDZS preempted the balanced development of other forms of user involvement in Slovak healthcare. At the sectoral level other formalized channels of user involvement, e.g. in form of sectoral fourpartism or healthcare councils remain underdeveloped.

A recent development in strengthening user involvement upon the motivation of the government relates to the government's initiative to adopt a strategic framework for health for the years 2014 – 2013 (*Strategický rámec starostlivosti o zdravie pre roky 2014 – 2030*). This document lays the foundations for further developments in the state health policy in the coming years. It aims at implementation of measures for improving quality, sustainability and efficiency of the healthcare system and the health status of population.[6] The state aims at maintaining public healthcare the basic pillar in care of citizens' health. Priorities in public healthcare include:

[5] For details on how user involvement is practiced through the ÚDZS, see section 3.1 of this report

[6] Source: Strategický rámec starostlivosti o zdravie pre roky 2014 – 2030. Ministry of Healthcare, Institute of Health Policy, available: http://www.health.gov.sk/Zdroje?/Sources/Sekcie/IZP/Strategic-framework-for-health-2014-2030.pdf

*"… develop a care system of the population's health at the national, regional and local levels, together with involvement of all relevant actors from the public and private spheres, including* ***active citizen involvement*** *within the proposed functional model."*[7]

The strategic framework targets improvement in measurable indicators of healthcare quality, including the planning of personnel resources in public healthcare. It is the only official document that directly stipulates user involvement and at the same time acknowledges attention to personnel resources. The focus on user involvement and the management of human resources offers a potential arena for interaction between user involvement and social dialogue in public healthcare.

Hospital corporatization, which belongs to key processes of NPM reforms, introduced formalized institutions of user involvement at the level of hospitals. Moreover, patient organizations were emerging and seeking ways to influence patients' rights, access to healthcare services, and the quality of services (ibid.).

Further references to user involvement are highlighted when setting out the monitoring and control mechanisms for implementing the goals outlined in the strategic framework. In particular, the Ministry of Healthcare shall establish a monitoring committee, comprising representatives of several ministries (including Labour, Finance and Education), patients' organizations, professional organizations of healthcare workers, non-governmental not for profit organizations, representatives of health insurance companies, healthcare providers, local administrative units and their associations, the Public Healthcare Authority (*Úrad verejného zdravotníctva SR*) and representatives of universities. This offers the most encompassing perspective on user involvement in shaping the quality of healthcare services in Slovakia. Based on the first meeting of the monitoring committee, the involved actors comprise employers' associations, regional administrative units, professional organizations and the Government's council for non-governmental not for profit organizations (Rada vlády SR pre mimovládne neziskové organizácie). The current structure of the committee lacks involvement of patient organizations. [8]

Finally, a potentially relevant platform for user involvement has been indirectly stipulated through healthcare reforms directly affecting the ownership and structure of hospitals. In mid 2000s, selected hospitals (except the largest state-operated hospitals and specialized care centers) underwent corporatization where the state bailed out hospital debt and handed over hospital ownership and management to lower-level administrative units (e.g., municipalities and regional administrative units) (Kahancová and Szabó 2014). Hospitals were transformed into public non-profit organizations, limited corporations or joint stock companies. Hospital governance councils (*správna rada*) and supervisory councils (*dozorná rada*) were introduced

[7] Source: ibid., page 21.
[8] Source: Minutes from the meeting of Monitoring Commission for surveillance over fulfillment of tasks of the Strategic framework for health for the years 2014-2030, dated 26.8.2014, available: http://www.health.gov.sk/Sources/Sekcie/IZP/Zapis-Monitorovacia%20komisia_26_08_2014%20.pdf

in hospitals with non-profit statute. Hospitals with a public joint stock company status witnessed the emergence of a board of directors and a supervisory council. In hospitals with a newly acquired public limited company status, a statutory representative acts next to the supervisory council. Nominations of members came from the Ministry of Healthcare, hospital managements, and other units participating in hospital ownership and/or management. While a limited extent of employee involvement has been observed in hospital governance councils, our interviews documented that user involvement has not been stipulated in these bodies.[9] Formal structures of user involvement in hospital governance are even less common in hospitals that did not face the corporatization process and remained in direct dependence of the Ministry of Healthcare. In these hospitals (mostly large faculty or university hospitals and specialized care centers), the Ministry directly nominates the hospital director and executes controls over hospital functioning. The penetration of professional managers into director positions has been documented especially in hospitals in private ownership, while in public hospitals medical professionals comprise almost 100% of director positions.[10]

An important turning point to institutionalized user involvement in hospital governance councils may emerge after a recent corruption scandal over intransparent purchase of medical equipment in the Hospital of Alexander Winther in the city of Piešťany. Despite the disapproval of employee representatives in the hospital‘s governance council, the council has approved a purchase of medical equipment exceeding its standard market price. After medialization of this case, the Minister of Healthcare Zuzana Zvolenská and all members of the hospital councils nominated by the state had to step down. The new Minister of Healthcare Viliam Čislák aims at reviewing the process of state nominations into hospital governance councils in non-profit hospitals. The minister admitted the possibility that instead of direct nominations of the Ministry, council members could be nominated by lower administrative units, municipalities, the civil society, and trade unions.[11] For the first time in the new history of the Slovak Republic, this initiative would introduce an encompassing formal structure of user involvement in hospitals through nation-wide regulation.

Table 2 summarizes the structure of user involvement in the Slovak healthcare system with focus on public inpatient care (hospitals).

**Table 2 Structure of user involvement: healthcare/hospitals**

| **HEALTHCARE** | | |
|---|---|---|
| **Level and character of user involvement** | **Organization name** | **User involvement individual vs. collective** |
| ***Sector level – advisory*** | | |
| Political/governmental/professional | Healthcare surveillance authority | individual |
| Political/governmental/professional | Monitoring committee for the Strategic Framework for Healthcare 2014-2030 at the Ministry of Healthcare | Collective (plan, no practice yet) |
| Political/governmental/professional | Advisory councils to the government (NGOs, senior citizens) | Collective, lack specific focus on healthcare |

[9] Source: interviews HEALTH2, 3 and 5.
[10] Source: HPI (2007) in http://www.hpi.sk/hpi/sk/view/2845/manazeri-v-zdravotnictve.html
[11] Source: SME, in http://ekonomika.sme.sk/c/7505287/pri-tendri-na-ct-pristroj-nasli-nedostatky.html#ixzz3JfRcyfwL

| | | |
|---|---|---|
| ***Sector level - patients' organizations*** | | |
| Specific groups of patients | League against cancer, League for mental health, and similar | collective |
| General representation of patients, targeting awareness raising, patients' rights and access to information | Association for the Rights of Patients, The Slovak Patient, Association of Nurses and Patients | collective |
| ***Hospital level - supervisory*** | | |
| Political/local governments/professional | Hospital governance boards in non-profit public hospitals | collective, potential new channel for user involvement in the future (plan, no practice yet) |
| Political/governmental/local governments/professional | Hospital supervisory boards in all types of public hospitals except for hospitals under direct rule of the Ministry of Healthcare | collective, potential new channel for user involvement in the future |
| ***Hospital level – patients' organizations*** | | |
| individual patient claims via hospital systems of quality, no organized representation | n/a | individual |

Source: own compilation

### 1.4 User involvement in education: structure and milestones

Similarly to the healthcare sector, user involvement in education especially involvement of students was officially institutionalized only ten years after the brake up of Czechoslovakia. Before independent Slovakia, the most active and visible user involvement in education sector was through the existence of voluntarily organized parents councils in kindergartens and primary and secondary schools. Not formally recognized by law, parents councils could not directly affect the management of schools and often served to legitimize the politically informed propaganda of the former regime at the school level.[12] Nevertheless, parents meetings played an important role for a face-to-face interaction between parents and teachers, with discussions revolving around issues that are directly connected to an individual performance of students.

The user involvement in education is regulated mostly at the level of concrete institution. The Act No. 542/1990 on State Administration in Education and School Self-governing Bodies established two self-governing organs: school council and district council (uniting school councils from one district).[13] The act was repelled in 2003 and replaced by a new Act No. 596/2003 Coll., which in part nine in addition to school and district councils recognizes new self-governing body: student council (§26).[14] As opposed to school council that is mandatory organ in each school, student councils can be established voluntarily. The functioning of self-governing bodies is further regulated by the Decree No. 291/2004 Coll. and Decree No. 230/2009 Coll.[15]

[12] Source: general knowledge, interview EDU13 and http://www.schoolboard-scotland.com/conference/Slovak.htm
[13] Source: The Act No. 542/1990 on State Administration in Education and School Self-governing Bodies, available: http://www.zbierka.sk/sk/predpisy/542-1990-zb.p-848.pdf
[14] Source: The Act No. 596/2003 Coll. on State Administration in Education and School Self-governing Bodies, available: https://www.minedu.sk/data/att/6585.rtf
[15] Source: Decree No. 291/2004 Coll. and Decree No. 230/2009 Coll. regulating the establishment, structure organization and financing of of school self-government, available: https://www.minedu.sk/data/att/679.pdf

At the sectoral level, there is no formal recognition of any organ or body that would unite parents or students. The user involvement is therefore voluntary and parents and students organizations are established and function as civic associations and organizations, regulated by the act on association of citizens.[16] Currently, several youth organizations exist at the national level, as well as local and/or regional youth organizations and parliaments. Their cooperation among each other, however, is not a rule. Moreover, local parliaments and student councils are not necessarily united at higher, regional level. The only known organization uniting parents is The Slovak Council of Parents'Associations *(Slovenská rada rodičovských združení - SRRZ)*. On the contrary, several youth organizations active at the national level aim to become an umbrella organization for youth participation.

Certain level of formalization of user involvement in education is visible through the more complex cooperation with the Ministry of Education, Science, Research and Sports of the Slovak Republic (hereinafter the Ministry of Education, *Ministerstvo školstva*). First, users enter the discussions with the Ministry of Education via several advisory organs (see Table 3 and Section 3 on user involvement). Second, users are organized in civic associations and organizations whose level of cooperation with the Ministry varies, for example the Youth Council of Slovakia (*Rada mládeže Slovenska)* has a status of a policy-maker (Miháliková and Škrabský 2014). In addition, the Ministry of Education manages a state contributory organization IUVENTA- *Slovak Youth Institute* that aims to represent the youth of Slovakia, administers various grants, cooperates in policy making and coordinates research in the field of youth.

The Strategy of the Slovak Republic for Youth for the years 2014 – 2020 *(Stratégia Slovenskej Republiky pre mládež na roky 2014 – 2020)* opens space for a future formalization of user involvement in education. In its part "Participation in a Modern Way", the strategy sets the aim to encourage innovative forms of youth participation at all three levels - national, regional and at the level of community. In particular, the focus is on the definition of *"the status of the local youth parliament and the status of the local youth council in the legislation and the extent of their influence on the co-decision-making process."*[17]

Currently, the increased need for user involvement is reflected by the effort to amend the Act No. 282/2008 on Youth Work Support. One of the aims is to create centres for youth in every region/higher territorial administrative unit of Slovakia.[18] In April 2014, the representatives of the Ministry of Education, IUVENTA and other organizations working with youth met on a first round of consultations. According to the agenda in the legislative program of the Slovak government, the government aimed at discussing this amendment in its November 2014 meeting.[19]

[16] Source: The Act No. 83/1990 Coll. on association of citizens, available: http://www.minv.sk/?obcianske-zdruzenia&subor=21014
[17] Source: The Strategy of the Slovak Republic for Youth for the Years 2014 - 2020, available: https://www.minedu.sk/data/files/3890_strategy_sr_for_youth-2014-2020_final-en.pdf
[18] Source: Public consultations on the amendment of the act on youth work support, in: https://www.minedu.sk/verejna-konzultacia-k-novelizacii-zakona-o-podpore-prace-s-mladezou/
[19] Source: Legislaive programme of the Government Office of the Slovak Republic, available: http://www.vlada.gov.sk/data/files/4324_plu_2014.pdf

Table 3 summarizes the structure of user involvement in the education sector with focus on secondary schools.

**Table 3 Structure of user involvement: education/secondary schools**

| **EDUCATION** | | |
|---|---|---|
| **Level and character of user involvement** | **Organization name** | **User involvement individual vs. collective** |
| ***Sector-level – advisory*** | | |
| Political/governmental | The Council for System Changes in Education | Individual/collective |
| Political/governmental | The Curricular Council | Individual/collective |
| Political/governmental | Education four-partite | Collective |
| Political/governmental/professional | The Council of the Minister for National Education | Collective |
| Political/governmental/professional | The Council of sport representation of the Slovak Republic | Collective |
| Political/governmental | The Slovak Youth Institute | Collective |
| ***Sector-level – parents' and students' organizations*** | | |
| General representation of parents at the sector level, targeting the quality of service | The Slovak Council of Parents' Associations. | Collective |
| General representation of students at the sector level, targeting the quality of service | The Student Council of High Schools of the Slovak Republic | Collective |
| General representation of students at the sector level, targeting the quality of service | The Union of High School Students of Slovakia | Collective |
| General representation of students at the sector level, targeting the quality of service | The Youth Council of Slovakia | Collective |
| ***Establishment level (secondary schools) - supervisory*** | | |
| General user representation at the establishment level | School Councils | Collective |
| ***Establishment level (secondary schools) – parents' and students' organizations*** | | |
| General user representation at the establishment level | Parents' councils | Collective |
| General user representation at the establishment level | Student councils | Collective |

Source: own compilation

## 1.5 Conclusions

User involvement in Slovak experienced growing significance with the transition to democracy and market economy. While education inherited a user involvement structure from state socialism, more significant user involvement processes started only in late 2000s with the establishment of school self-governance. In healthcare, a user involvement structure is gradually developing along the challenge of overcoming the direct state rule in hospital functioning prior to the regime change in 1989.

The remainder of this report provides an in-depth analysis of user involvement practice, its (potential) role and current challenges in both sectors. More importantly, we focus on the interaction between user involvement and social dialogue in shaping the quality of public services in secondary schools and hospitals. In the analysis, user involvement serves as the independent variable; quality of services serves as the explained/dependent variable; and

social dialogue structures and practices serve as a procedural variable, which interacts with user involvement in its impact on the quality of services. Figure 1 shows the relationships studied in this report.

**Figure 1 Analytical framework**


# 2. Social dialogue in the hospital and school sectors

This section reviews the main characteristics, developments and social dialogue structures in the hospital and school sectors. The ILO defines social dialogue as a process including *„…all types of negotiation, consultation or simply exchange of information between, or among, representatives of governments, employers and workers on issues of common interest relating to economic and social policy."*[20] The European Commission maintains that *„..social dialogue is the most suitable tool for promoting better living and working conditions and greater social justice."*[21] Social dialogue can serve as an important channel of enhancing the quality of public services, because shaping the working conditions of individuals engaged in service provision. In the public services sector, social dialogue may be tripartite when involving public authorities next to employer representatives (e.g., associations of schools or hospitals), or bipartite when employers or their representatives engage in discussions and negotiations with employee representatives, most often trade unions.

In this study, social dialogue is understood in terms of its structure, processes and outcomes. The relevant social dialogue structures in healthcare and education systems are presented in sections 2.1 and 2.2 respectively. Processes refer to the type and character of interaction between the social partners. Collective bargaining, with its established practices and bargaining levels, is the most important but not the only process that characterizes social dialogue. Finally, the outcomes of social dialogue refer to joint actions, agreements, statements, collective agreements and bargaining coverage relevant for hospitals and schools.

[20] Source: ILO website, http://www.ilo.org/public/english/dialogue/
[21] Source: adaptation from European Commission, in http://ec.europa.eu/social/main.jsp?catId=329&langId=en

## 2.1 Hospitals

The public healthcare sector and especially the hospital sector in Slovakia underwent a series of reforms since 2001. Between 2002 and 2006, the pro-reform government coalition introduced market principles into the healthcare system, including user fees, organizational decentralization of hospitals, flexibility in payment mechanisms and contracting (Szalay et al. 2011). A central element in NPM-style changes to public sector organizations was hospital corporatization. In mid 2000s, the network of regional and smaller hospitals was corporatized, or turned from government-run organizations into public corporations. Corporatization of other hospitals, concerning mostly large state-operated and university hospitals, was put on halt under the 2006-2010 social democratic government. After 2010, the right-wing government coalition attempted to continue the corporatization process. However, the process was again stopped after organized trade union action and professional chambers' negotiations with the government. In result, a full marketization of healthcare was not completed, and the halfway liberalisation reinforced variation in organizational forms of public hospitals and their access to public finances (Kahancová and Szabó 2014). In particular, corporatization yielded differentiated roles and access to public finances for university hospitals in direct state ownership; and for smaller public hospitals operated by regional governments, municipalities and other local public entities.

The differentiated access to public finances fuelled a growing gap in working conditions between the corporatized and the non-corporatized hospitals. First, upon reforms, hospital employees lost their public employee status; and remuneration was based on independent bargaining rather than the wage tariffs relevant for public service. Second, motivated to act like private market actors, corporatized hospitals adopted severe austerity measures, which also influenced their bargaining position towards trade unions. Finally, corporatized hospitals with greater budgetary constraints experienced shortages of health personnel and migration to better paying state hospitals or abroad (Kaminska and Kahancová 2011).

Despite the above trends, employment in healthcare remained relatively stable and wages continued to rise (see Table 4 and 5). Nurses comprise the largest occupational group and at the same time the one facing the threat of labor shortages due to nurses' departure to better paying jobs or abroad (see Table 5) (Kaminska and Kahancová 2011, Kahancová and Martišková 2014). Employment in healthcare is considered stable, without threat of dismissals and the need for particular employment guarantees. The slight employment decline can be explained by pressure for hospital efficiency in the post-reform period, but also by wage rises for doctors since 2011 and nurses since 2012 endorsed through legislation.

Healthcare employees work under standard full-time employment contracts; alternative forms of employment, including agency work, bogus self-employment, job sharing and similar are marginal and mostly limited to non-medical professions. The exception in alternative employment forms is working on work agreement contracts with lower social protection than standard employment contracts. Work agreements are common among medical doctors who work for several healthcare providers besides their main employment contract. Next to wage issues, social partners identify overtime and work organization as the most important challenges and subjects in negotiations. Recent legislative changes, including the

transposition of the EC Working Time Directive into the Slovak legislature, did not help mitigating overtime work in hospitals.

**Table 4 Employment and average wages in public healthcare**

| | 2009 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| Employees in public healthcare | 54,569 | 55,417 | 54,608 | 54,308 |
| Average wage in public healthcare | 765 EUR | 812 EUR | 925 EUR | 958 EUR |

Source: SOZZaSS calculations using the statistics of the National Centre for Healthcare Information (*Národné centrum zdravotníckych informácií*).

**Table 5 Employment in healthcare according to professional groups**

| Employee category | | Number of employees | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2002 | 2004 | 2006 | 2008 | 2010 | 2012 |
| Total | | 113,734 | 108,752 | 107,115 | 109,874 | 108,079 | 105,397 |
| Medical employees | | 81,251 | 76,663 | 75,781 | 79,134 | 79,551 | 79,234 |
| Including | doctors | 19,205 | 16,707 | 17,040 | 18,121 | 18,110 | 18,193 |
| | dentists | | 2,870 | 2,714 | 2,745 | 2,663 | 2,665 |
| | pharma employees | 2,556 | 2,828 | 3,032 | 2,777 | 3,267 | 3,522 |
| | nurses | 37,265 | 34,007 | 32,568 | 33,778 | 32,745 | 31,478 |
| | midwives | 1,087 | 1,739 | 1,552 | 1,761 | 1,874 | 1,765 |
| | other* | 21,138 | 18,512 | 18,875 | 19,952 | 20,892 | 21,611 |
| Total of non-medical professions** | | 32,483 | 32,089 | 31,334 | 30,740 | 28,528 | 26,163 |

Source: Health Policy Institute (HPI) 2014, adaptation from data of the National Centre for Healthcare Information (*Národné centrum zdravotníckych informácií*).
* includes laboratory workers, healthcare assistants, technicians, physiotherapists, medical orderlies and similar.
** includes technical and economic professions, operator professions, teachers and employees with the statute of state servants and similar.

In social dialogue, healthcare reforms brought stabilization of institutions at the sector level with high organization rate and bargaining coverage (see Table 6). Initially covered by bargaining in public services, the healthcare sector developed its own bargaining structure after 2006. Employers' adaptation to corporatization included a split of the single employer federation into two employers' associations AFN SR (later AŠN SR) and ANS, separately representing non-corporatized and corporatized hospitals, respectively.

**Table 6: Industrial relations in public healthcare (hospitals)**

| | |
|---|---|
| Trade unions | Slovenský odborový zväz zdravotníctva a sociálnych služieb (SOZZaSS)<br>Lekárske odborové združenie (LOZ)<br>Odborové združenie sestier a pôrodných asistentiek (OZSaPA) |
| Estimated trade union density in the hospital subsector | 51% (2006) |
| Trade union density with regard to the sector* | SOZZaSS: 46.5% (2006)<br>LOZ: 4.2% (2006)<br>OZSaPA around 2,000 members (2014), estimated density n/a |
| Employers' associations | Asociácia štátnych nemocníc Slovenskej republiky (AŠN SR), 24 members (2014) – formerly known as Asociácia fakultných nemocníc Slovenskej republiky (AFN SR)<br>Asociácia nemocníc Slovenska (ANS), 57 members (2014) |
| Dominant bargaining level for collective agreements | Sectoral/multi-employer level (ASN and ANS separately) and establishment level<br>Sectoral tripartism with the Ministry of Healthcare – without collective agreements |
| Sectoral bargaining coverage** | 95% (2006) |

Source: Czíria (2009), authors' interviews with sectoral social partners (2014).

* Estimated density of particular unions within the healthcare sector.

** Percentage of employees in the sector covered by a multi-employer (higher-level) collective agreement

Fragmentation on the side of trade unions derived only after the 2011-2012's campaigns for wage rises of doctors and later nurses. The two established trade union organizations, one representing broad employee interests of all occupational groups (*Slovenský odborový zväz zdravotníctva a sociálnych služieb, SOZZaSS*) and one representing medical doctors (*Lekárske odborové združenie, LOZ*) saw the rise of a new trade union representing nurses and midwives (*Odborové združenie sestier a pôrodných asistentiek, OZSaPA*) who felt misrepresented by the other trade unions. The establishment of OZSaPA also strengthened the alternatives instruments of trade union action in the healthcare sector beyond the traditional channels of collective bargaining. While the SOZZaSS trade union enjoys a strong bargaining position in sector-level collective bargaining, LOZ engages in bargaining, protests and other kinds of public action to gain influence. The third union OZSaPA faces difficulties to penetrate into existing structures of social dialogue, strongly dominated by SOZZaSS. Therefore, the union of nurses and midwives focuses its capacities on public actions, protests, negotiations with governments and municipalities.

The structure of social dialogue in the hospital sector can be summarized as follows. At the sectoral/multi-employer level, two employers' associations, representing larger state-owned hospitals (AŠN SR) and smaller regional hospitals (ANS) conclude collective agreements independently with relevant trade unions (SOZZaSS and LOZ). OZSaPA strives for becoming part of sector-level bargaining but does not enjoy great support by other trade unions in this effort. At the hospital level, bargaining takes place with relevant unions established in particular hospitals. Here the position of SOZZaSS also dominates, and employers prefer to bargain with SOZZaSS because this union has broad interest representation coverage.[22]

Recent legislative changes, initiated by trade unions campaigns, stipulate wage rises for doctors and for nurses and midwives directly without further rights of these occupational groups to wage bargaining coverage. The unions' initiatives for wage rise started in 2011

[22] Source: interviews with social partners.

when the LOZ union requested wage rises and the stop to further hospital corporatization. This action was accompanied by massive threats of job retreats of hospital doctors. In 2012, nurses and midwives engaged in public protests and petition for wage growth. The well-organized and influential social dialogue and collective bargaining structure in healthcare has suffered under the campaign for improving nurses' working conditions. While still relevant, the sustainability of sector-level bargaining is questionable after the bargaining coverage of the most important occupational groups in healthcare (doctors and nurses) has been squeezed out by recent legislative stipulations on wage increases for doctors (2011) and nurses (2012).

In sum, while the embedded post-2006 social dialogue structure in the hospital sector faces important changes, sector-level or multi-employer coordination is still an important feature of industrial relations institutions in Slovak healthcare. Two employers' associations, representing larger state-owned hospitals (AŠN SR) and smaller regional hospitals (ANS) conclude collective agreements independently with the relevant trade unions (SOZZaSS, LOZ and OZSaPA).

## 2.2 Schools

The education system in Slovakia is divided into regional and higher education. The system of regional education consists of three levels: pre-school kindergartens, primary schools and secondary schools (see Table 7). Within secondary education, students can pursue three streams of education: gymnasia, technical/professional secondary schools and vocational secondary schools. Secondary schools can be established by state via a municipal office, municipality (town/village), or higher territorial administrative unit (*vyšší územný celok, VÚ*C) after the approval of the respective central body of the state administration (for the employer structure in education, see Table 9). Schools may also be established by churches, legal entities and private persons. While education is provided free of charge, church and private schools may charge tuition fees.[23]

Gymnasia, on which this study is focused, have recently grown in terms of numbers and students. Since 1989 when 51,531 students attended 128 gymnasia, the number of gymnasia increased to 223 with more than 100,000 enrolled students in 2003.[24] Between 2003 and 2013, the number of gymnasia increased to 247 but the student body declined to 76,711 students. Out of the 274 gymnasia, 151 are public (state) gymnasia. 60,439 students are enrolled in these public gymnasia.[25]

[23] Source: Educational System in Slovak Republic, The Institute on Information and Prognosis of Education (UIPS), available: http://web.uips.sk/download/rs/Educational_system_in_Slovak_Republic.pdf, p.13
[24] Source: ibid, p. 15
[25] Numbers for 15.9.2013. Source: UIPS in annual statistics on gymnasia, http://www.uips.sk/prehlady-skol/statisticka-rocenka---gymnazia

**Table 7 Regional education: number of schools, students and teachers according to the type of founder***

| Number of schools, students and teachers according to the founder | | Established by municipal office | Established by municipa-lity | Established by higher territorial admin. unit | Church | Private | Total |
|---|---|---|---|---|---|---|---|
| Kindergartens | schools | - | 2,724 | - | 62 | 75 | **2,861** |
| | students | - | 142,816 | - | 3,414 | 3,281 | **149,511** |
| | teachers | - | 13,784 | - | 315 | 416 | **14,515** |
| Primary schools | schools | 3 | 2,016 | 4 | 113 | 41 | **2, 177** |
| | students | 486 | 402,249 | 705 | 22,351 | 4,348 | **430,139** |
| | teachers | 33 | 32,690 | 62 | 1, 955 | 644 | **35,384** |
| High schools | schools | 21 | 5 | 490 | 75 | 133 | **724** |
| | students | 11,579 | 799 | 192,265 | 16,861 | 19,783 | **241,287** |
| | teachers | 1,018 | 85 | 17,628 | 1,978 | 2,969 | **23,678** |
| • Gymnasia | schools | 16 | 4 | 131 | 55 | 38 | **244** |
| | students | 10,094 | 749 | 52,760 | 12,904 | 3,839 | **80, 348** |
| | teachers | 879 | 82 | 4,552 | 1,388 | 689 | **7,590** |

* Data as of September 15, 2012. Numbers for special needs schools, art schools, language schools and other institutions excluded.

Source: The Report on the State of Education in Slovakia, 2013 (https://www.minedu.sk/sprava-o-stave-skolstva-na-slovensku)

The employment in education sector is stable, with more than 127, 000 employees in regional education reported for 2014, out of whose 7,385 are employed in gymnasia (see Table 8). The majority of teachers working in public schools are employed on full-time contracts. Part-time contracts account for about one fifth of contracts and are more concentrated in private and church owned schools.[26]

**Table 8 Employment and average wages in regional education**

| Year | Number of employees in regional education* | Average wage in regional education | Number of employees in gymnasia | Average wage of employees in gymnasia |
|---|---|---|---|---|
| 2013 | 126,575 | 741 EUR | 7,558 | 796 EUR |
| 2014** | 127,040 | 756 EUR | 7,385 | 848 EUR |

* including all employees (pedagogical, non-pedagogical) in regional education

**30.06.2014

Source: UIPS, OZPŠaV

[26] Source: UIPS in annual statistics, available: http://www.uips.sk/prehlady-skol/statisticka-rocenka---suhrnne-tabulky

The Union of Workers in Education and Science of Slovakia *(Odborový zväz pracovníkov školstva a vedy na Slovensku - OZPŠaV)* is the largest teachers' trade union covering all levels of education in Slovakia (see Table 9). In addition, a smaller section of about 1,000 members from within the Independent Christian Trade Unions of Slovakia (NKOS) represents Christian teachers - The Association of Employees in Education and Science, The Independent Christian Trade Unions of Slovakia *(Zväz pracovníkov školstva a vedy, Nezávislé kresťanské odbory Slovenska (ZPŠaV NKOS))*. After the series of strikes of teachers who demanded wage increases in 2012 – 2013, teachers who felt that OZPŠaV does not have a sufficient capacity to negotiate wage increases and better quality of education created a new trade union – the New Education Trade Unions *(Nové školské odbory, NŠO)*.

**Table 9: Industrial relations in public education**

| | | |
|---|---|---|
| **Trade unions** | Trade Union of Workers in Education and Science of Slovakia<br>*(Odborový zväz pracovníkov školstva a vedy na Slovensku (OZPŠaV))*<br>The Association of Employees in Education and Science, The Independent Christian Trade Unions of Slovakia<br>*(Zväz pracovníkov školstva a vedy, Nezávislé kresťanské odbory Slovenska (ZPŠaV NKOS))*<br>The New Education Trade Union<br>*(Nové školské odbory (NŠO))* | |
| **Trade union density with regard to the sector** | OZPŠaV: around 53,000 members, estimated density: about 37% (Czíria 2011)<br>ZPŠaV NKOS: 976 members (2008), estimated density: N/A<br>NŠO: membership and estimated density N/A | |
| **Employers' associations** | Representatives of government, higher territorial units, and towns and municipalities | The Association of Self-governing Schools of Slovakia<br>*(Združenie samosprávnych škôl Slovenska (ZSŠS))*<br>The Association of Directors of State High Schools of Slovak Republic<br>(*Asociácia riaditeľov štátnych gymnázií Slovenskej republiky (ARŠG SR))*<br>The Association of Private Schools and School Facilities of Slovak Republic<br>*(Asociácia súkromných škôl a školských zariadení Slovenska (ASŠŠZS))*<br>The Association of Secondary Professional Schools of Slovakia<br>*(Asociácia stredných odborných škôl Slovenska (ASOSS))*<br>The Association of Secondary Vocational Schools of Slovakia<br>*(Združenie odborných učilíšť Slovenska (ZOUS))*<br>The Association of Towns and Municipalities<br>*(Združenie miest a obcí Slovenska (ZMOS))* |
| **Professional associations** | The Slovak Chamber of Teachers<br>*(Slovenská komora učiteľov)* | |
| **Dominant bargaining level for collective agreements** | Covered in public sector bargaining (collective agreement for the public services)<br>Individual collective agreements at multi-employer level<br>Sectoral fourpartism with the Ministry of Education – without collective agreements | |
| **Sectoral bargaining coverage** | 100% (estimate of Czíria 2011) | |

Source: authors, Czíria (2011)
Note: The employers' association for tertiary education – The Council for Higher Education (RVŠ SR) is excluded from the table

The salaries of teachers are regulated by the Act on Public Service (Act No. 313/2001 Coll. and its later amendments). The education sector participates in public sector bargaining. The official partners for negotiations are OZPŠaV (member of the Confederation of Trade Unions of the Slovak Republic – KOZ SR) and the ZPŠaV NKOS representing employers. Moreover, collective agreements can be signed at the level of particular establishments. In late 2014 social partners have agreed on a collective agreement for 2015, which includes a 1.5%

increase in wages for public service employees. The agreement shall be signed in first week of December 2014.[27]

In addition to public sector bargaining, independent social dialogue in education also exists, however, without the conclusion of a sectoral collective agreement. In 2010 on the recommendation of the European Commission, OZPŠaV signed an agreement with employers, in which they agreed to create a national working group on sectoral social dialogue in education (*Národná pracovná skupina pre oblasť sektorálneho sociálneho dialógu v školstve SR* (NPS)).[28] In 2012, the incumbent Minister of Education Dušan Čaplovič created a new platform for sectoral social bargaining – the educational fourpartism *(Školská štvorpartita)* with four members representing each actor: trade union (OZPSaV), employers, representatives of regional self-governments and the Ministry of Education. On its fist meeting in May 2012, social partners discussed the government program and the legislative objectives of the Ministry. This to the extent set the agenda of future negotiations. According to the interviewees all other meetings of fourpartism were held in a similar nature.[29]

In sum, we argue that social dialogue in education predominantly focuses on legislative changes instead of an agenda to be addressed in collective bargaining between the social partners. As a result, user involvement in discussions and negotiations concerning legislative developments is limited, since high school students are often not seen as relevant partners to enter professional discussions on legislative changes in education.

# 3. Service user involvement in hospitals and schools

This section presents evidence on service user involvement at the sector level in the hospital and school sectors in Slovakia. Tables 2 and 3 in Section 1 highlighted the formal structure of user involvement in both sectors. In this section, we elaborate on the presented channels of influence and discuss also other, less formalized but equally important, channels of influence through voluntary actions of patient organizations, parent and teachers. This section presents the involved actors, the levels of user involvement, forms and scope of involvement, and finally the perceptions of social partners on the current state of user involvement on shaping service quality, as well as its potential impact on the social dialogue processes and agenda.

## 3.1 Hospitals

As outlined in the first section of this report, multiple forms of user involvement in healthcare remain formally underdeveloped at the sector level. A potential explanatory factor for this finding is the unique and dominant role of the *Healthcare Surveillance Authority (ÚDZS)*, which to some extent preempts other forms of user involvement.

[27] Source: http://www.kozsr.sk/?page=./informacie/info_24_11_2014
[28] The agreement is available here: http://www.ozpsav.sk/files/documents/zakladne/narodny-sektoralny-dialog-dohoda.pdf
[29] Source: interviews EDU1 and 4.

### 3.1.1 Healthcare Surveillance Authority

Any citizen has a right to submit a request or a complaint to the UDZS after the impression that the provided care was not adequate. Citizens have a direct opportunity to turn to UDZS with their claims, and UDZS shall act as an independent supervisory body in each individual case. If UDZS rules in favor of the citizen's claims, it has the right to fine the particular healthcare provider, to request improvements in the particular issue at stake, or to facilitate service quality improvement through engaging other responsible actors, e.g., higher territorial units, municipalities, the Ministry of Healthcare and similar.

UDZS shall serve as an independent surveillance authority channeling individual user involvement in shaping the quality of health care. Another major role of UDZS is to execute a controlling function over health insurance companies. The latter function motivated the recent governments to adopt changes in the UDZS's independence from the state. In particular, the Ministry of Healthcare now has a direct right to revoke the UDZS's director, thus in fact UDZS became subordinated to the Ministry. This fact produced the resignation of the previous UDZS director in 2012, criticizing the fact that UDZS lost its independence.[30] Political nominations of representatives of UDZS with the Ministry and hospital directors have also been observed.[31] This is the reason why social partners, especially trade unions in the healthcare sector show reservations to the role of UDZS in user involvement. The president of the Doctors' trade union federation (LOZ) argues that

*„...It is a pity for the patients that the UDZS is not independent and often rules against the patient. I have a personal experience with this. In the recent scandal of erasing parts of the patient's records in the Nitra hospital, the media reported about political ties between the hospital director and a representative of UDZS. Such a surveillance authority does not exist in most European countries and I think it is redundant also in Slovakia. Abroad it is the professional associations and independent experts that decide cases whether health care has been adequately provided."*

The representative of the nurses' trade union OZSaPA claims that the role of UDZS is controversial because increasing the frustration of health care providers to provide care, and also because of frustrating patients with too many redundant examinations just to avoid complaints.[32]

Despite these hesitations, social partners recognize the potential role of UDZS in shaping the quality of healthcare services. Developments after 2005 show that UDZS has been receiving a constant number of requests and complaints each year directly from patients, which documents patient trust towards this almost exclusive structured user involvement institution at the sector level (see Table 10). The share of patient's requests in relation to the quality of health care service received has been increasing. At the same time, the share of justified cases in favour of the patient remained below 15% with the exception of 2011.

[30] Source: Pravda, 28.6.2012, in http://spravy.pravda.sk/domace/clanok/247157-sef-udzs-gajdos-odstupil-z-funkcie/ [accessed 27.11.2014].
[31] Source: HEALTH1 and HEALTH5 interviews.
[32] Source: interview HEALTH2

**Table 10 Patient involvement through the Healthcare Surveillance Authority (2005 – 2013)**

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| Patient requests/complaints received in particular year | 1632 | 1321 | 1249 | 1452 | 1634 | 1469 | 1391 | 1563 | 1647 | Stable |
| Cases from previous year | 0 | 202 | 153 | 179 | 212 | 265 | 260 | 224 | 289 | Increase |
| Total number of patient requests/complaints | 1632 | 1523 | 1402 | 1631 | 1846 | 1734 | 1651 | 1787 | 1936 | Increase |
| Number of completed cases | 1430 | 1168 | 990 | 1406 | 1581 | 1474 | 1427 | 1498 | 1651 | Increase |
| Number of cases related to adequate provision of health care services | 510 | 748 | 678 | 933 | 1049 | 1016 | 961 | 1005 | 1085 | Increase |
| Justified cases from total | 101 | 211 | 146 | 214 | 206 | 245 | 282 | 228 | 227 | Increase |
| Unjustified cases from total | 409 | 537 | 532 | 719 | 843 | 771 | 679 | 777 | 858 | Increase |
| Share of justified cases in favour of the patient | 6% | 14% | 10% | 13% | 11% | 14% | 17% | 13% | 12% | Stable but low |

Source: Healthcare Surveillance Authority (*Úrad pre dohľad nad zdravotnou starostlivosťou, ÚDZS*), adaptation from Health Policy Institute

Except the quality of healthcare services, other reasons of patient involvement included inadequate behavior of the health care provider vis-à-vis the patient, or complaints related to work organization. This evidence suggests an indirect influence of user involvement on the social dialogue agenda, because the UDZS' rulings and recommendations also concern employee behavior and working conditions. Table 11 documents that part of the cases received by the UDZS were delegated to other actors in healthcare, including professional chambers and units of territorial governance. This documents the complex network of relationships in user involvement through UDZS.

**Table 11 Third parties' rule in the interaction between users and the UDZS**

| | | 2005 | 2006 | 2007 | 2009 | 2010 |
|---|---|---|---|---|---|---|
| Rule taken outside of UDZS competence | | ✓ | ✓ | ✓ | ✓ | ✓ |
| by | Higher-level administrative units | ✓ | ✓ | ✓ | | |
| | Particular hospital management or other healthcare provider | ✓ | ✓ | ✓ | | |
| | Professional organizations (chambers) | ✓ | ✓ | ✓ | | |
| | Ministries, Social Security Authority, and other state actors | ✓ | ✓ | ✓ | | |
| Ad acta cases | | ✓ | ✓ | ✓ | ✓ | ✓ |

| | | | | | |
|---|---|---|---|---|---|
| Cases solved through a letter to the client | ✓ | | | ✓ | ✓ |
| Cases revoked by the client | ✓ | ✓ | ✓ | | |
| Cases sent for decision to other actors | | ✓ | ✓ | | |

Source: UDZS annual reports.

Together with the Ministry of Healthcare of the Slovak Republic, the UDZS participates in the *European Union Network for Patient Safety and Quality of Care (PaSQ*), co-founded and supported by the European Commission within the Public Health Programme. Developing patient involvement in elaborating safety measures is among the priorities of the action.[33] Despite its EU wide scope, none of our interview respondents made reference to this project as a relevant item in the patient involvement in shaping the quality of healthcare in Slovakia.

### 3.1.2 Patient organizations

Patient organizations in Slovakia underwent a growing importance for user involvement, although a structured participatory model has not yet been developed. As the head of one patient organization, the Slovak Patient (*Slovenský pacient,* SP), claimed,

*„...here there is a long tradition of not talking back, obeying, not saying anything, standing in line, remaining silent, and so on. For this nation to mature, there must be precedencies of some people...., which lead to the development of an attitude 'look, they were not afraid, they have tried it, they did not resign, they did it, they finished it, so it exists'."*[34]

An analysis of the Health Policy Institute (2014) shows that the involvement of patient organizations on shaping the health policy remains underdeveloped. In a survey conducted between 2010 and 2012, only 14 out of about 300 patient organizations actively commented on legislative proposals in healthcare. Comments from patient organizations only concerned 7 out of 110 legislative proposals (6%). 63% of comments from patient organizations raised serious issues, and 77% of their comments were accepted. This shows that despite low overall involvement, the influence of those patient organizations that active engaged in legislative changes was highly relevant (Balík and Starečková 2012).

The current landscape of patient organizations in Slovakia shows fragmentation along interest groups, most commonly consisting of disease-specific patient organizations seeking influence through a variety of instruments, at different levels and targeting various actors. There are two encompassing umbrella type of patient organizations, the Slovak Patient (*Slovenský pacient,* SP) and the Association for Protection of Patients' Rights (*Asociácia na ochranu práv pacientov*, AOPP), which attempt to unite patient interests and seek efficient forms of organized collective user involvement. In the eyes of SP, the many small patient organizations are often incapable to gain legitimacy because of diverging interests and lack of financial resources.

[33] Source: PaSQ website www.pasq.eu and http://www.pravo-medicina.sk/aktuality/882/mudr-peter-bandura-phd---projekt-vytvorenia-europskej-siete-pre-bezpecnost-pacientov-a-kvalitnu-zdravotnu-starostlivost-pasq--patient-safety-and-quality-of-care

[34] Source: interview HEALTH4.

Each of these organizations adopted a distinct strategy of influence and cooperation between them remains underdeveloped despite AOPP being listed among SP members[35]. While AOPP is better integrated in formal negotiation platforms and advisory councils of the government, SP believes that this route will not produce enhanced legitimacy for patient organizations and improvements resulting from user involvement in shaping the quality of healthcare. Instead, SP is outcome oriented and opts for developing user pressures through media campaigns, improved access to information for patients, organizing events and conferences and patient-oriented publications, in order to monitor the needs of the whole spectrum of its 337 registered patient organizations and equip them with better tools to gain legitimacy and influence. In contrast, the AOPP prioritizes the process of gradual development of representation structures at various advisory platforms of the government and parliament.[36] Since 2013, AOPP through its member organizations representing handicapped citizens joined the Governmental Council for Non-Governmental Non-Profit Organizations (*Rada vlády pre mimovládne neziskové organizácie*), which is an intersectoral advisory platform on government policy.[37] AOPP is also represented in the governmental Council for the Rights of Senior Citizens and Adaptation of Public Policy to the Process of Population Ageing (*Rada vlády SR pre práva seniorov a prispôsobovanie verejných politík procesu starnutia populácie*).[38] AOPP claims that the government, as well as the health insurance companies, have a welcoming attitude to user involvement from patient organizations.[39]

The perception of user involvement influence on the social dialogue agenda and improvement in healthcare services also differs between the two organizations. While SP does not ascribe high relevance to influence on social dialogue agenda, the AOPP through its structured involvement believes that patient influence on social dialogue issues can be extensive. However, in the campaigns for wage rises for doctors and nurses, which dominated the social dialogue in healthcare since 2011, patient organizations did not take an active supporting role or influence. AOPP argued that the benefits to the patients were not clear in these campaigns, and the social partners (trade unions) approached patient organizations for support only when seeking support to legitimize their own wage claims. When AOPP raised the question "is the wage increase of doctors going to be to the benefit of patients?" in one of many negotiations on this topic (with representatives of the government and social partners), none of the engaged parties could offer a clear and systematic answer. Therefore, AOPP adopted an attitude that *[…we will not let ourselves be pulled into this issue and we do not want to be blackmailed*].[40] In contrast to the doctors' campaign, the AOPP openly supported the nurses' campaign for wage increases just one year later in 2012. In this case AOPP valued the process through which nurses sought patient support in contrast to the strategy adopted by the doctors' trade union LOZ in approaching patient organizations in their 2011 campaign.

[35] Source: SP website, www.slovenskypacient.sk, and interviews HEALTH4, 6 and 7.
[36] Source: interviews HEALTH4, 6 and 7.
[37] Source: interview HEALTH 6 and the Council's website http://www.tretisektor.gov.sk/index.php?cms_location=rada-pre-mimovladne-neziskove-organizacie
[38] Source: interview HEALTH6 and the Council's website http://www.employment.gov.sk/sk/ministerstvo/rada-vlady-sr-prava-seniorov/
[39] Source: interviews HEALTH6 and 7.
[40] Source: interview HEALTH7.

The only patient organization that directly integrates the social dialogue and user involvement agendas in itself is the Association of Nurses and Patients (*Asociácia sestier a pacientov, ASP*). This non-profit civil association systematically points attention to the consequences of low healthcare quality for patients, clients, their families and communities. Also, vice versa, the association strives for improving working conditions in the field of nursing. Although not directly involved in social dialogue structures, the ASP is unique in overcoming the diverging interests of trade unions and patient organizations that the representatives of other organizations highlighted in the project interviews. In November 2014, ASP openly declared support to efforts aiming at stopping the ongoing corruption scandals in healthcare, and thus requiring a greater user involvement pressure on the quality of healthcare.[41]

### 3.1.3 Hospital quality systems and hospital boards

Besides the above patient involvement targeting predominantly the legislation, political and governmental channels and influence on health policy through media, an increasing number of Slovak hospitals develop their own quality evaluation systems. These often involve an element of direct user involvement through a feedback mechanism. Although this system lacks coordination at the sector level, its scope and relevance is increasing. Two reasons behind this finding can be specified. First, the fact that the sector-level lacks a coordinated system defining 'quality' or benchmarks of quality across hospitals. The Ministry and health insurance companies each publish quality charts of hospitals, but use different methodologies. For political and competitive reasons, the evaluations by the Ministry lack an in-depth evaluation and set the intervals for 'standard quality' very wide to encompass almost all hospitals. These benchmarks are unsatisfactory for hospital management's internal purposes; but at the same time there is hidden rivalry between hospital directors on quality and performance.[42] Therefore, hospitals prefer targeted and addressed user involvement at the hospital level. When patient complaints directly address issues of work organization or other aspects of human resources, direct interaction between user involvement and social dialogue emerges at the hospital level. More evidence on the functioning of this channel of user involvement is provided in Section 4 on the case study hospital in Banská Bystrica.

In late 2014, several corruption scandals in Slovak hospitals produced a heated debate among the government, the public and social partners on new forms of hospital management. The government considers the idea that the state will no longer nominate hospital board members in those hospitals that require an existence of a board (e.g., not for profit public hospitals). Instead, nominations shall come from the social partners, civil society, municipalities and similar actors, which opens a new channel of user pressure. While this initiative is in the making and concerns only hospitals in particular ownership form, professional chambers in healthcare suggest the establishment of similar supervisory boards also in state hospitals, which currently lack any kind of control other than by the Ministry of Healthcare.[43]

[41] Source: http://www.asapoz.eu/clanky/nase-aktivity/asap-sa-pripaja-k-verejnym-protestom-proti-tunelovaniu-a-rozkradaniu-v-zdravotnictve.html
[42] Source: interviews HEALTH11 and 12.
[43] Source: SME 27.11.2014, http://www.sme.sk/c/7517134/lekarska-komora-navrhuje-kontrolu-cez-nemocnicne-rady.html#ixzz3KZUwpgIF [accessed 30.11.2014].

In sum, structures of user involvement are gradually developing in Slovakia. User organizations often recognize opportunities (e.g., in finding relevant agenda for action, which may overlap with a social dialogue agenda), but fail to take action or lack capacities, legitimacy or resources for action. Common challenges in establishing user pressures through organized patient organizations relate to interest-based politics, intransparent financing, political ties and the strong say of pharmaceutical donors in funding patient organizations (HPI 2014). To overcome fragmentation in interests on the side of patient organizations and the diversity in defining and measuring 'quality' in hospital services, hospitals increasingly tend to develop their own systems of quality with a user involvement component in it. This trend lacks cross-sector coordination and its implementation – either as a component of ISO 9001 quality system or as an exclusive establishment-based initiative – is at exclusive discretion of hospital managements. The representative of the employers' *Association of State Hospitals of the Slovak Republic* (AŠN SR) claims that user pressures can be taken more extensively into account in smaller and private hospitals.[44] In contrast, in large state-operated hospitals, the management lacks power and trade unions have established strong channels of influence, while patient organizations and trade unions often diverge in their interests.[45]

### 3.1.4 User pressure without user involvement

Finally, a recent and highly relevant phenomenon in the Slovak Republic is the increase of indirect user involvement pressures through actors other than users themselves. Above we have reviewed the forms and trends in individual and collective user involvement via UDZS and patient organizations. Moreover, the role of NGOs, which are not patient organizations, in increasing user pressures on the quality of public services has been growing in the past five years. The two dominant organizations are the Institute for Economic and Social Reforms (Inštitút pre ekonomické a sociálne reformy, INEKO), and the Transparency International Slovakia (TIS). These organizations strive for facilitating reforms and transparency in public services. Responding to the lack of transparency and systematic measurements of quality of healthcare provision, INEKO collected the dispersed evidence on patient feedback surveys and launched an online portal comparing particular hospitals in their quality indicators. Over 60 variables across 150 hospitals are part of the comparison.[46] The two private health insurance companies supported this aim, while the largest state-run health insurance company refused to disclose patient feedback statistics in the project's first phases. Currently INEKO gained access also to the remaining evidence, which should lead to more precise comparisons of hospital quality available to the public.[47] The NGO's motivation for this activity directly relates to increasing user involvement pressure in healthcare:

*"Through providing objective evidence we aim at drawing attention of the public to the discussion about quality and effectiveness of healthcare provision. When individuals possess better evidence, they are able to take informed decisions and develop more effective pressure*

[44] Source: interviews HEALTH8 and 9.
[45] Source: interview HEALTH3.
[46] Source: INEKO Blog from 28.11.2014 at http://www.ineko.sk/clanky/porovnajte-si-nemocnice-podla-ukazovatelov-kvality-a-efektivnosti,
[47] Source: INEKO Blog from 18.12.2014 at http://www.ineko.sk/clanky/dva-predvianocne-pribehy-o-ne-transparentnosti-v-zdravotnictve.

*on improving the quality of public services. We think that the project will help patients and their relatives, but also healthcare providers."*[48]

The comparison of hospital quality uses evidence collected by health insurance companies, Ministry of Healthcare, UDZS, higher territorial administrative units, and internal evidence of TIS and INEKO. Despite its complexity, uniqueness and systematic methodology, the fact that the analytical tool draws together individual rather than collective user feedback raises concerns about objectivity of evidence (e.g., patients in different health conditions enter different kinds of hospitals and have different personal quality benchmarks). Despite this shortcoming, the initiative is highly relevant; and currently dominates the efforts of creating user pressures to improve hospital inpatient services.

In sum, one of the most important channels facilitating user pressures comes not from the users or their organized interests, but through the efforts of NGOs striving to increase quality and transparency in public services. In analytical terms, the mediated NGO effort aims at strengthening the users's real power and thereby moving from tokenism to real value of individual user feedback. More precisely, referring to Arnstein's (1969) ladder of participation, such NGO efforts help moving from patient information and placation to more active user involvement pressure forms, namely, partial citizen control over service quality. This shall not occur via formalized or institutionalized patient participation in healthcare/hospital governance structures, but through increasing the *legitimacy* of user pressures among both users and healthcare providers.

## 3.2 Schools

Service user involvement in education sector exists at three levels:
- at the ***establishment level*** (the system of school self-governance)
- at the ***national/regional level*** (student organizations and NGOs promoting transparency in public services)
- at the ***Ministry's level*** (fourpartism in the education sector)

However, the only institutionalized user involvement is at the level of concrete school. Student organizations at the national/regional level operate as civil associations, hence, their number is unlimited and only one has a status of an official partner in negotiations with the Ministry: The Youth Council of Slovakia (Miháliková and Škrabský 2014). At the ministerial level, no formally recognized institution that would represent students as one whole group exists. This contrasts with the tertiary education in Slovakia, where the Student Council for Higher Education has an official legal status and is also an official partner in negotiations with the Ministry.

[48] Source: INEKO at http://nemocnice.ineko.sk. Authors' translation to English.

### 3.2.1 The system of school self-governance

The system of school-self governance represents the only institutionalized user involvement in education sector in Slovakia. In schools, daily functioning is managed by their directors. In addition, schools operate under the system of self-governance and employers, students and their parents are also involved in school management (see Table 12).

**Table 12 The system of school self-governance**

| Self-governance body | Number of members | Composition |
|---|---|---|
| The School Council | 11 | 2 pedagogical employees<br>1 non-pedagogical employee<br>3 parents representatives<br>1 student representative<br>4 representatives of a self-governing region (higher territorial unit) |
| The Parents Council | dependent on the number of classrooms | Parents representatives |
| The Student Council | 5-11 | Students of a school |
| Class self-governance | without specific number | Students of a class |

Source: Ďurajková et al., 2011

Students are voluntarily organized in the **student council** *(žiacka rada)* with 5-11 members, elected by the majority of students in a secret ballot election. According to the Act No. 596/2003 Coll., student council represents all students of a school, gives an opinion on substantial questions, proposals and measures in the field of school education and training, participates in the creation of school code of conduct and elects and dismisses the representatives to the school council.[49] According to the survey among high-school directors on the areas of interests of student councils, the most common initiative of student councils is proposals of events (33%) followed by complaints on the technical state of the school (20.8%) and educational process itself (10.3%) (Bieliková et. al 2012).

The number of high schools where student councils are established varies across the country (see Table 13). When comparing the number of student councils according to the type of secondary schools, student councils are less common in gymnasia. The highest number of established student council is in the Nitra region (75%) and the region with the lowest number of student councils is the Košice region. In some schools, student councils may be formally established but are not active. In others, e.g. in Gymnázium Šrobárova in Košice, which is our case study in this project, the student council actively operates in the school despite lacking a formal statute regulating its activity. The differences between the number of reported student councils and those actually active shall therefore remain the subject of further research.

**Table 13 Gymnasia in Slovakia with established student councils (2012)**

| Region | G: total | G with student council | % | High schools: total | High schools with student council | % |
|---|---|---|---|---|---|---|
| Bratislava | 44 | 20 | 45.5 | 112 | 54 | 48.2 |

[49] Source: Act No. 596/2003 Coll. on State Administration in Education and School Self-governing Bodies, https://www.minedu.sk/data/att/6585.rtf

| | | | | | | |
|---|---|---|---|---|---|---|
| Trnava | 22 | 14 | 63.6 | 71 | 37 | 52.1 |
| Trenčín | 19 | 11 | 57.9 | 63 | 43 | 68.3 |
| Nitra | 28 | 21 | 75 | 90 | 66 | 73.3 |
| Banská Bystrica | 30 | 18 | 60 | 88 | 55 | 62.5 |
| Žilina | 29 | 21 | 72.4 | 96 | 73 | 76.0 |
| Prešov | 40 | 16 | 40 | 118 | 57 | 48.3 |
| Košice | 36 | 12 | 33.3 | 90 | 46 | 51.1 |
| **Total** | **248** | **133** | **53.62** | **738** | **431** | **58.4** |

G = Gymnasiums

Source: Bieliková et al. (2012)

**Parents Councils** *(Rodičovské združenia/Združenia rodičov)* are not explicitly regulated in the act on school self-governance and are also voluntarily established. The decree on school self-governance stipulates that three representative of parents to the school council are elected by the parents of a school. Hence, the decree does not assume the existence of parents councils as opposed to student councils, where it explicitly states that student representatives to the school council are elected by the student council.

**School Council** *(Rada školy)* is established in all three levels of regional education: pre-school kindergartens, primary schools and secondary schools. School council functions as a public control body that shall promote and represent the interest of students, parents and its employees. It is the highest control organ that shall express its opinion on all substantial matters within the school. School council is composed of two pedagogical employees, one non-pedagogical employee, three representatives of parents, one student representative and four representatives of a self-governing region (see Table 13). The most important function of school council is election and dismissal of a school director. According to some interviewees, the composition of a school council should be changed in the near future for the fact that it does not reflect the needs of modern age.[50] Unfortunately, we were not able to verify this statement.

### 3.2.2 Student and parents organizations

Several student organizations (in a legal form of civic associations) operate at the national level, aiming to be an umbrella institution uniting the voice of students. Currently, we identified three most active organizations at the national level: the Youth Council of Slovakia, the Student Council of High Schools of the Slovak Republic and the Union of High School Students of Slovakia. The only known parents organization uniting parents councils is the Slovak Council of Parents'Associations *(Slovenská rada rodičovských združení - SRRZ)*. In addition to the most active and visible organizations at the national level, a high number of other youth organizations exist, such as regional youth parliaments, youth parliaments operating in cities, regional youth councils, etc. Student school council can be voluntarily associated in any of above-mentioned organizations.

[50] Source: interview EDU12.

**The Youth Council of Slovakia** *(Rada mládeže Slovenska, RmS)*, created in 1990 currently unites 33 civic associations in Slovakia, covering more than 40 000 young people.[51] The scope of their activities varies from supporting volunteerism to organizing different youth events and activities, such as United Nations Youth Representative. As already mentioned, according to the Report on the State of Education in Slovakia, RmS has a status of a youth policy-maker in Slovakia (Miháliková and Škrabský 2014).

**The Student Council of High Schools of the Slovak Republic** *(Študentská rada stredných škôl Slovenskej republiky, ŠRSŠ SR)* is **an umbrella organisation** for student councils at high schools, youth parliaments in towns and cities, for organisations working with the youth and for individual members.[52] ŠRSŠ SR aims to support active citizenship through the participation of young people in decision-making process and therefore cooperates with the Ministry of Education as well as with the Ministry of Labour.[53]

**The Union of High School Students of Slovakia** *(Stredoškolská študentská únia Slovenska, ŠÚS)* has similar objectives and aims, although targeting individual students rather than student councils via individual membership in their organization. According to their President, in comparison to the ŠRSŠ SR, their scope is more broad and although they also claim to cooperate with the Ministry of Education, they do see other channels for influencing youth policies in Slovakia.[54]

The only known parents organization uniting parents councils is the **Slovak Council of Parents'Associations** *(Slovenská rada rodičovských združení - SRRZ),* which is also member of the European Parents' Association (EPA). SRRZ directly targets the improvement of the quality of education through its activities, focusing on public debates, lectures, discussions with policy makers and facilitating interaction between parents and local and establishment-level parent organizations.[55] The statutes of SRRZ do not list any activities related to social dialogue themes, other than 'protecting teachers, students and parents against corruption, intrigues and various pressure groups.[56] We have no direct evidence of cooperation between SRRZ and social partners, suggesting that the channels of influence of SRRZ as an organized user group and social partners representing the interests of teachers and employers remain distinct and separate from each other.

### 3.2.3 NGOs: user pressure without user involvement

As already mentioned in section 3.1.4, a recent phenomenon in Slovakia is the increasing role of NGOs that mediate and facilitate user pressures on the quality of public services. The Institute for Economic and Social Reforms (Inštitút pre ekonomické a sociálne reformy, INEKO) has played an active role in this process. In 2012, INEKO has launched an online comparative tool evaluating school quality based on 33 indicators. The analytical tool served

[51] Source: web page of the Youth Council of Slovakia, available: http://mladez.sk/rms/english/
[52] Source: web page of the Student Council of High Schools of the Slovak Republic. http://www.srss.eu/
[53] Source: interview EDU5.
[54] Source: interview EDU6.
[55] See the official web page of the Slovak Council of Parents'Associations, available: http://www.srrz.sk/
[56] Source: SRRZ Statutes at http://www.srrz.sk/index.php?poc=no&subor=stanovy

as an input for various analyses and contributed to an ongoing discussion of quality and competition in public education, thereby motivating user pressures and improving their legitimacy for education reforms. With this aim, NGO initiatives of transparency and competition for quality among public schools dominate over direct forms of user involvement through organized user interests.

In healthcare, the INEKO initiative does not link its effort to present evidence on hospital performance and patient satisfaction with issues relevant from a social dialogue perspective. However, in education, the INEKO website links its effort to present school evaluations to the recent heated debate of wage increases in education. From the perspective of this report, this is an important observation, which potentially motivates debates on intersections between service user pressures and social dialogue:

*"INEKO considers a major wage increase of teachers to be a necessary condition for increasing and maintaining the quality of our education. At the same time, it is necessary to maintain its effectiveness at highest possible level and this is not possible without measuring output. We believe that publishing a user-friendly version of school performance evidence helps to shape the public discourse in the direction that our younger generations receive increasingly better education."*[57]

The initiative's potential for creating and extending user involvement pressure on the quality of education, incorporating themes of wages and working conditions as mentioned above, has been also recognized by the OECD:

*„In general, the OECD very much supports transparency in publishing results of external school evaluations conducted by inspectorates or other review bodies. Websites like yours have proven to sharpen and make more coherent external school evaluation reporting on individual schools and has heightened their impact on the school community."*[58]

In sum, in education just like in healthcare one of the relevant channels facilitating user pressures comes not from the users' organized interests, but through efforts of external actors - NGOs. These facilitate user legitimacy and motivate users to increase their involvement in shaping the quality of public services. In Arnstein's (1969) ladder of participation, the above NGO efforts facilites a shift from user information and placation (through formal user involvement structures) to recognize more active user pressure forms through public debates and competitive forces (parents choosing better performing schools). An increasing legitimacy of students/parents pressures by policy makers, but also by the schools concerned, is a key target in this process.

[57] Source: INEKO at http://skoly.ineko.sk
[58] Citation of Andreas Schleicher, Advisor to the Secretary-General on Education Policy, Deputy Director, OECD. Source: INEKO at http://skoly.ineko.sk/o-projekte/?k=4#k4.

### 3.2.4 User involvement at the Ministry of Education

Users of education cooperate with the Ministry of Education most commonly through its advisory bodies, which open an institutional space for user involvement at the highest level. The Ministry of Education recognizes the following advisory bodies:

- **Council for System Changes in Education** *(Rada pre systémové zmeny v školstve)*
- **Education Fourpartism** *(Školská štvorpartita)*
- **Curricular Council** *(Kurikulárna rada)*
- **Council of the Minister for Education of Minorities** *(Rada ministra pre národnostné školstvo)*
- **Council of Sport Representation of the Slovak Republic** *(Rada športovej reprezentácie SR)*

Based on OECD recommendations, *the Council for System Changes in Education* was established in mid-December 2012 by an incumbent minister for education Dušan Čaplovič, aiming to improve the quality of "system of education as a whole" (Ministry of Education 2012). Currently, the Council for System Changes has eleven members appointed by the Minister, who is also a head of the Council. According to the ex-minister and a founder of the Council, members do not represent any organization, but are experts from different spheres such as finance, economy, or public services.[59] Nevertheless, the current composition of the Council includes persons such as a president of the Student Council of High Schools of the Slovak Republic and a president of the Student Council for Higher Education. Even if they do not formally represent their home organizations, they certainly represent users' voice in the Council (Ministry of Education, 2014). Although evidence on the real effect of user pressures through the Ministerial councils is limited, we conclude that the institutional space that these councils offer for user pressures certainly have a future potential for improving user involvement from consultation and placation to formalized partnerships (Arnstein 1969). To reach this development, users themselves will have to seize opportunities to take a more active role in exercising user pressures through organized interests.

***The Curricular Council*** was established by the Act no. 245/2008 Coll., ("The Education Act"[60]) as an advisory body for content of education and training and state education programs. The Curricular Council is composed of experts for regional education, mostly of pedagogical background, with a president of the National Institute for Education (*Štátny pedagogický ústav*) serving as a chairman. For its specific nature, this advisory body does not have students or other end users of education as members.

Similarly, ***the Council of the Minister for National Education*** (established in April 2013) and ***the Council of Sport Representation of the Slovak Republic*** (established in January 2013) are composed of experts and at the same time representatives of national minorities and

[59] Source: http://www.minedu.sk/minister-dusan-caplovic-zriadil-radu-pre-systemove-zmeny-v-skolstve/
[60] Available in Slovak here: https://www.minedu.sk/zakon-c-2452008-z-z-o-vychove-a-vzdelavani-skolsky-zakon-a-o-zmene-a-doplneni-niektorych-zakonov-v-zneni-neskorsich-predpisov/)

experts in sport education, respectively. None of above mentioned advisory bodies has an end users (being it students or parents) among its members.

To conclude, interviews and desk research show that officially user involvement in education exists at three levels: institutional, sectoral and at the level of the Ministry of Education. The system of school self-governance can be considered as the most direct user involvement in education sector for its possible impact on policies within the school. The interviews and the desk research show that the regulation of the Ministry of Education stipulates the establishment of *school councils* in every high school, while the existence of *student councils* is not obligatory. While school councils do officially exist in every school, they are in some cases not active. At the same time, the survey of the Ministry of Education shows that student councils exist in only 58,4% of Slovak high schools.

At the sectoral level, youth organizations operate as civic associations and organizations and thus, it is not possible to "limit" their number. Student councils can be organized in one of the three organizations operating at the higher level. However, while the Student Youth Council of Slovakia is considered to be an actor in policy-making, the Student Council of High Schools cooperates with the Ministry of Education and union representatives more closely and thus have a potential impact on the social dialogue at the sectoral level through a different channel. Furthermore, there is no formal link among organizations at the national level: user organizations compete rather than cooperate with each other and tend to see themselves as representing different types of users.

## 3.3 Responses of social partners and consequences for social dialogue

In both sectors, direct interaction between user organizations and social partners remains marginal. Diverging interests between users and social partners (mainly trade unions), and also the fragmentation of interests on the side of trade unions as well as on the side of user organizations prevent a more intensive collaboration and user pressures on the social dialogue agenda.

In healthcare, all three trade unions claim that a more active patient voice would be highly beneficial for improving the quality of healthcare services. At the same time, this general support lacks a systematic approach and particular elements that trade unions would see possible and beneficial for service improvement. In fact, when it comes to the analysis of particular topics, evidence suggests that social partners and patient organizations diverge in their interests. This is most notable on two most important aspects in social dialogue – wages and working time issues. The stance of patient organizations towards trade unions campaigns on wage increases for doctors (2011) and nurses (2012) has already been discussed above. In working time issues, trade unions criticize and aim to decrease the high amount of overtime currently reported in healthcare. It is not clear whether patients would support this effort, because it is in the interest of patients to receive service without waiting periods, which operates against working time decrease. At a more in-depth level of engagement and interest analysis, patients would benefit from relaxed healthcare personnel instead of doctors working long shifts and potentially running the risk of mistreatment because of overworking.

However, the patient organizations in Slovakia currently base their argumentation on short-term interests and the face value of evidence. A similar argument applies to the issue of wages, when patients refused to support the doctors' wage increase claims because of not perceiving clear benefits to the patients.

The employers' side would also welcome a more active patient voice in shaping the quality of services. However, state hospitals admit that managements have tied hands and the strong trade union presence keeps the focus of social dialogue agenda in traditional domains.

It is a paradox that the ongoing corruption scandals in Slovak hospitals, which intensified in late 2014 and caused the resignation of the Minister of Healthcare and the Chairman of the Parliament, seem to facilitate a new window of opportunities for better user involvement structures and possibly also more interaction between social dialogue procedures and user involvement pressures. First, user involvement should be strengthened in hospital councils where the government declared to limit its influence.[61] Second, professional associations, most notably the Chamber of Nurses and Midwives, which played a key role in the nurses' wage rise campaign and continues its active engagement also in the social dialogue agenda, declared support for greater participatory governance in hospitals with the aim to introduce clear public procurement methods and avoid corruption.[62] All actors in social dialogue and user involvement seem to support a de-politicization of healthcare, which is a highly discussed issue in Slovakia. At the same time, political ties and interest-based funding of some organizations prevents them from active engagement in systemic changes.

In education, trade unions claim that the social dialogue agenda evolves mostly around 1) employment, 2) wages, 3) safety at work and 4) social security of employees. With this traditional view on social dialogue themes, trade unions see limited space for user involvement in sectoral social dialogue.[63] Nevertheless, trade unions support the view that the system of school self-governance offers an opportunity for users to enter institutional social dialogue. Unions as well as employers see the consultations between students and teachers or parents voice (expressed during meetings of parent councils) as the most visible form of user involvement.

Most commonly, students express their concerns and problems via day-to-day interaction with teachers and specifically during regular "class-hours" *(triednicke hodiny).* These are regularly scheduled meetings between a class and its teacher to discuss a variety of practical issues of class functioning. Although the issues discussed are often more about daily life of students in school rather than about traditional themes of social dialogue, a system of evaluation of teachers is an example of how students could influence one of the traditional themes of social dialogue – wages of teachers. The students satisfaction with the teaching process or individual performance of a teacher is however hard to quantify. Union representatives, employers and teachers expressed their concerns on whether a simple questionnaire would be sufficient.[64]

[61] Source: Pravda, http://spravy.pravda.sk/domace/clanok/336912-ministerstvo-prevetra-spravne-rady-nemocnic/
[62] Source: Pravda, http://spravy.pravda.sk/domace/clanok/336597-pre-komoru-sestier-sa-kauza-ct-odstupenim-pasku-nekonci/
[63] Source: interview EDU1.
[64] Source: interviews EDU1, 4, 7 and 11.

Currently a system of student evaluations that would be translated into a motivational bonus for teachers in gymnasia does not exists and teachers are paid according to tariffs for employees in public services.

Another way how users influence the themes of social dialogue in education is through public debate. In the 2012 debate over teacher's remuneration system that escalated in nation-wide teachers strike, an internal trade unions survey reported approximately 90% of public support for the unions. Consequently, backed by the strong public support, trade unions used the "user support" argument to strengthen their bargaining position. As a result, the government agreed to increase teachers' wages by 5%.

The common concern of social partners in terms of involvement of high school students is, whether they can be a relevant partner in professional discussions.[65] Students, often under the age of 18, are often seen as an "advisory group" rather than a group that should have formal representation in the education fourpartism. Given that the social partners see the bargaining process in education more as meetings on legislative changes proposed by the government and the Ministry, it is not surprising that high school students are not formally recognized as an official negotiating partner. The students' capacity to enter the formal discussion on education system is also questioned by the students themselves. As one interviewee maintains,

*"…unfortunately, we represent not only the intellectual, clever secondary school students, but also those less intelligent […].When you come to school and ask what decision would they [students] like to take, the first thing they want is to cancel the school. Yet when you give them the second question, how many of them want to go to college, all of them will raise their hands. So on the one hand, they want to abolish education, on the other hand they want to go to college. Those students themselves, those young people do not even know that they want to do."*[66]

# 4. Case studies

This section presents two case studies of user involvement in one hospital and one school and explores the link between user involvement and social dialogue at the establishment level.

The hospital selected as a case study is a state-operated large public hospital, which belongs to the group of relevant university and faculty hospitals that were spared of corporatization efforts. The hospital remains directly subordinated to the Ministry of Healthcare, which limits its self-governance and the development of formalized user involvement structures similar to those emerging in the corporatized hospitals. Despite that, the hospital actively seeks user feedback through a continuous patient survey, which has already yielded service improvements also in themes relevant for the social dialogue agenda. The hospital also has firmly anchored negotiation structures between the management and trade unions. Interviews

[65] Source: interviews EDU1, 2, 3 and 4.
[66] Source: interview EDU5.

in the case hospital were conducted in person by the authors. None of the key informants wished the interviews to be recorded, therefore, notes were taken during the interviews. Evidence collected in the interviews has been supplemented by the hospital's internal document evaluating the patient survey and listing improvement measures already adopted upon user pressure. The conducted interviews are listed in the Annex.

A high school from Eastern Slovakia – Gymnasium Šrobárova in Košice - has been selected for a case study because of an active exercise of user involvement through the school council. This contrasts with other cases wehere school councils may formally exist but do not exercise user pressure. Our case is further justified by the fact that the selected school is located in the Košice region, which documents the lowest number of gymnasiums with established student councils in Slovakia (see Table 13).[67] Interviews at the selected school were conducted in person by one of the authors, recorded and transcribed. In case the key informant did not wish to be recorded, notes were taken during the interview. The Annex presents the list of conducted interviews.

### 4.1 Hospital case study: the F. D. Roosevelt Hospital in Banská Bystrica

The F. D. Roosevelt hospital is located in the regional capital of Central Slovakia – the city Banská Bystrica. This hospital belongs to large public hospitals that were spared of corporatization processes during healthcare reforms and continue their operation under direct control of the Ministry of Healthcare. While hospital funding is channeled through payments by health insurance companies, state-run hospitals enjoy privileged access to bailouts in case of debt accumulation, which distinguishes them from smaller public hospitals that underwent corporatization in mid 2000s. This distinction is relevant for understanding hospital incentives to user involvement and to bargaining concessions in social dialogue processes.

The hospital was established in its current organizational form in 1990. Despite formal changes in it statute in 1995 and 2004, the hospital remains a public legal person. Since 2004 the Hospital's formal name is F. D. Roosevelt Faculty Hospital with Polyclinics Banská Bystrica. The hospital offers a wideranging scale of inpatient and outpatient services and offers services of highest professional quality in Slovakia in selected domains of care, e.g. robotic surgery.

The hospital also belongs to large employers. At the end of 2011, the hospital employed 2,142 employees.[68] The number of employees dropped to 2,066 at year-end of 2012. Employee fluctuation accounted to 8.8 per cent in 2013. The largest occupational group in 2012 was nurses, comprising 39.55 per cent and 16.51 per cent of the total staff employed, respectively. Employment characteristics show a trend of healthcare feminization, with 81 per cent of all hospital employees being women. The highest concentration of women is among the largest occupational group (nurses). The second relevant trend is a shift of the core of employment

[67] Source: interviews EDU9, 11 and 12.

[68] Hospital employment statistics and evidence on economic performance is based on the hospital's annual report for 2012, available at http://www.fnspbb.sk/index.php/spravy-o-hospodareni.html. The hospital published statistics on employment and economic performance in all its annual reports available on the website, except the latest year 2013, where this evidence is no longer available.

structure towards older age cohorts. Most employees are employed under standard employment contracts, with other forms of employment being marginal. Wage costs accounted to 32.99 per cent of total costs in 2010 and have increased to 33.84 per cent in 2012. This is due to a national legally stipulated wage rise of doctors and nurses, implemented in 2012.

In terms of economic performance, the hospital achieved a loss of almost 11.7 millions of EUR in 2010, 17.8 millions of EUR in 2011 and 12.7 millions EUR in 2012. In 2011, the hospital was bailed out from its debt by a state transfer of over 62 millions EUR, which in fact transferred the 2011 loss into a profit of 44.5 millions EUR. Debts of large public hospitals and politically motivated bailouts have dominated the debate of public management reforms in Slovakia. From the perspective of user involvement and social dialogue, it is important to state that hospitals directly controlled by the Ministry of Healthcare, such as our case study hospital, are motivated to pursue a different kind of user involvement policy and also possess different bargaining capacities vis-à-vis trade unions than smaller, corporatized hospital without access to state bailout.

### 4.1.1 Hospital governance structures and user involvement

The hospital's governance structure is determined by its organizational form. Under direct control of the Ministry of Healthcare, the hospital lacks formally established governing bodies with involvement of various stakeholders, including employees and potentially also service users. The hospital director is directly named by the Ministry and responsible to the Ministry. Addressing the quality of service provision is legally stipulated, but the Ministerial strategy for hospital performance does not offer exact guidelines on the implementation of quality control and relevant processes therein. Therefore, the hospitals' approaches and particular steps in monitoring/assuring service quality are not coordinated at the sectoral level.

The F. D. Roosevelt hospital ascribes a high role to the improvement of service quality and developed an internal system for monitoring the quality of services and patient satisfaction. The involvement of service users (patients) is seen by the hospital as a key input for the processes of quality improvement. Currently the dominant user involvement form is a continuous structured user survey on hospital service provision. Collective user involvement through patient organizations is marginal. The hospital representatives report cooperation with a patient organization League against Cancer (*Liga proti rakovine*), which sponsors a psychologist in the Oncological department. Other forms of direct interaction with patient organizations are ad hoc and irregular.[69]

Individual user involvement is channeled through several bodies that monitor and overlook the quality of service provision, namely, the Department of Quality, Department of Control, and the Quality Council. These bodies are exclusive to the establishment level and their operation is not coordinated with other bodies at the Ministry or other hospitals within the Association of State Hospitals (AŠN SR) of which the Roosevelt hospital is a member. The hospital also interacts with the Healthcare Surveillance Authority (ÚDZS) in patient-filed

[69] Source: interview HEALTH11 and 12.

complaints and requests that directly relate to the particular hospital. In the past five years the hospital developed its own internal user involvement mechanism through systematic feedback collection, evaluation and service improvement measures based on this evaluation. We present evidence on this system below.

The **Department of Quality** operates, supervises and manages the most important tool in the hospital's user involvement strategy – a continuous user satisfaction survey. Based on the evaluation of surveys the Department proposes and helps implementing systemic improvements in the hospital's healthcare provision. In contrast, the existence of the **Department of Control** is legally stipulated and deals with individual patient complaints from the perspective of hospital structure, economic processes, and work organization. Both departments interact with the **Human Resources Department**, especially when analyzing patient complaints and suggestions regarding personnel issues or changes in working time and work organization. However, institutionalized cooperation between Quality/Control departments and the HR department do not exist, the relationship is gradually being developed and is according to the interviewed representatives 'hard to establish' given the different focus of each departments' activities.[70] The hospital also operates a **Quality Council**, which serves as an independent advisory body to rule in cases of recurring patient complaints, e.g., against particular hospital employees. The next opportunity for user involvement is to some extent granted through the hospital's **Ethical Commission**. Internal members of this Commission may invite external stakeholders to join the commission's decision on an ad hoc basis. As an example, the Ethical Commission invited a religious representative to the decision concerning ethical principles in healthcare provision and biomedical clinical research. This is not a permanent user involvement platform, but has a potential role as an additional user involvement channel under the discretion of more formalized hospital governance structures.

As already mentioned, a direct interaction between the F. D. Roosevelt hospital and patient organizations is limited. Besides the single case of systematic (but small scale) cooperation in the Oncology Department, contact with patient organizations mostly occurs on ad hoc basis, e.g., when a particular organization supports fundraising or donor activities to supply medical equipment and technique to the hospital.

The hospital finds interaction with the UDZS a relevant feature in its own interaction with users and pressures for quality improvements. Upon individual patients requests to the UDZS that relate to the Roosevelt hospital, the UDZS requests hospital opinion and evidence. On the hospital side, it is the responsibility of the vice-director for healthcare and prevention to represent the hospital vis-a-vis the UDZS.[71]

From the above described channels and potential channels for user involvement, the most important one is the hospital's own survey of patient satisfaction, covering both inpatient and outpatient services. The methodology of the survey derives from a decree of the Ministry of

[70] Source: interviews HEALTH10, 11 and 12.

[71] We refrain from detailed evidence on the rulings of the UDZS vis-à-vis the Roosevelt hospital, which are available elsewhere (UDZS internal documents and the F. D. Roosevelt Hospital's Report on Evaluation of Patient Satisfaction [*Správa o hodnotení spokojnosti pacientmi*] (2013).

Healthcare for collecting quality indicators, as published in its 57th volume on 21.5.2009.[72] The survey uses the same 12 survey questions that are used by other establishments, most importantly, health insurance companies, in their patient surveys. The aim is to make future comparisons possible, although currently comparative initiatives are limited to the online tool developed by INEKO based on surveys of health insurance companies (see section 3.1.3 above). Among others, the survey questions comprise questions on the patient's views on employee behaviour (separately for doctors and nurses) and the quality of care experienced by doctors and nurses (again in separate survey categories). In 2013, the hospital collected 9,205 individual anonymous patient surveys, accounting for a 22.04% response rate vis-a-vis the number of completed inpatient care cases (thus not patients treated). Compared to year 2012 the response rate has improved by 0.32%. The hospital argues that achieving a higher response rate in the survey equips the hospital with additional power resources when negotiating contracts with health insurance companies.[73]

Evaluation of patient satisfaction is conducted separately for inpatient and outpatient care; and separately for various services, i.e., provision of healthcare, nursing services, and other hospital services (e.g., transport, catering, accomodation). The above-mentioned Departments for Quality and Control evaluate the survey results on an annual basis and identify opportunities for service improvement. In this regard, the survey does serve the purpose of user involvement pressure. Instead, it helps improving the service quality albeit without direct interaction of user organizations and the hospital. Hereby we confirm our earlier finding at the sector-level that the most efficient form of creating user pressure is without an organized involvement of users, but through a collection of individual user responses.

The survey analysis reveals several key areas of patient dissatisfaction, which overlap with the agendas of human resource management and social dialogue. These include long waiting times and inappropriate behaviour of individual doctors or nurses, which all relate to the theme of hospital working conditions. The hospital's report concludes that in the evaluation of nursing services, potential for improvement the service quality lies mainly in the increasing of average time devoted to the patient. This has direct repercussions for work organization (administrative tasks vs. patient care) and employment (pressure to hire more employees to increase the ratio between patients and nursing personnell). Based on user feedback and direct patient complaints (see Table 14), the hospital adjusted the employees' working time, and released a formal warning for inapropriate behaviour in 4 cases in 2014. The patient feedback did not lead to a dismissal of an employee in the past 5 years, but the interviewees recalled one dismissal case motivated by user pressures about 10 years ago.[74] In 2013, the user survey also informed the hospital's decision to improve medical coordination of outpatient services through creating a new job function in this area.[75] The hospital also attempted to address patient complaints on the quality of hospital catering and room equipment.[76]

[72] Source: Report on Evaluation of Patient Satisfaction [*Správa o hodnotení spokojnosti pacientmi*] (2013).
[73] Source: ibid, p. 2.
[74] Source: interviews HEALTH10, 11 and 12.
[75] Source: ibid, p. 9.
[76] In patients' assessment, the quality of hospital catering decreased in the past 4 years. Interestingly, in this period the hospital has outsourced its catering facilities, which became subject to a major corruption scandal across several public hospitals at the end of 2014. In result, the Ministry of Healthcare recalled four hospital directors, including the director of the Roosevelt hospital. Source: Transparency International Slovakia and media coverage (SME, Pravda).

**Table 14 Focus of patient complaints, F. D. Roosevelt Hospital, 2009 – 2013.**

| Focus of patient complaints | Number of patient complaints | | | | |
|---|---|---|---|---|---|
| | 2013 | 2012 | 2011 | 2010 | 2009 |
| Dissatisfaction with healthcare provision | 7 | 6 | 10 | 4 | 3 |
| Inapropriate behaviour of healthcare personnel | 2 | 10 | 14 | 6 | 17 |
| Dissatisfaction with work organization | 3 | 0 | 2 | 5 | 1 |
| Conflicts among employees at the workplace | 2 | 0 | 0 | 3 | 0 |
| Doctor on duty under the influence of alcohol | 1 | 0 | 0 | 0 | 0 |
| Inapropriate behaviour of an employee – hospital security (kategórie bezpečnostná a strážna služba spolu) | 2 | 1 | 2 | 0 | 0 |
| Long waiting lists for outpatient care | 0 | 0 | 0 | 1 | 0 |
| Lack of information provided to the patient regarding healthcare provision | 0 | 0 | 0 | 0 | 2 |
| Prioritizing selected patients in their access to healthcare | 0 | 0 | 0 | 0 | 2 |

The table includes only selected categories of patient complaints, relevant for exploring the overlap in themes of user involvement pressure and social dialogue. Selection by the authors.

Source: Internal analysis of the F. D. Roosevelt Hospital

Based on the above, we maintain that the hospital actively seeks user involvement through already established channels of involvement. Given the marginal role of organized user pressures through patient organizations, this is an important sign of emerging hospital-level user involvement. However, there persists a large power asymmetry between hospital management and user access to hospital governance, with the management keeping large discretion over transparency and extent of user involvement. The management wishes to improve its user involvement system and evaluation to align with its goal to be a ‚patient-oriented hospital'. However, the hospital feels limited in its efforts especially what concerns coordination and benchmarking across other state-run hospitals. Financial limitations to introduce an improved methodology for user involvement and evaluation are also a serious concern. The hospital aims to find a system that would increase the objectiveness of patient evaluations and allow avoiding or minimizing external factors (e.g. cultural factors behind patient complaints, or the fact that patients in different departments have different quality expectations). The hospital also remains critical towards the support of the Ministry and health insurance companies to introduce objective benchmarks and disclose performance indicators of all hospitals in order to stimulate their competitiveness. According to the interviewed representatives, evidence on hospital quality exists, but is not published, and stakeholders are generally satisfied with the current intransparent situation. The quality evaluations currently published by the Ministry set very wide standards, which almost all hospitals meet, and therefore hinder objective comparisons of quality of healthcare provision. In fact, state hospitals act as competitors vis-a-vis each other and therefore are not overtly keen on introducing transparent benchmarks of hospital quality evaluations. The extent to which this interest-based exlanation of the lack of hospital motivation to engage in deeper and comparative quality assessments through user involvement may be gradually altered because of the recent INEKO initiative (see section 3.1.3). The evaluation will be possible only in a few years.

In sum, the hospital sees value added in user involvement and voluntarily utilized individual user pressures to take improvement measures. However, remaining challenges are the definition of quality standards and benchmarking with other hospitals. The current benchmarks from the Ministry are too broad; and the reliability and objectiveness of surveys conducted by health insurance companies remain contested.

### 4.1.2 User involvement and social dialogue

Like other state-run hospitals, the Roosevelt hospital has a developed system of social dialogue and collective bargaining. Besides establishment-level negotiations with two trade unions (SOZZaSS and LOZ), the hospital is covered by multi-employer bargaining and collective agreements through its membership in the ASN SR employers' association. Currently no direct interaction between the social dialogue and user involvement channels exist, and the interviewed stakeholders do not see topic of common interest emerging in the near future. The hospitals' head of HR department remains skeptical about patient involvement in shaping the processes and agenda of social dialogue.[77] The reasoning behind this perspective has several motives.

First, the interests of trade unions are distinct from the interests of patients, as confirmed also in other interviews. Although unions would in general welcome more interaction with patient organizations, they do not have particular ideas on how this cooperation could work and what common goals it could follow.[78] Moreover, the activity of organized patient organizations in the Roosevelt hospital is marginal.

The second reason of the missing link between social dialogue and user involvement is a purposeful interest of the hospital management to keep the two channels of influence distinct. While the hospital aims to strengthen the user involvement channel, it expresses that *'patients should not realize there is social dialogue going in on in the hospital'*.[79] This effort is indirectly supported by the action of the establishment-level trade union (hospital base organization of the sectoral SOZZaSS), which, in the eyes of the hospital's HR representative, have based their argumentation in collective bargaining on patients' satisfaction. Moreover, it is impossible to evaluate whether patient satisfaction could indeed be an objective driver of trade union interests. As an example, the management was not able to evaluate whether the trade unions' pressure for increasing the number of employees in a particular department was motivated by patient satisfaction or by employee interests to decrease their own workload.

Acknowledging the principally diverging interests that prevent the interaction between the social dialogue and user involvement channels of influence on the quality of healthcare provision, the next possibility of exploring the link between social dialogue and user involvement is through themes or topics relevant for patients as well as to social partners. A performance-pay based on patient satisfaction is a key theme here. While trade unions as well

[77] Source: interviews HEALTH9 and 10.
[78] Source: interviews HEALTH3, 10 and 13.
[79] Source: interview HEALTH9 and 10.

as the hospital management support an introduction of such a performance-pay scheme, until now they were not able to develop an objective measurement tool that would reflect the criteria for patient satisfaction.[80] Therefore, we conclude that the current state of social dialogue remains largely without user involvement pressures, with the two channels operating distinctly and without overlapping themes and interests. Work organization and a performance-pay system however resemble themes that emerge as relevant in both channels of influence, and will possibly help establishing more cooperation between the user involvement channel and the social dialogue channel in the future.

## 4.2 School case study: Gymnasium Šrobárova Košice

The Gymnasium Šrobárova is located in the city of Košice, the largest city in Eastern Slovakia and the second largest city in Slovakia after the capital Bratislava. The school was built in 1892-1896 and in its 122 years of history underwent several transformations from a school for girls to a gymnasium focused on general 4-year secondary education. Currently, there are 22 classrooms with more than 700 students (the average number of students in gymnasia is 329[81]) who can choose from classes with different specializations such as natural sciences, humanities, mathematics, physics and informatics or bilingual English and German classes. There are 43 teachers employed at the gymnasium and 15 non-pedagogical employees. The average age of a teacher is 47.3 years.[82]

### 4.2.1 The school's governance structure and user involvement

The Gymnasium Šrobárova has all three structures of school self-government present: the student council, the parents' council and the school council (see Table 15). In addition to these bodies, there is a Club of Friends of Šrobárka *(Klub priateľov Šrobárky)*, operating as a civic organization. Through this organization, supporters can contribute financially to the development of the school.

**Table 15 The system of school self-governance at Gymnasium Šrobárova, Košice**

| Platform | Number of members | Composition |
|---|---|---|
| The School Council | 11 | 2 pedagogical employees<br>1 non-pedagogical employee<br>3 parents representatives<br>1 student representative<br>4 representatives of a self-governing Košice region (higher territorial administrative unit ) |
| The Parents Council | Approximately 20 members | Parents representatives |
| The Student Council | Approximately 20 members | Students of a school |

Source: authors' own compilation

[80] Source: interviews HEALTH 9, 10 and 11.
[81] Source: Herich, J. (2013) Prognóza vývojaukazovateľov gymnázií do roku 2025, available: http://www.uips.sk/sub/uips.sk/images/JH/prognoza_g13.pdf
[82] Source: Hodnotiaca správa výchovno-vzdelávacej činnosti, jej výsledkoch a podmienkach školy za rok 2013/2014, available: http://rozne.srobarka.sk/zast/doc/sprava20132014.pdf

**Student Council**

The Student council at the Gymnasium Šrobárova became active in last two- three years. Although previously existing, its activities became visible only recently. The student council has no official statutes. Interestingly, the reference on its roles is stated in the school's Code of Conduct, signed by the director on September 1, 2014.[83] To give a few examples of student council activities, among their recent successes is organization of a highly attended masquerade and a creation of a student clubroom. The director of the school ascribes this increased activity to a particular type of student personalities that study at the Gymnasium. Moreover, contributing factor to the increased student council's activities is its coordination done by a young, enthusiastic teacher.[84]

**Parents Council**

Individual parents meetings at the level of classes are organized three to four times per a school year. Each parents meeting at the level of class elects its representatives to all-school parents council. This council then meets regularly every month. The attempt to cooperate with students is visible from the minutes of the last meeting from 6.11. 2014:

*"The Parents Council invites for each next meeting representatives of students and welcomes suggestions, ideas and requests directly from them."*[85]

**School Council**

The School Council is the highest control organ of the Gymnasium that *"gives an opinion on all significant aspects that relate to the work of the school."*[86] The Council has eleven members and the representatives of parents are elected in direct election by all parents of the Gymnasium. According to interviewees, student representatives are also elected by all students and not just by the student council, as stipulated in the Act No. 596/2003 Coll. The Director of the Gymnasium has no official role in the school council. Nevertheless, according to his own words he regularly attends the meetings:

*"There was one gymnasium where this [attending the meetings of school council] was a problem, but in our school there is a dialogue in this regard."*[87]

The School Council meets four times per year and amongst its most important functions are the election of the director of the Gymnasium and the right to comment on the budget proposals. The latter was criticized by few interviewees, since the budget proposal was so far never submitted on time. The composition of the Council suggests that students, parents, employees and representatives of the Kosice higher territorial unit enjoy an equal distribution

[83] For the roles of student councils, see again the chapter on user involvement in education. The Code of Conduct is available here: available at: http://rozne.srobarka.sk/zast/doc/vp20142015.pdf
[84] Source: interview EDU7.
[85] Source: http://www.srobarka.sk/zr201411/
[86] Source: Statutes of the School Council, http://www.srobarka.sk/rsstatut/
[87] Source: interview EDU7.

of powers. However, when it comes to the election of the director, additional representatives of the higher territorial unit are invited to vote, thus leaving the founder (referred to as "outsiders" by the interviewees) deciding on the most important managerial function at the gymnasium.

**Cooperation with the higher territorial unit**

Via its organization - the Centre of Leisure Time (CVC) – The regional Centre for Youth, the higher territorial administrative unit supports the student councils in the region since 2006. The Centre regularly organizes workshops for the representatives of student councils as well as their coordinators. In document titled "The Action Plan for working with Youth of Kosice self-governing region for 2015-2016" the Centre admits that it failed to unite the student councils into a unified regional unit:

*"Despite the fact that we were able to support several members of student councils in the establishment of Regional Council of student school councils, its functioning was successful only in a short period of time and was not continuous. We also lacked the identification with the mission of the Regional Council of student school councils."*[88]

### 4.2.2 User involvement and social dialogue

The example of how students and their parents at the Gymnasium Šrobárova can influence employment relations at the level of an institution is a case of dismissed teacher, whose contract was terminated on the initiative of parents and students. First, students seeked the support of their parents in order to express a stronger voice, who then channeled their concerns about the quality of education process to the director. According to an interviewee, the credibility of student voice increases when supported by parents. In other words, *"[w]hen parents push, it is easier to change something. Everything that students want to change is very difficult to enforce."*[89]

This supports our argument that high school students (maybe because of their age) are often seen as not so relevant partners for discussions. Concerning other issues such as wages of teachers, a trade union representative expressed her belief that students of the Gymnasium as well as their parents supported teachers in 2012 nation-wide teachers' strike. Given the fact that wages are set at the national level with little maneuvering space at the institutional level, this user support has only a marginal effect on both social dialogues at the institutional and sectoral level. Similarly as observed from the discussions with social partners at the sectoral level, interviewees from the Gymnasium named daily teacher-student interaction as one that may have potential impact on the type of questions that are set on the table during collective bargaining.

[88] Source: The Action Plan for Working with Youth in Kosice Higher Territorial Unit for 2015-2016, http://web.vucke.sk/files/skolstvo/ap-prace-mladezou-2015-2016.pdf
[89] Source: interview EDU8.

In sum, Gymnasium Šrobárova represents a positive example of the school from the region with the lowest number of voluntarily established student councils, where all three levels of school self-government are active and functioning: student council, parents council and school council. Based on the interviews with representatives of employees and students, those organs are not only formally created but increasingly active in recent years (especially the student council). The system of school self-government in the Gymnasium Šrobárova offers a possibility for users to influence social dialogue at the establishment level. The elected representatives of students and parents are members of School Council that, in contrast to some other schools in the region, regularly meets and fulfills its formal roles. Via the School Council, students and parents can vote on candidates for director of the Gymnasium and thus indirectly influence management of their school.

# 5. Conclusions

User involvement in Slovakia experienced growing significance only in the past 10 years when the country embarked on stabilized economic growth following a turbulent transition period from state socialism to democracy and market economy after 1989. While education inherited the foundations of a user involvement structure from state socialism, user involvement processes with potentially greater impact on the quality of education were institutionalized only in late 2000s with the establishment of school self-governance. In healthcare, a user involvement structure is gradually developing along the challenge of overcoming the direct state rule in hospital functioning prior to the regime change in 1989.

The aim of this report is to provide evidence for developments in user involvement and its effects on the quality of public services. The focus is on actors, structures and interaction between user involvement and more traditional channels of interest representation through social dialogue. The concluding section also aims at presenting the main findings withing the analytical framework of Arnstein's (1969) ladder of citizenship participation, focusing on the outcomes of user involvement pressures.

Recalling the terminology of Arnstein (1969), we assess the Slovak experience of sector-level user involvement as *consultation* in healthcare and *placation* in education. *Consultation* in healthcare refers to little feedback and policy influence of users. With lacking formal structures and real outcome-oriented procedures of user involvement in healthcare, the voice of users does not play a significant role in policy making when compared to the voice of business and employee interests. In contrast, identifying user involvement in education as *placation* means that formal structures for involvement exist at the sector level with the involvement of user representatives, but their real input for policymaking remains contested. The main characteristics comparing our findings in the education and healthcare sectors are summarized in Table 16.

**Table 16 Main characteristics of user involvement pressures in Slovakia**

| **Interrupted institutional developments to user involvement** |
|---|
| The long-term developments in the (lack of) user involvement were interrupted by the regime change from state socialism to democracy and market society. |
| **Diversity in institutionalized collective user involvement structures** |
| The two sectors studied – health and education – resemble great differences in levels of collective user involvement structures. These differences derive from the continuity of institutional developments before and after 1989 in education and the lack of such continuity in healthcare. |
| **Dominance of individual user involvement structure preempts collective user involvement** |
| The underdeveloped system of formal user involvement, especially in healthcare, can be partly explained by the establishment of the national structures that facilitate individual user involvement in shaping the quality of public services. This is one of the factors that preempt the increasing role of organized user involvement through user associations. |
| **User pressures without user involvement** |
| A relevant push to user involvement pressures comes from external actors. With the aim of improving service quality and transparency in public services, external NGOs facilitate an increase in individual user pressures without a direct involvement of organized user associations. |
| **User involvement and social dialogue: an interest-based explanation** |
| Some user involvement platforms in the education sector directly bring together representatives of end users and social partners, whereas a similar trend does not apply to healthcare where user involvement and social dialogue remain distinct channels of influence. The diversity of interests of employers, trade unions and users is the main obstacle of the weak link between user involvement and social dialogue.<br>The relevance of '*user pressures without user involvement*' for social dialogue is that such efforts motivate users to seize opportunities from their voice, feedback and influence also on themes relevant in social dialogue, i.e., working time and work organization in schools and hospitals. Users are motivated to understand that improvements in service quality develop hand in hand with improvements in wages and working conditions of service providers. |

Source: the authors

In the remainder of the report we seek to evaluate the above findings along the lines of four research questions listed below:

1. How is the pressure of service user involvement (if any) altering which actors are represented directly/indirectly within the system of social dialogue?
2. To what extent has an emphasis on service user engagement encouraged new forms of direct user involvement and what are the implications for traditional representative voice?
3. How is the scope of social dialogue changing? In what ways has the agenda of social dialogue changed and are the concerns of service user compatible with the interests of the social partners?
4. What are the consequences for the social partners and workplace practice of these new challenges?

### User involvement pressure and actors

User involvement has been gradually increasing in Slovakia, however, remains of limited

importance for public service quality and for social dialogue processes. Marginal improvements relate to the emergence of new actors and structures (breadth) rather than processes based on user pressures that would have a significant impact on service quality (depth).

In the past two decades, user involvement in education did not witness the significance of new actors emerging, the dominant trend being the transformation and redefinition of roles of the inherited structure of user involvement councils and the formation of the school self-governance system.

In the healthcare sector, user involvement has been shaped by the challenge of overcoming the direct state rule in hospital functioning from time periods before 1989. In consequence, user involvement in healthcare saw the emergence of new actors since mid 2000s. The extensive healthcare reform, focusing mainly on NPM-oriented hospital corporatization, facilitated some room for user involvement e.g. in hospital governance systems of corporatized hospitals. This opportunity has been utilized only marginally, and a collective interest representation of users remains underdeveloped both at the hospital and sector levels.

We conclude that user involvement pressures had a negligible effect on actors in social dialogue at both sector and establishment levels. Separate actors represent the interests of users and of employees and employers; with a marginal and indirect overlap in the interest of these groups.

**Forms of user involvement pressures and implications for social dialogue**

We locate the current forms of user involvement in healthcare at the level of *consultation* (Arnstein 1969), without extensive user involvement structures and impact on social dialogue and service quality. A preoccupation with NPM reforms in healthcare brought new opportunities for user involvement both at the sector and the establishment levels. At the national/sector level, reforms incorporated the policy makers‘ goal to an active promotion of patient feedback through the Healthcare Surveillance Authority (UDZS). This step resembles a creation of user involvement in a top-down perspective. The existence of UDZS motivates individualistic forms of voice and has preempted collective user voice in healthcare. At the establishment level, the first years after hospital corporatization reforms rent-seeking behavior and political nominations dominated hospital governance structures. A new impetus to improve user involvement comes from 2014 corruption scandals in hospital governance. The pressure of public and trade unions has pushed the government to propose reforms in governance structures with more room for users and other stakeholders. This indirect and delayed effect leads to a hypothesis that indeed NPM reforms enhance user involvement. This hypothesis will have to be tested in future research.

In education, the forms of user involvement are more stable are underwent less turbulences than in healthcare. The introduction of education self-governance in mid 2006 has been the most important impetus for user involvement. However, in terms of Arnstein’s (1969) framework, the extent and form of user involvement stays at the level of *placation*, where

formal involvement structures exist but real processes and visible outcomes of user involvement are illusory.

Finally, we found that since 2012 user involvement pressures receive a great push upon the initiative of third actors, namely, from NGOs aiming at transparency and quality improvement of public services. These NGOs aim at increasing user pressure through accessible comparative analyses of service quality through publishing micro-level evidence on individual user responses. We have called this initiative 'user pressure without user involvement', because it develops without direct involvement of user representatives or any organized action of users. The effect of this initiative on social dialogue is currently indirect and limited. However, such external initiatives motivate public debate on the quality of schools and hospitals and a better understanding among users of the connection between service quality and working conditions in schools and hospitals. These findings lead us to formulate a hypothesis for future research: user pressure push from third parties improves opportunities to shift user involvement from *placation* to real *partnerships* within governance structures of schools and hospitals (c.f. Arnstein 1969). The extent to which partnership develops will depend on the users' capacities to seize opportunities from external pressures, and from their interaction with social partners and policy makers.

**Changing scope of social dialogue agenda and (in)compatibility of interests**

The scope of social dialogue agenda did not undergo major changes, focusing largely on the traditional issues of wages, working time and other working conditions. The pressures of user involvement have a marginal impact on this agenda. A divergence of interests between social partners and user representatives is a key issue in understanding the reasons of limited interaction. Different user organizations see themselves as representing different types of users. Such structural fragmentation motivates competition among user interests rather than a sector-wide cooperation of users; and leaves a formalized and functioning system of user involvement through collective interest representation of users underdeveloped.

In education, the fragmentation of interests becomes visible through the lack of legitimacy and recognition that user organizations receive from other actors in social dialogue and policymaking. In other words, users are often not seen as legitimate partners for influencing the themes of working conditions and service quality.

In healthcare, users are considered legitimate, but a divergence in interests accounts for little interaction. Hospitals prioritize economic performance, employees/trade unions wage growth and patients the quality of service. Moreover, patients are weakly organized and all user involvement happens at the micro-level through individual (although systematically organized) feedback mechanisms. Trade unions rarely use the argument of 'patient benefit' in their reasoning, and even if they do, it is hard to evaluate whether union interests are informed by patient interests or their own interests (e.g., when negotiating new hospital jobs – unclear whether this is to patients' satisfaction or to decrease workload for current employees). Our hospital case study also documented that the employer's interest is to prevent a closer interaction of social dialogue and user involvement pressures/channels/feedback.

To reach more interaction between social dialogue and user involvement pressures, we argue that first the interests of involved actors should converge, whereas the current trend shows divergence.

**Consequences for social partners and workplace practices**

Evidence from Slovakia shows that social partners view user organizations neither as allies nor as competitors. Their channels of influence remain separate, however, we have documented several relevant cases of indirect influences of service user pressures on social dialogue and the quality of working conditions. In general terms, trade unions would welcome more support from user organizations. This also holds for user organizations welcoming support from trade unions, albeit their direct interaction remains marginal. Employers engage in closer interaction with users (individually or through user organizations), but their interests do not clearly align with the interests of users. Our hospital case study has shown that employers even try to prevent an increasing interaction between the user pressure channel and the social dialogue channel.

In sum, user involvement pressure has a marginal impact on social dialogue processes and agenda at the sector level. At the establishment level, where the user involvement is less formalized and structured, indirect influences on social dialogue can be observed because of closer direct or indirect interaction between the users with school and hospital representatives. Such interaction varies from *modest formalization* (the quality system through user feedback survey in the case study hospital) to *limited formalization* (direct interaction of users with teachers in the case study school).

The impact of service user pressures on working conditions remains indirect, but more relevant than the impact on social dialogue processes. This is because user feedback often addresses themes of work organization, which are directly perceived by users in each sector. Our case studies report cases when work organization has been adjusted upon user pressures and employer interest to undertake such adjustments.

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No. 2, pp. 1-200.

# Annex: List of interviews

| Label | Sector | Level | Respondent category | Organization name | Interview respondent position | Date of interview | Interview proceedings |
|---|---|---|---|---|---|---|---|
| EDU1 | Education | Sector | Trade union | Odborový zväz pracovníkov školstva a vedy na Slovensku *(Trade Union of Workers in Education and Science of Slovakia)* | President | May 25, 2014 | Recorded, transcribed |
| EDU2 | Education | Sector | Government | Inštitút vzdelávacej politiky, Ministerstvo školstva, vedy, výskumu a športu Slovenskej republiky *(Institute for Education Policy, Ministry of Education, Science, Research and Sport of the Slovak Republic)* | Director | August 13, 2014 | Recorded, transcribed |
| EDU3 | Education | Sector | Government | Inštitút vzdelávacej politiky, Ministerstvo školstva, vedy, výskumu a športu Slovenskej republiky *(Institute for Education Policy, Ministry of Education, Science, Research and Sport of the Slovak Republic)* | Analyst | August 13, 2014 | Recorded, transcribed |
| EDU4 | Education | Sector | Government | Ministerstvo školstva, vedy, výskumu a športu Slovenskej republiky – Sekcia regionálneho školstva, Odbor stredných škôl *(Ministry of Education, Science, Research and Sport of the Slovak Republic – Regional Education Division, Department of Secondary Education)* | Head of Department | October 23, 2014 | Recorded, transcribed |
| EDU5 | Education | Sector | Users | Študentská rada stredných škôl Slovenskej republiky *(Student Council of High Schools of the Slovak Republic)* | President | July 16, 2014 | Recorded, transcribed |
| EDU6 | Education | Sector | Users | Stredoškolská študentská únia Slovenska *(Union of High School Students of Slovakia)* | President | September 10, 2014 | Recorded, transcribed |
| EDU7 | Education | Case study | Employee | Gymnázium Šrobárova 1, Košice | Director | October 7, 2014 | Recorded, transcribed |
| EDU8 | Education | Case study | Employee | Gymnázium Šrobárova 1, Košice | Teacher, vice-president of the School Council and coordinator of the Student Council | October 7, 2014 | Recorded, transcribed |
| EDU9 | Education | Case study | Employee | Gymnázium Šrobárova 1, Košice | President of the School Council | October 7, 2014 | Recorded, transcribed |

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|---|---|---|---|---|---|---|---|
| EDU10 | Education | Case study | User | Gymnázium Šrobárova 1, Košice | Student and vice-president of the Student Council | October 7, 2014 | Recorded, transcribed |
| EDU11 | Education | Case study | Trade union representative; Employee | Gymnázium Šrobárova 1, Košice; Odborový zväz pracovníkov školstva a vedy na Slovensku (OZPSV) *(Trade Union of Workers in Education and Science of Slovakia)* | Teacher and trade union representative | October 7, 2014 | Notes |
| EDU12 | Education | Case study | Employees | Gymnázium Šrobárova 1, Košice | Two teachers | October 7, 2014 | Personal communica-tion, notes |
| EDU13 | Education | Sector | Former employee | Former teacher (elementary and secondary school, Rožňava) | One former teacher | November 15, 2014 | Personal communicatio n, notes |
| HEALTH1 | Healthcare | Sector | Trade union | Lekárske odborové združenie (LOZ) *(Trade Union Federation of Medical Doctors)* | President | June 3, 2014 | Recorded, transcribed |
| HEALTH2 | Healthcare | Sector | Trade union | Odborový zväz sestier a pôrodných asistentiek (OZSaPA) *(Trade Union Federation of Nurses and Midwives)* | President | May 30, 2014 | Recorded, transcribed |
| HEALTH3 | Healthcare | Sector | Trade union | Slovenský odborový zväz zdravotníctva a sociálnych služieb (SOZZaSS) *(Slovak Trade Union Federation of Healthcare and Social Work)* | President; international coordinator; legal advisor (group interview) | June 2, 2014 | Recorded, transcribed |
| HEALTH4 | Healthcare | Sector | Users | Slovenský pacient *(The Slovak Patient)* | President | June 26, 2014 | Recorded, transcribed |
| HEALTH5 | Healthcare | Sector | Expert | *Independent health policy expert, without affiliation* | Independent; former vice-president of the Healthcare Surveillance Authority | June 24, 2014 | Recorded, transcribed |
| HEALTH6 | Healthcare | Sector | Users | Asociácia na ochranu práv pacientov *(Association for the Protection of Patients' Rights)* | President | June 24, 2014 | Recorded, transcribed |
| HEALTH7 | Healthcare | Sector | Users | Asociácia na ochranu práv pacientov *(Association for the Protection of Patients' Rights)* | Legal and strategy advisor | June 24, 2014 | Recorded, transcribed |

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|---|---|---|---|---|---|---|---|
| HEALTH8 | Healthcare | Sector | Employer | Asociácia štátnych nemocníc Slovenskej republiky (AŠN SR),<br>*(Association of State Hospitals of the Slovak Republic)* | AŠN representative and head of HRM Department at the Roosevelt Hospital | Feb.28, 2014 | Notes |
| HEALTH9 | Healthcare | Sector | Employer | Asociácia štátnych nemocníc Slovenskej republiky (AŠN SR)<br>*(Association of State Hospitals of the Slovak Republic)* | AŠN representative and head of HRM Department at the Roosevelt Hospital | June 2, 2014 | Notes |
| HEALTH10 | Healthcare | Case study - hospital | Employers | Fakultná nemocnica s poliklinikou F.D. Roosvelta v Banskej Bystrici<br>*(F. D. Roosevelt Hospital in Banská Bystrica)* | Head of Deparment – HRM | July 3, 2014 | Notes |
| HEALTH11 | Healthcare | Case study - hospital | Employers | Fakultná nemocnica s poliklinikou F.D. Roosvelta v Banskej Bystrici<br>*(F. D. Roosevelt Hospital in Banská Bystrica)* | Head of Department – Quality | July 3, 2014 | Notes |
| HEALTH12 | Healthcare | Case study - hospital | Employers | Fakultná nemocnica s poliklinikou F.D. Roosvelta v Banskej Bystrici<br>*(F. D. Roosevelt Hospital in Banská Bystrica)* | Head of Department – Control and Complains | July 3, 2014 | Notes |
| HEALTH13 | Healthcare | Case study - hospital | Trade Union | Fakultná nemocnica s poliklinikou F.D. Roosvelta v Banskej Bystrici; Slovenský odborový zväz zdravotníctva a sociálnych služieb (SOZZaSS);<br>*(F. D. Roosevelt Hospital in Banská Bystrica; Slovak Trade Union Federation of Healthcare and Social Work)* | Trade union representative, hospital-level | July 3, 2014 | Notes |


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