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Collective bargaining and the changing governance of hospitals: A comparison between United Kingdom, Italy and France

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In the face of growing budgetary pressures and changes in demand for both the volume and quality of the health care, public authorities across Europe have moved to reform the organization and governance of publicly-provided care through hospitals. In all countries these reforms have been strongly influenced by the 'New Public Management' (NPM) approach, though not in a uniform manner. The paper identifies four key processes shaping the directions of the reforms: managerialization, corporatization, marketization and privatization. It then explores the implications for collective bargaining and other workforce governance arrangements in hospitals providing publicly funded health care in the United Kingdom, Italy and France. Drawing on the findings from coordinated studies of developments over the past two decades in the three countries, but with a focus on the 2000s, two sets of questions are addressed. First, to what extent have hospital reforms prompted changes in arrangements for collective bargaining and/or other workforce governance mechanisms? Second, what is the resulting direction of change in the mechanisms of workforce governance? How far has the embrace of 'new public management', which aims to propel the organization, management and provision of public services towards private sector practice, resulted in workforce governance arrangements which also more closely resemble those found in the private sector? And how do political contingency and actors' interests and responses impact on this dynamic?

The first section identifies the main processes characterising reforms to publicly provided hospital care, and the implications for collective bargaining and other mechanisms of workforce governance. In the second part we introduce the design of, and methods utilised in, the research. The third part establishes the trajectories of change in hospital governance in the three countries, whilst the fourth examines the implications of the respective reforms for the governance of health workforce through collective bargaining and other mechanisms. The final section discusses the findings and draws conclusions.

Reform of hospital health care provision and implications for employment regulation: mapping the field

Health care provision through hospitals is confronted by a number of medium-term pressures, which reach across the countries of the EU. These include the ageing population, and associated growth in both acute and chronic health problems requiring care; new demands for health care as medical technologies improve and the range of available treatments increases; growing attention to the quality of care; and budgetary / financial constraints, which are becoming even tighter as a consequence of the financial and economic crisis (Méhaut et al. 2010; Weber and Nevala 2011).

According to Méhaut et al.'s (2010) study of five west European countries, and the US, hospitals have responded to these challenges in similar ways. First, through efforts to increase patient throughput including by shifting post-operative care and rehabilitation outside of hospitals, development of outpatient facilities as well as improvements in medical technology requiring shorter in-hospital stays. Reflecting this, they document a reduction in beds per 1000 patients between the mid-1990s and mid-2000s across countries of around 15%. Second, through initiatives to reform funding arrangements, involving the introduction of principles under which hospitals are funded according to a set of fixed average prices for each hospital activity even though the actual cost incurred by a given hospital may differ. This forms part of a wider shift, the timing of which varies across countries, towards a quasi-market regulation of hospital care provision associated with the doctrine of 'new public management' (NPM) (Pollitt and Bouckaert 2004).

Through the introduction of market-oriented mechanisms of governance, NPM aims to render the mode of operation and delivery of public services more similar to the private sector (benchmark) model. Bordogna (2008b: 383) identifies a number of 'doctrinal components' to NPM including: an increase in the discretionary power and control exercised by senior management over organizations; the implementation of formal, measurable standards of performance in place of previous reliance on professional norms and expertise; mechanisms of performance control based on outcomes / outputs in place of those based on inputs and/or processes; disaggregation of organizational units and decentralisation of provision; introduction of contract-based competition for provision of services, and associated scope for privatization of service provision; adoption of a private sector management style; and 'greater discipline and parsimony in resource use, including human resources' (p383).

The diffusion of these NPM precepts into the governance of hospital care provision is discernible in four main trends, which vary in extent and differ in timescale across countries (Méhaut et al. 2010; Weber and Nevala 2011). *Managerialization*, or the adoption of private sector management techniques in place of professional conventions, relates to the first three components of NPM identified by Bordogna. *Marketization* refers to the adoption of fixed average price funding principles, and the fostering and spread of contract-based competition for service provision. *Corporatization* builds on the disaggregation of organizational units and the decentralisation of decision making through formalising greater hospital autonomy by granting them independent legal status. Finally, *privatization* refers to growing scope for private providers in the provision of hospital care.

The ramifications of NPM-inspired reforms to hospital health provision for the regulation of employment are considerable. Bordogna (2008b) contends that because of the labour intensive nature of the hospital sub-sector, and its high levels of union membership density and organization, the implementation of public service reforms consistent with NPM doctrine cannot be realised unless public service employment relations are simultaneously reconstructed. This entails confronting the traditional approaches to public service employment regulation embodied by the 'sovereign' and 'model' employer approaches (Bach and Kessler 2007), respectively, and replacing them with arrangements which resemble those found in the private sector. Under the 'sovereign' employer model, evident to greater or lesser extent amongst many continental western European countries and also in central Eastern Europe, public service workers - often with special, privileged employment status - are subject to unilateral employment regulation by state authorities, either administrative or legally-based. Under the 'model' employer approach, which prevails in Italy and the UK, encompassing collective bargaining is promoted by the state as the preferred means of employment regulation. In short, changes to institutional arrangements for workforce governance are a necessary condition for the implementation of hospital health-care reform, and these will be greatest where NPM-inspired reform initiatives have been most extensive (Proposition 1).

What direction are these changes likely to take? Bordogna (2008b) spells out the implications of NPM doctrine for the two traditional approaches to employment regulation. First, a decline in the share of public service employees with special employment status, with the implication that, second,

– in those countries where the sovereign model has prevailed hitherto - voluntary collective bargaining becomes the main mechanism of employment regulation at the expense of legally- and administratively-based forms of unilateral regulation. Third, collective bargaining will be under pressure to become more decentralised, in order to become responsive to organizational needs. Fourth, at the same time, public policy preference for collective bargaining under the ‘model’ employer approach is likely to wane and thereby erode the implied support for trade unionism in favour of the assertion of managerial prerogative. In sum, workforce governance arrangements in hospitals providing publicly-funded care will tend to converge on those prevailing in the private sector in a given country (Bach 1999) (Proposition 2A).

Institutional arrangements governing employment regulation in the hospitals sub-sector in each country differ (Grimshaw et al. 2007), in part reflecting national-level, economy-wide differences in collective bargaining institutions and in part reflecting differences in the organization of hospital care provision (see below), and hence intervene in the relationship between NPM-inspired reforms to hospital care provision any consequent / associated reconstruction of employment regulation. The countries where most or some employees in hospitals enjoy special employee status, such as France and Germany, are also amongst those where institutional arrangements for the sub-sector are integrated into a wider framework for setting terms and conditions in the public sector. Typically, where the provision of hospital services is organised around multiple (public and private) pillars, then these different pillars are covered by different collective bargaining (or other) arrangements. Reflecting this, different associations of employers organise the respective pillars, and engage in the relevant negotiations. Such differentiation on the union side is not so evident, with the same unions organising in both the public and private segments in some countries, such as France and Italy. Coordination across these differing bargaining arrangements is more apparent in some countries, including France, than others, including Germany. Multi-employer bargaining arrangements are substantially more encompassing in their workforce coverage than single-employers ones. Where the ‘sovereign’ employer model does not apply the former characterise the public hospitals sector in all western European countries concerned, but there are differences in the private pillar with multi-employer arrangements in many of the relevant countries, including France and Italy, but single-employer ones in Germany. Single-employer arrangements amongst public hospitals are found amongst some central eastern European countries. Under multi-employer bargaining, scope for further negotiation at lower levels varies (considerable in Denmark, less so in Italy and the UK, highly constrained in France).

Empirical evidence for the wider public sector provides a mixed picture in terms of the emergence of private-sector type forms of workforce governance under the pressure of NPM-inspired reform measures (Bach 1999; Bordogna 2008a, 2008b). Differing institutional arrangements are not the only factor accounting for these variegated outcomes: ‘political contingency’ (Ferner 1988) and actor strategies also intervene. Bordogna (2008b: 385) identifies some inherent limitations of the NPM doctrine, including the central assumption that ‘by changing organizational and contextual factors it is possible to eliminate any political orientation of, and influence on, the logic of action of the public employer’. However, the continuing salience of ‘political contingency’ – that is the imperative for governments to attend to their electoral constituency on questions of public service provision – is above all evident in the provision of health care, including hospitals, underscoring the persistence of a logic of action different from that prevailing in the private sector. The role of actors is also accorded insufficient attention in the NPM literature (Kahancová and Szabó 2012). Actors’ interests and responses shape the outcome of reform initiatives, as demonstrated by Schulten et al. (2008) in their cross-country analysis of repertoires of trade union responses to privatization initiatives in the public services. This suggests a counter-proposition: political contingency and actor strategies may confound the impact of NPM-inspired reforms in driving workforce governance arrangements towards those prevailing in the private sector (Proposition 2B).

Research design and methods

Public hospital care provision is organised differently in the three countries on which this paper focuses. Although the public funding basis of hospitals is based on the social insurance system in France, and on general taxation in Italy and the UK, the proportion of hospital budgets accounted for public funds is high, at around 95%, in all three (Méhaut et al. 2010). The budgetary context has however differed. This matters because it is likely to influence the way in which pressure from reforms in hospital governance feed through into changes in institutions and structures of workforce governance. Pressure to contain financial expenditure has been most sustained in Italy, with budget constraints being a constant feature right through the 1990s and 2000s. This is underlined by the number of regions which have incurred substantial financial deficits and been required to implement recovery plans involving significant restructuring. In 2010, such measures were in place in 8 of the 20 regions. In France and the UK, whilst pressure to contain costs in the face of rising demand for hospital healthcare is a common factor, both countries have also seen expansion of health budgets during the 2000s. In the UK, this followed a period dating back to the 1980s where health expenditures had stagnated, whereas in France this continued a trend already evident in the 1990s. Two differences in the generic characteristics of the organization of public hospital care are also potentially salient. First, such care is organised around a unitary pillar in some countries and separated pillars in others. The UK's National Health Service is an example of the former, whereas in France and Italy there are three pillars (with differing weights in each): public hospitals, private not-for-profit hospitals and private for-profit hospitals. Second, public hospitals can be centrally or locally 'owned'. Whereas the former situation prevails in France and the UK, in Italy regional public authorities govern public hospitals¹.

The three countries are associated with different country clusters in terms of institutional arrangements for workforce governance (Bordogna 2008a)². In France, employees in public hospitals have special public employee status, and collective bargaining in public hospitals has remained secondary to administrative regulation under the 'sovereign' employer model. In this respect, France shares similarities with a cluster also including Belgium, Germany and Austria. It has separate multi-employer collective bargaining arrangements covering the private sector. Density of union membership in both the public and private sectors is comparatively low amongst western European countries. In different ways, Italy and the UK both represent 'cases apart' from other clusters of countries. Employees in Italy's public hospitals no longer (since 1993) have special employee status, although the regulation of the employment relationship under collective bargaining in the public sector differs from that in the private sector. This distinction carries over into different bargaining arrangements in the public and private hospitals sub-sector, as in France. Density of union membership is in the middle to upper part of the western European range. Although grouped in a Mediterranean cluster, Bordogna (2008a) suggests that Italy bears some resemblance to the Nordic countries in respect of its two-tier bargaining arrangements with some form of central coordination. In the UK public service employees have never enjoyed special employment status, and in health care (multi-employer) collective bargaining has, by and large, continued to be the preferred model of employment regulation. However, independent review bodies now determine pay for almost all the public hospital workforce. The relatively small private hospital sector is not covered by a multi-employer arrangement. Density of union membership is in the middle to upper part of the western European range.

The research focused on hospitals' nurses, ancillary and technical staff. Nurses, in particular, represent the largest professional groups within hospitals (55% in the UK; 60% in France and 40% in

¹ In Hungary, local authorities exercise this role.

² Bordogna identifies five main clusters of countries for the wider public service sector: Nordic (also including the Netherlands); central western Europe (Austria, Belgium, France, Germany); central eastern Europe (except Slovenia); Mediterranean (although Italy is something of a 'case apart'); the UK.

Italy). Doctors and managers, whose terms and working conditions are governed separately from that of 'health staff', are excluded from our study. The starting point for the research was a qualitative reconstruction of the main changes that characterised publicly-provided hospital care, and the governance of the workforce, in the three countries. This based on the collection of documents, analysis of the literature in the fields of social sciences and industrial relations and interviews with experts on health sector employment relations in the respective countries. The preliminary phase was used to inform the field work, based on semi-structured interviews with representatives of employers' organizations and trade unions, at national (for all the three countries) and regional levels (in two countries: Lombardy (Italy) and West Midlands (UK)). The interviews were carried out between September 2010 and May 2011, then transcribed and manually coded. The interviews (between four and seven for each country) focused on trends in the 2000s. Common topics ranged from the nature of reforms and their implications, to the relationship between public and private providers in the national health services and to the procedural and substantive changes in the collective bargaining and other workforce governance mechanisms at the different levels.

Trajectories of change in the reform of hospitals

Reforms in the governance of health care commenced earliest and have travelled furthest in the UK, where each of the four main trends is apparent. They have travelled the least, and are most recent, in France, where managerialization has been the predominant trend, whilst corporatization and privatization have not featured. Italy, where reforms were initiated not long after the UK, lies in between, with clear evidence of both managerialization and corporatization, whilst marketization and privatization vary according to region.

The UK, with some degree of continuity between different governments (Buchan 2000, Bach 2004), has seen important reforms of its universal public National Health Service (NHS) over the past three decades in which all four processes identified above have featured. Until the mid-2000s, publicly-funded hospital care was provided entirely by publicly-owned and operated hospitals. The first reforms introducing techniques of 'new public management' in the mid-1980s followed a government-commissioned report, and included the introduction of elements of competition among the organizations operating in the health service, of devolved budgeting and of performance management systems based on targets (Kessler and Purcell, 1996). In the 1990s managerialization and marketization were taken further, with four linked elements central in the successive interventions of the Conservative government: decentralisation of managerial responsibility; strengthening of performance management systems and increasingly pervasive use of performance metrics and targets; introduction of autonomous ('Trust') status for hospitals and primary care providers; and introduction of a 'quasi market', or internal market, through splitting the provision of health care, including acute care by hospitals, from its purchase by public agencies and general practitioners. The effect on relationships between purchasers and providers seemed, in many cases however, to prompt formal or informal cooperation rather than competition. At the same time, implementation of a compulsory requirement to put ancillary activities such as catering and cleaning out to tender opened up scope for private companies within the NHS.

Whilst the change to a Labour government in 1997 brought an official emphasis on encouraging cooperation and collaboration between purchasers and providers and a pragmatic mix of providers, continuity was evident in the further steps taken to develop the quasi-market, emphasise performance metrics and targets, and enhance the involvement of the private sector within the NHS (Bach and Kessler 2011). A sustained commitment to increase expenditure on health included a major hospital-building programme financed through the private finance initiative (PFI) under which private contractors build hospitals under a long-term cost-plus (i.e. profit) arrangement and which are then run by the hospital Trusts. Reinforcing the earlier move to open up provision of ancillary services to private companies, up until 2004 compulsory competitive tendering of such services was

a requirement of all PFI hospital contracts. From 2005 onwards, private healthcare providers secured a role within the NHS (in England only) with the establishment of a growing number of independent treatment centres. These are private-sector run hospital units within the public service, usually co-located with NHS hospitals, which undertake 'bulk', routine surgical procedures. A year earlier (2004), a more autonomous status for NHS hospitals ('Foundation Trusts') was introduced. Although still publicly owned, Foundation Trusts take the process of corporatization a step further. Strongly performing hospitals could apply for this status, under which governance responsibility shifts from the Department of Health (Ministry) to an independent board, and there is a greater degree of independence in decision making related to the organization of health provision and the governance of workforce. Out of 290 hospitals in Britain, 137 had acquired Foundation Trusts status by 2010. Yet despite the rhetoric of decentralisation, governments have, through the allocation of financial resources and the enforcement of a battery of performance metrics, retained considerable central control.

Italy's key reforms of hospitals took place in the 1990s with corporatization, and also regionalisation, to the fore. Managerialisation and marketization have also featured on the reform agenda, but not as prominently and in the case of marketization with significant regional variation. The Italian SSN has long been characterised by the dual presence of public and private hospitals. The public organizations account for the dominant share, with the private ones being 'complementary' in the overall national health provision. Although there has been no substantial shift between public and private hospital providers over the recent period, outsourcing of ancillary services to private contractors has become widespread.

In 1992 (law decree n. 502), local health departments (*Unità Sanitaria Locale, USL*) were transformed into local health organizations (*Azienda Sanitaria Locale, ASL*)³. Also 'hospital organizations' (*Aziende Ospedaliere, AO*) were introduced. AOs are hospitals which can become independent from the ASL and then, like ASLs, report directly to the regional administration. There has been a reduction of the 659 USL in 1992 to 183 ASL in 2005 as a result of mergers of organizations and an enlargement of their territorial remit. Both ASL and AO are based on management principles of efficiency deriving from the private sector model, being obliged, for example, to break even and entitled to manage bids for the provision of services.

The regionalisation of the national health system is the second prominent change of the past two decades. Starting with the 1992 reform, and cemented in 2000 with the regional federalism of the public service (law decree n. 5 of 1992), regions became an important financial source for the health system. The incidence financing coming from regional taxation is 39%, but the average hides significant variations ranging from the 10% of Calabria to over 60% of Lombardy. Whilst having to ensure nationally set minimum levels of service (known as LEA, *Livelli Essenziali di Assistenza*), regions have taken charge of deciding how public and private providers should interact, for example, therefore establishing different regional health systems.

In 1999, another reform (law decree n. 229) further stressed the private sector oriented vision through two main instruments. First it explicitly encouraged a system of quasi-market (or 'administered') competition to be developed by the regions according to their local context. However, with the exception of Lombardy, where competition between private and public providers was achieved, the most common approach adopted by regions has been that of making public and private providers 'cooperate' with each other (Neri 2006). Second, the 1999 reform aimed to enhance the entrepreneurial autonomy of ASLs' general directors. However, this movement towards managerialization was a compromised one. General directors of ASL, for example, are still appointed on a political basis by the regional government, rather than according to selection criteria which typically apply to their private sector counterparts.

³ The translation of *azienda* as 'company' is not appropriate and possibly ambiguous. We use the term *organization* to indicate the potential diversity of forms of health providers.

The main outcome of the territory-based 'organised decentralisation' of the various reforms is a national health system characterised by different regional health models (Neri 2009). Coordination between the State and the regions is devolved upon the 'Conference between State and Regions' (CSR). In collaboration with the Ministry of Health, the CSR ensures that minimum standards are respected and expenditure is under control. Because of persistent failure of a number of regions to attain the latter objective, in 2005 the Conference and the Ministry of Health imposed 'recovery plans' on them which include measures to reach financial balance such as mergers, closures of hospitals, downsizing and re-organization of service provision.

In France, publicly provided hospital care has undergone major reforms since the mid-1990s, resulting in two main developments: increased control over budget allocations, especially for public hospitals, and increased managerial authority (managerialization) within establishments in order to secure control of costs. The formal legal status of public hospitals has remained unchanged, and privatization has barely featured. The hospital sector has a dual structure, combining public and private providers, which since the 1970s has been characterised by effective coordination across its main pillars. On the one hand, hospitals which are part of the public health service ('*participant au service public hospitalier*' - PSHP) may be either publicly owned and financed, or privately owned and operated on a non-profit basis. On the other hand, privately owned hospitals, usually referred to as clinics ('*cliniques*'), operate on a profit-making commercial basis. There has been little change in the balance between of activity between public and private providers over the recent period. In 2006, the private sector accounted for 35% of bed capacity, split roughly 2:3 between non-profit and profit-oriented hospitals (DREES 2008).

Successive reforms in the 1990s were mainly aimed at reducing costs. 1995, with the Plan Juppé, brought consolidation of administrative competences at regional level. The regional hospitalisation agencies (*Agences régionales d'hospitalisation*, ARH) became in charge of allocating the resources to hospitals, both public and private, on the basis of a new contractual instrument (*contrat pluriannuel d'objectifs et de moyens*). The reform essentially amounted to a reinforcement of state planning and regulation, and served to initiate restructuring.

A radical reform of public hospitals financing was introduced in 2004 involving the introduction of fixed prices for all medical and surgical procedures ('*tarification à l'activité*', or price per act) in place of the global budgets which had operated previously. Health provision by private hospitals was already financed on an activity, or procedure, basis. The main objective was thus to harmonise the rules applying to public and private providers around a single model of resource allocation. Given the extent of the change, it is being implemented gradually through until 2012. The introduction of management tools to monitor hospital activity led to the development of several kinds of instruments at the establishment level: reporting boards, real-time monitoring of the occupancy rate, computerized tracking of drugs circulation, reporting tools for budget and finance monitoring, etc. The use of all these instruments has spread significantly in public hospitals (Cordier 2008:7). Although the alignment of the resource allocation model for public and private providers, around activity-based pricing, potentially lays the basis for the introduction of a quasi-market in hospital provision, there are as yet no concrete proposals for its introduction.

The most recent legal step, the 2009 law on hospital modernisation, patients and territory changed the governance of hospitals and introduced a new form of governance at the establishment level with a clearly managerial orientation. The reform significantly reinforced the powers of hospital directors to the detriment of co-management governance structures such as the 'conseil d'administration' and the medical commission. New or reformed institutions include: a surveillance council replacing the former 'administrative council' and exerting a management control function, including screening the financial accounts and results; a pluriannual contract with the Regional Health Agency (ARS) linking objectives and budgetary resources granted to the hospital; and a hospital director who is accountable to the ARS with respect to the hospital's objectives and targets.

These measures provided instruments and measures aiming to initiate a major restructuring of the hospital sector and give local health organizations a stronger management (Jacquin 2009).

Implications of the reforms for workforce governance

Changes in collective bargaining and other, administrative mechanisms of workforce governance have occurred in each of the three countries. Though the extent and nature of the reforms have played a role in these changes, it has not been a determining one: political contingency and actors' strategies are also to the fore.

In the UK, reform measures have been accompanied by initiatives to decentralise arrangements for collective bargaining, but these have taken a very different form under Labour governments through the 2000s from the direction embraced by Conservative governments in the 1990s. Although scope for local, hospital-based negotiation has grown it remains relatively limited in extent. A weakening of public policy preference for collective workforce governance arrangements, including national bargaining, under earlier Conservative regimes was subsequently reversed.

Unlike the decentralised arrangements for determining pay and conditions which prevail in the private sector in the UK, those covering the NHS feature a centralised, national-level framework. Increases in pay, which used to be the subject of national negotiations, are determined by an independent Pay Review Body (PRB) covering all non-medical staff. Originally established for nurses in 1983, PRB arrangements were extended to cover other non-medical staff in 2004 and 2007. According to employer and union officials interviewed, local negotiations in recent years have mainly focused on supplementary payments not detailed by national agreements, such as 'on call' payments, workforce and work organization implications of restructuring at hospital level and implementation of the 2004 national pay and job grading agreement.

Two main phases can be identified in actual and attempted changes to workforce governance arrangements, and draw attention to the salience of 'political contingency' and actors' responses. The first corresponds to the reforms introduced by Conservative governments in the first half of the 1990s. Under their newly-attained Trust status, hospitals could choose to either opt-out of national arrangements and negotiate their own terms and conditions or vary / supplement nationally-determined provisions through local negotiation – a measure intended by government to foster local pay bargaining. Studies, however, indicated that, by the late 1990s, although local pay supplements had been negotiated in a majority of Trusts the amounts involved were small when compared to the nationally-determined element. Moreover, only a minority had opted to negotiate local variations to national terms and conditions on other matters (Bach 2004; Thornley 1998). Several reasons lay behind the relative failure of this initiative to devolve bargaining to hospital level: continuing central government control of budgets, which fixed the parameters of negotiations; union resistance to the erosion of national arrangements; employer caution in the face of the scope for comparability bargaining across hospitals, given the national nature of labour markets for professional occupations, and the absence of in-house capacity at hospital level in terms of HR resources and expertise (Bach 2004; Kessler et al. 2000).

At the same time, the employment of a new grade of health care assistant (HCA) in hospitals – on less skilled tasks previously undertaken by nurses - as a cost reduction measure grew rapidly (Grimshaw 1999). HCAs, however, fell outside the scope of existing national agreements, and their terms and conditions were determined locally by hospitals utilising the scope afforded by their Trust status. Also, compulsory competitive tendering resulted in significant numbers of ancillary staff being removed from the coverage of the national agreement. Although the terms and conditions of staff actually transferred to private contractors were in principle protected by transfer of undertakings legislation, in practice this was not always the case; moreover, protection does not extend to newly recruited employees. In sum, although the initiative to devolve collective bargaining

to local, hospital level never really took off, in two important respects national arrangements became less complete in their coverage of the NHS hospital workforce.

The second period ensued from the further reforms introduced by Labour governments in the 2000s and is characterised by a different, contrasting trajectory. Change has entailed a double shift in which the framework of national collective bargaining was substantially recast, to simultaneously consolidate pay grading arrangements for all groups of staff under a single scheme and provide more scope for an element of local determination within the national framework. At the same time the coverage of national-level arrangements was extended. Government support to employers and trade unions in framing and implementing these changes played a crucial role (Bach and Kessler 2011). Substantial change came with the new, 2004, national agreement on pay grading, known as 'Agenda for Change' (AfC). This replaced eleven previous, long-established occupationally-focused national agreements each specifying job grading for different workforce groups. The AfC arrangements swept away almost 650 different job grades, and multiple different allowances and working conditions for different staff groups, and replaced them with nine national pay bands, a national 'equality-proofed' scheme for evaluating jobs, and harmonised terms and conditions. With responsibility for evaluating jobs and placing them within the pay bands moving to hospital level, this streamlined national framework facilitates the development of new, hospital-specific work roles and ways of working, thereby opening up work organization as an arena for local consultation and negotiation. The direction of travel towards 'organised decentralisation' (Traxler 1995) was reflected in other developments under AfC, including the accompanying employee development scheme. And whereas under the previous occupationally-focused agreements, pressures on pay in particular localities or for particular groups could only be got round by either over-grading jobs or setting the rules outside (employer interview), AfC provides for local or national recruitment and retention premium payments. Local premia can be implemented at the decision of local management and unions.

Concerning extension of the coverage of national-level arrangements, the new HCA grade was brought within the scope of the AfC's national pay grading arrangements and, in 2007, became covered by national pay determination arrangements when the remit of the PRB was further extended. In addition, the growth of a 'two-tier' workforce as a result of growing outsourcing of ancillary services was addressed by a 2005 'two tier code of practice' introduced by the government to protect the terms and conditions of employees working for the private contractors concerned across the public services. Widely implemented in the NHS, the effect was to extend de facto the coverage of the NHS' national agreement to contractors' workforces (Grimshaw et al 2010).

However, according to both the employer and union officials interviewed the further reforms to hospital health provision initiated in the mid-2000s contain ingredients which could erode the coverage of the AfC national arrangements and/or lead to the ad hoc erosion of particular terms and conditions on a local basis. Crucially, hospitals with Foundation Trust status have even more autonomy – and can call on greater in-house resources – to opt-out of the national agreement than their Trust counterparts. At the time of the research, just one hospital had done so. Within the national AfC framework, however, many more hospitals were described as 'pushing at the boundaries' (employers' official) on some non-core issues such as the period for which pay is protected for staff negatively affected by restructurings. Tensions are apparent between the AfC national framework and enhanced autonomy in hospitals' governance arrangements. More recent developments underline the continuing importance of political contingency. As part of its programme of austerity measures the incoming Government announced a two-year pay freeze for all but the lowest paid staff in the public services, including health, as from 2011. It then revoked the two-tier code of practice in early 2011, re-opening the scope for private contractors to compete for outsourced activities on the basis of inferior terms and conditions.

MORE ON ACTORS' RESPONSES (2B) In Italy, the health system reforms of the early 1990s were accompanied by the 'contractualization' of employment in the sector, with the 'sovereign' model of

statutory and administrative regulation being abandoned in 1993 in favour of collective bargaining as the primary mode of workforce governance. Bargaining arrangements involve the articulation of two levels: a national and a decentralised, organization- based (ASL or AO) level. The political contingency has reasserted influence on national level bargaining since the early 2000s. The development of bargaining at the lower level has been uneven, and its scope has been curtailed under a recent legislative measure. There are three separate national agreements for the private health sector, reflecting the distinctions between private hospitals, represented by the employers' organization Aiop (*Associazione Italiana Ospedalità Privata*); the religious not-for-profit hospitals, represented by Aris (*Associazione Religiosa Istituti Sociosanitari*); and a group of religious private hospitals separately represented by *the Don Gnocchi Foundation*. The regionalisation of the funding and organization of publicly provided hospital care has prompted the informal, but not formal, development of collective negotiations at regional level.

The formal two-tier bargaining arrangements which cover public hospitals in Italy parallel those prevailing in private industry. However, reflecting the statutory and administrative regulation which prevailed until 1993, the highly detailed national collective agreements retain distinctive public sector features. The contents range from professional profiles, to union rights, to training and centrally determined fixed quotas of agency and flexible workers. At the decentralised level local, the issues which representatives of workers and management are meant to jointly regulate include the organization of work, shifts and overtime, eligibility criteria for part-time work, and variable (incentive) pay criteria. This complementary relationship between the national and the organization levels of collective bargaining has been subject to fluctuations over the years (Bordogna 2007; Carrieri and Nastasi 2009). It worked well until the early 2000s, with the achievement of objectives like inflation control, introduction of flexibility, 'responsabilization' of the local level for career progression. With the renewals of the national agreement in 2002 and 2006, however, delays and a revival of government intervention affected the outcomes of collective bargaining, and made innovations more difficult to introduce. At hospital level, in practice the development of bargaining has been uneven across the agenda reserved for local negotiations. The most significant failure involves variable pay. In line with agreements in the private sector, individual productivity and performance were to be measured and rewarded at local level through locally negotiated schemes. In practice this has hardly been achieved. Instead local management and unions often colluded to distribute the financial resources available at the organization level as a collective top up to constrained national wage increases (Bordogna and Ponzellini 2004).

Renewed state intervention has marked the years since the onset of the crisis. The 2009 bill on the public sector⁴ imposed a pay freeze for the 2010 – 2012 bargaining round and further enhanced managerialization by limiting collective bargaining at the decentralised level to 'duties and rights strictly related to industrial relations', excluding HRM practices. The measure also allows local, hospital-level management to unilaterally decide on subjects that haven't been resolved through negotiations where these do not lead to an agreement in reasonable time (Bordogna 2009).

Though uneven and diverse between regions, and generally not formalised, the emergence of a regional level of collective negotiations reflects the enhanced role of the regions in the financing and organization of hospital care. In the regions subject to recovery plans, 'normal' organization-based collective bargaining struggles to function because of the serious economic constraints and re-organization processes imposed by the regional governments (ultimately subject to State approval). Unions officials interviewed reported that any local negotiation was mainly to deal with transfer of employees, mobility and dismissals. By contrast, elsewhere a more proactive role has been played by the regional government in terms of health workforce governance (Neri 2009). For example, in the past decade, Lombardy's centre-right government has been investing significant resources stabilise employment of temporary workers and to tackle nurse shortages through, for example, provision of

⁴ Law n. 15, 4 March 2009 and Law decree n. 150, 27 October 2009.

accommodation facilities to nursing staff from outside the region. According to the representatives interviewed, the national collective agreement has proved important in maintaining coordination between the better and poorly performing regions, ensuring a minimum common level of terms and conditions for employees. By contrast, lack of coordination leaves the private hospitals segment (see below) seems more exposed to regional differences. In regions with recovery plans, private hospitals have been hit hard by the cost containment measures. However, they rarely declare bankruptcy and therefore no 'social shock absorbers' can be claimed for the workforce (union official). In better off regions, like Lombardy, there is increasing demand from private hospitals to apply different, 'more flexible' sectors' collective agreements, such as the one for social assistance, education and charitable institutions.

The first national collective for the private segment of the sector was signed in 1995 by all the three employers' organizations and the same federations of the three main trade unions which negotiate the agreement for the publicly-owned segment (health federations of Cgil, Cisl and Uil). At the organization level, collective bargaining is less widespread than in public hospitals mainly due to more limited workplace union presence. Coordination between the two segments was established on the basis of the agreement for the publicly-owned segment being concluded first, providing a benchmark for the private hospitals' agreement. However this has broken down following the protracted and contentious latest renewal of the private hospitals' agreement, concluded in September 2010 after a five-year delay. Some pre-agreements were signed at the regional level with the private employers' organizations to update pay levels during this interregnum (Neri 2010).

In France, the state has traditionally been, and remains, more present than in other countries. Public hospital staff belong to a specific branch of the civil service with its own statutory regulation (*'fonction publique hospitalière'*) derived from general public sector staff status. As a consequence, the workforce are governed primarily by administrative law and statutory regulations, although the role of collective bargaining has grown. There are two channels of social dialogue: an institutionalized one, through various national and local bi-partite bodies, and a less institutionalized form of collective bargaining involving unions on one side and on the other the Ministry for health, state employers or public sector managers (depending on the level of negotiation), which has developed since the 1980s. Considerations of actors' strategies and political contingency are integral to this development. Employment relations in private hospitals are governed by the labour code alongside their own collective bargaining arrangements. There are separate agreements covering the non-profit and for-profit segments of the private sector, respectively. Both agreements are legally extended to cover the entire workforce concerned.

Collective bargaining in the public sector originated in a law of 1983 recognizing centralised wage bargaining. Until the 1990s, peak level bargaining never went beyond the negotiation of pay increments between the unions and the state. The same law gave unions a right to 'debate' working conditions and work organization at various levels, which in effect gradually transformed into a right to enter negotiations on these issues (Rehfeldt & Vincent 2004:15). Unions which are considered representative⁵ and employer organizations are also consulted by the Minister of Health on certain issues, most often in an ad-hoc manner, for instance on pay, staffing, working time; funding, organization and governance of hospitals; and also with respect to the reforms in the past decade. Although it remains weakly institutionalised, since the 1990s, the scope of collective bargaining in the public sector has gradually expanded. Most recently, a 2008 inter-sector agreement (Accords de Bercy), translated into law in 2010, aimed to give collective bargaining stronger institutional foundations and expand the scope for negotiations.

The public hospital sector followed this trend, although with some delay due to the need to adopt specific reforms to hospital civil service statutory regulations. Growth in the role of collective

⁵ In practice, reflecting the results of workplace elections, there are eight: CFDT, CFTC, CFE-CGC, CGT, FO, SUD, UNSA and SNCH.

bargaining stemmed from the conflicts which the sector had experienced in the second half of the 1990s and at the turn of the 2000s, as well as a government stance that became generally more favourable to social dialogue. January 2000 saw a nationwide strike by staff in public hospitals around demands for improvement in working conditions, more jobs and increases – rather than retrenchment - in hospital budgets. As a result of further discontent amongst health workers, in particular over working time and workloads in relation to implementation of the 2000 law on the 35-hour week, more consideration was given to collective bargaining, which gained more recognition. Although not obliged to engage in collective bargaining on the issue at a central level, the Ministry of Health opened negotiations on the introduction of a shorter working week which led to an agreement being concluded with (only) four of the eight unions represented in the sector, despite a promise to invest in creating new jobs. Nevertheless, together with the procedural requirements of the 2000 law, this paved the way for subsequent, widespread local negotiations to secure implementation of shorter working time. While working time has been the most important issue underpinning growing recourse to collective bargaining in the 2000s, new themes are now appearing on the agenda.

In 2006 a five-year sector procedural agreement covering the public hospitals was signed (then transformed into law, as required to have full coverage) and set out the domains that could be open for negotiations and clarified the issues to be addressed at each level: general civil service social dialogue / hospital civil service bargaining / intra-establishment negotiations, usually framed by the law. Only implementation issues can be negotiated at the establishment level. The recent decentralization of health service administration on a regional basis has thus far not been followed by a decentralization of collective bargaining. Although collective bargaining is gaining an increasingly important role, compared to the past, as yet it remains highly centralized overall and closely linked to legal regulation.

There is a tradition of informal coordination between the public and private parts of the hospital sector in terms of wage determination, in which the public sector has tended to lead. If anything, such coordination has strengthened in recent years, contrary to the Italian case, with the conclusion of a 2002 agreements in the private sector including a commitment to improve working conditions within a framework of convergence over wage rates.

Discussion

Reviewing the trajectory of reforms to publicly provided hospital care in terms of the four main trends identified earlier, some similarities as well as differences are evident across the three countries. Managerialization features strongly in all three, with senior management at hospital level being accorded greater authority and discretionary power and formal systems of performance control put in place at the expense of professional norms and autonomy. In Italy, however, greater managerial autonomy risks being politically compromised given the politicised nature of the appointment process of ASL directors. Marketization has been and continues to be prominent in the UK. There is now an extensive quasi-market in hospital services within the NHS, in which private providers are increasingly players. Moves towards marketization vary between Italy's regions. Although encouraged by central government, implementation of marketization has largely been confined to the northern region of Lombardy. In France, the adoption of an activity-based pricing model for allocating budgets lays the basis for marketization, but so far there has been no initiative to introduce competition. Corporatization is prominent in both the UK and Italy, but has not featured in France. In the UK, the introduction of Foundation Trust status in the mid-2000s further augments the governance and operational autonomy of hospitals. In Italy, the introduction of *azienda* status in the early 1990s gave larger hospitals independent status in respect of local health authorities. Concerning privatization, the private sector has a long-established role in the provision of hospital care for the public system in both Italy and France. With the exception of the Italy's

Lombardy region, there has been no substantial recent change in the balance between public and private hospital providers in either country. In the UK, there was traditionally no such role for private providers within the NHS. From the early 2000s onwards the possibility of private provision has been introduced and subsequently grown. The timing of the main health care reforms is also relevant, since their effects on collective bargaining and other workforce governance arrangements may be lagged. Reform initiatives came earliest in the UK, with impetus towards managerialization dating back to the mid-1980s and the first measures promoting marketization and corporatization being introduced in the early 1990s. Italy's first measures promoting managerialization and corporatization were also introduced in the early 1990s. Whereas in France, the main measures promoting managerialization are more recent, only being introduced in the early 2000s.

Overall, this suggests that pressure for changes in the institutions for workforce governance would be greatest in the UK and least in France. In broad terms, the findings are consistent with this. However this seeming support for Proposition 1 needs to be qualified. Changes in collective bargaining and other administrative mechanisms of workforce governance have occurred in each of the three countries. As proposed by Bordogna (2008b) these changes are connected to the reforms introduced in each. However, the reforms have not played a determining role. Other factors, including containing and channelling workforce unrest, political choice and the capacity of employers and unions to frustrate initiatives and, conversely, to promote others which consolidate their role are also important, providing strong support for Proposition 2B. In France, the growing, if still secondary, role for collective bargaining is consistent with growing managerial authority at hospital level, which brings variation in actual working conditions across hospitals. A centralised administrative model has problems in coping with such variation, whereas collective bargaining and forms of social dialogue – which entail multi-level arrangements – bring the capacity to address issues at hospital level. However, greater prominence for collective bargaining is not only a consequence of managerialization. It also represented a response, or institutionalised accommodation, to widespread, organised workforce discontent. Since the late 1990s too, public policy has become more favourable to collective bargaining.

In Italy, the emergence, however, of a regional level of collective negotiation – uneven between regions and generally not formalised – is a clear reflection of the enhanced role of the regions in the financing and organization of hospital care. Corporatization and managerialization has been accompanied by the introduction of two-tier bargaining arrangements, giving scope for local level negotiation over a range of issues. Yet whilst there is indeed significant lower-tier negotiation on working conditions and the effects of restructurings, lower-tier negotiations over pay for performance – where they have taken place - have not generated the outcomes intended. In the absence of the devolution of full budgetary responsibility to hospital level, the incentives to improve performance for either of the negotiating parties is weak and the scope for collusive behaviour between them correspondingly strong (Bordogna 2008b). Recent government intervention to circumscribe the scope of the local bargaining agenda in favour of managerial prerogative underlines the role of political contingency.

In the UK, reform measures promoting managerialization, marketization and corporatization have been accompanied by initiatives to decentralise arrangements for collective bargaining. But the character of the initiative undertaken by a Conservative government in the 1990s, differed from that pursued by a Labour government a decade later and underlines the scope that exists for the exercise of political choice, and the capacity of organised actors – employers and trade unions – to frustrate or promote change initiatives (Schulten et al. 2008). The earlier, 1990s initiative was intended to promote an 'uncontrolled' decentralisation of collective bargaining to local, hospital level and thereby undermine the national framework. Amongst the reasons for its relative failure, noted above, was employer caution over the potential negative consequences of embracing local bargaining coupled with union resistance (Bach 2004). In contrast, the thrust of the subsequent initiative in the 2000s has been to effect a 'controlled' decentralisation through recasting national

agreements as more flexible frameworks, in which there is a greater role for negotiated local implementation and variation. The success of Agenda for Change is in part attributable to the commitment of both employers and unions to the objectives and outcomes, since both had interests in the retention of a modified national framework. But it also rested on the commitment of resources by government: a union official described AfC as an 'expensive reform'.

Whilst change in collective bargaining and other mechanisms of workforce governance are connected to, but not determined by, hospital reforms, the expectation of the proponents of 'new public management' that the outcome would be arrangements which more clearly resemble those found in the private sector seems, however, to be wide of the mark. Calibrated against the four changes to workforce governance specified by Bordogna (2008b), support for Proposition 2A is limited.

First, staff in public hospitals in France continue to have special employment status as public servants, and to be primarily subject to administrative and statutory regulation. There has been little change in the scope of these or the standards involved. Collective bargaining plays a secondary role. In contrast, their counterparts in Italy lost their special employment status in 1993, and – second - voluntary collective bargaining has become the main mechanism of workforce governance. In formal terms, the two-tier bargaining arrangements covering public hospitals mirror those found in the private sector, but the national collective agreements have incorporated many features of the previous administrative regulation and remain highly detailed in the conditions they specify. This sets them apart from their private sector counterparts, whose provisions have become more framework in character and less detailed (Baccaro and Pulignano 2010). Voluntary collective bargaining was, and continues to be, the principal mechanism of workforce governance in the UK, although the extension of the remit of the PRB to all non-medical staff means that determination of wage increases is now independently rather than collectively regulated. The continued centrality of a national, multi-employer agreement and pay setting arrangements sets the health sector apart from the single-employer bargaining which characterises the private sector.

Third, the growing role for collective bargaining in France has been accompanied by some, although not marked, decentralisation. Coordination across the agreements covering public and private sectors involved in publicly provided hospital care has focused on bringing standards in the private sector up to those in the public, which runs counter to this. In Italy the picture is mixed: local level bargaining on a range of non-pay issues has developed, but not over pay related to performance or productivity which is a key feature of larger organizations in the private sector. Coordination between the agreements covering the public and private sectors has broken down. In the UK, the explicit attempt in the 1990s to devolve bargaining to the local level, and simultaneously undermine national arrangements, ended in relative failure. The subsequent renewal of the national framework for collective bargaining sets hospitals, and the wider NHS, apart from the dominant private sector trajectory, which in the 1980s and 1990s saw the dismantling of national-level, sector-wide bargaining arrangements in favour of company- and site-based ones⁶. Fourth, public policy in France has become more, not less, favourable towards collective bargaining, and the scope of the agenda has widened, whereas in Italy the years since 2008 have seen a shift in which public policy has sought to strengthen managerial prerogative at the expense of collective bargaining, thereby constricting its scope. No consistent trajectory is evident in the UK: in the 1990s there was a retreat from the long-established public policy preference for collective bargaining, only for this to be reversed in the 2000s. The scope of the local bargaining agenda has, if anything, broadened as a consequence of the recast national agreement. Amongst the three countries, support for

⁶ This renewal has more in common with private sector exceptions, such as printing - where there continues to be a national agreement which has been substantially recast, than the private sector rule.

proposition 2A is strongest for Italy, although still mixed, weak in France and, given the extent of hospital reforms, also weak in the UK.

Conclusion

NPM-inspired reforms to publicly provided hospital care have prompted changes in mechanisms of workforce governance, but these are not straightforwardly driving collective bargaining and other workforce governance arrangements towards those which characterise the private sector in a given country. Our findings on hospitals are consistent with those of Bordogna (2008b) for the wider public sector, and as such confound the expectation of NPM proponents. The logics which have shaped changes in collective bargaining and administrative and statutory mechanisms are multiple, and not solely the imperative of emulating the private sector. Political contingency, deriving from the nature of the demand for health care where the role of market forces is limited by political mobilisation and pressure, and the responses and strategies adopted by employers and trade unions in the face of reform initiatives, have been shown to be crucial factors also, confirming findings from earlier European cross-country studies of public service reform (Schulten et al. 2008) and parallel research on hospitals in Hungary and Slovakia (Kahancová and Szabó 2012). Accordingly, differences between countries relate not only to the extent and nature of hospital reforms, the organisation of publicly provided hospital care and institutional arrangements for workforce governance, but also to the responses of actors.

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