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Manuela Galetto, Paul Marginson, Catherine Spieser

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

Manuela Galetto (IRRU, University of Warwick), Paul Marginson (IRRU, University of Warwick), Catherine Spieser *(Centre d'études de l'emploi, Paris)*

Introduction

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 organisation and governance of publicly-provided care through hospitals. In all countries these reforms have been strongly influenced by the doctrine of 'new public management'. The paper identifies four key processes shaping the direction of these reforms. One is *managerialisation*, or the adoption of private sector management techniques, in place of professional control; a second is *marketisation*, involving the introduction of mechanisms of market competition in the provision of health; a third process is the *corporatisation* of hospital organisations, that is giving them a more autonomous status intended to resemble that of a private company; the final one is *privatisation*, as private providers undertake more public healthcare provision and public organisations are transformed into private ones. To what extent and how have these trajectories of reform affected well-established arrangements for the governance of the health sector workforce?

The paper explores the relationship between these reforms in the organisation and governance of hospitals on the one hand, and workforce governance, through collective bargaining and other, statutory and administrative mechanisms, on the other. It then examines the impact of these two-fold changes on employment conditions in hospitals. The paper addresses three main questions. First, to what extent have hospital reforms prompted changes in arrangements for collective bargaining and/or other governance mechanisms? Following Bordogna (2008b), the expectation is that because of the labour-intensive nature of hospital operations and the strength of established patterns and mechanisms of collective regulation, reforms inspired by 'new public management' ideas can only be realised if traditional models of workforce governance in public hospitals, associated with the public service, are themselves also changed in fundamental ways. 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 organisation, management and provision of public services towards private sector practice, resulted in arrangements which also more closely resemble those found in the private sector? Does this lead to a decentralisation of employment relations? Third, what changes have occurred in employment conditions? How far, and in what ways, has flexibility been enhanced? Has employment security been undermined?

New public management principles have been influential in all countries, but not in a uniform manner. Building on a selection of contrasting country cases, our research seeks to (i) map cross-country variation in terms of reform trajectories (ii) highlight common trends where one would expect to find only differences. The starting point, public hospital health care organisation, is largely country-specific. The timing and nature of the four processes of hospital reforms that we identify vary across European countries. Likewise, prevailing arrangements for workforce governance, including the balance between collective bargaining and statutory and administrative mechanisms and structures of collective bargaining, also differ across countries. The paper draws on the findings from coordinated studies of developments over the past two decades, but with a focus on the 2000s, in three countries: the UK, Italy and France. This allows us to capture the relationship between changes in hospital governance and those in the institutions and mechanisms of workforce governance.

In the first part of the paper we consider the implications of the recent reforms in hospital health care provisions for the governance of health workforce through collective bargaining and other mechanisms, and outcomes in terms of employment conditions. The second section briefly presents the design of the research and the methods used. The third establishes the trajectories of change in hospital governance in the United Kingdom, Italy and France. The fourth section then examines the implications of the respective reforms for the governance of health workforce through collective bargaining and other mechanisms and the impact on employment conditions. The final section discusses the findings in terms of the three main questions identified above.

The changing governance of hospital health care provision and implications for employment regulation

Health care provision through hospitals is confronted by a number of medium-term pressures, which reach across the countries of the EU and date back to the 1990s. 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 hospitals in 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 all the countries varying around a 15% average. Second, through initiatives to reform funding arrangements, involving the introduction of funding 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 health care provision associated with the doctrine of 'new public management' (NPM) (Pollitt and Bouckaert 2004).

The precepts of NPM have driven wider public service reform processes across Europe, responding to pressures to contain public expenditure, increase efficiency in service provision and quality of services, for more than a decade (Bach and Kessler, 2007; Bordogna 2008b). 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 identifies a number of 'doctrinal components' (p383) to NPM including: an increase in the discretionary power and control exercised by senior management over organisations; 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 organisational units and decentralisation of provision; introduction of contract-based competition for provision of services, and associated scope for privatisation 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 within the hospitals sub-sector is readily apparent from recent studies focused on hospital health provision (Grimshaw et al. 2007; Méhaut et al. 2010; Weber and Nevala 2011). Four main trends in the governance of hospital health care provision are discernible, to varying extent and according to differing timescales across European countries. *Managerialisation* relates to the first three components of NPM identified by Bordogna. *Marketisation* refers to the adoption of fixed average price funding principles, and the fostering and spread of contract-based competition for service provision. *Corporatisation* builds on the disaggregation of organisational units and the decentralisation of decision making through formalising greater hospital autonomy by granting them independent legal status. Finally, *privatisation* refers to growing scope for private providers in the provision of hospital health care.

One 'baseline' reason for the cross-country variation in the reach of these broad trends is that they are refracted through the different institutional arrangements which characterise hospital health care provision in each country. Salient differences can be captured according to some generic characteristics of these arrangements. Although the public funding basis of hospitals differs between social insurance based systems in some countries, including France and Germany, and systems based on general taxation in others, including Denmark, the UK and Italy, the proportion of hospital budgets accounted for public funds is generally high (at least three-quarters). Nonetheless, according to OECD data reported by Méhaut et al. 2010 there are differences between France, Denmark and the UK at around 95%, on the one hand, and Germany and the Netherlands on the other, 88 and 77 per cent respectively. Second, publicly-funded hospital health 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, Italy and Germany there are three pillars (with differing weights in each): public hospitals, private not-for-profit hospitals and private for-profit hospitals. Germany in particular, has seen a rapid increase in private for profit at the expense of public hospitals since the mid-1990s (Méhaut et al. 2010). Third, 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 hospitals, and in Hungary it is local authorities which exercise this role.

Differences in pace, extent and timing notwithstanding, the ramifications of NPM-inspired reforms to hospital health provision for the regulation of the employment relationship are considerable. Indeed Bordogna (2008b) contends that because of the labour intensive nature of the hospital sub-sector, and its high levels of union membership density and organisation, the implementation of public service reforms consistent with the NPM doctrine cannot be realised unless public service

employment relations are simultaneously reconstructed. In short, the proposition is that changes to the regulation of employment are a necessary condition for the implementation of public service reform. The NPM reform agenda therefore 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 and also for parts of the public service workforce in other west European countries, encompassing collective bargaining is promoted by the state as the preferred means of employment regulation.

Bordogna (2008b) spells out the implications of the NPM doctrine for these two traditional approaches to employment regulation. In terms of governance arrangements these include a decline in the share of public service employees with special employment status, with the implication that – 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 state regulation. Collective bargaining will be under pressure to become more decentralised, in order to become responsive to organisational needs. 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. This suggests a second proposition (Bach 1999; Bordogna 2008b), which is that workforce governance arrangements in the public service, including those in the hospitals sub-sector, will tend to converge on those prevailing in the private sector (in a given country).

Turning to the impact on employment conditions, Bordogna (2008b) anticipates that those public service employees who continue to have special employment status are likely to experience a reduction in the scope and magnitude of the prerogatives attached to such status – for example through a weakening of job security or pension entitlements. Also 'automatic and collectivist criteria' (p386) which shape pay determination and career paths, such as length of service are also likely to be displaced in favour of more differentiated, selective and individualised criteria, associated with performance appraisal and other HRM techniques. In particular, pay will become more related to the circumstances of individual hospitals, and to the performance of individuals and teams within them. In addition, an emphasis on enhancing different kinds of flexibility in the deployment of the workforce can be expected. Insofar as this involves (greater) recourse to contingent forms of employment, job security is likely to be eroded. Accordingly, a third proposition is that employment conditions will undergo a shift in the balance between job and income security and different forms of flexibility in favour of the latter.

Institutional arrangements governing employment regulation in the hospitals sub-sector in each country differ, in part reflecting national-level, economy-wide differences in collective bargaining institutions and in part reflecting differences in the organisation of hospital health care provision (see above), and hence intervene in the relationship between NPM-inspired reforms to hospital health care provision any consequent / associated reconstruction of employment regulation. Important lines differentiating institutional arrangements are the extent of integration with the wider framework for setting wages, other benefits and conditions in the public sector; the extent to which parts, or most, of the workforce have special (public servant) employee status; fragmentation

/ integration in interest representation and, closely associated, collective bargaining and other joint arrangements in the sub-sector; coordination across arrangements covering public and private providers, respectively; whether multi-employer or single-employer collective bargaining arrangements prevail ; and whether multi-employer or other centrally determined arrangements can be supplemented by further negotiation at territorial or organisational level (Grimshaw et al 2007; Méhaut et al. 2010).

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, as is the case in France, Germany and Italy. 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 of the sub-sector 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. In Italy, after a convergence phase between 1995 and 2006, the recent renewal of the national private health collective agreement showed a demand for differentiation from the public health one. Multi-employer bargaining arrangements are substantially more encompassing in their workforce coverage than single-employers ones, and where the 'sovereign' employer model does not apply the former characterise the public hospitals sector in all western European countries concerned. Single-employer arrangements are found amongst some central eastern European countries such as Hungary. Differences in western Europe revolve around three considerations: whether the terms of agreements can be, and in practice are, legally extended to workers who would otherwise not be covered by an agreement (widespread in continental western Europe, but not found in the UK – although a de facto arrangement has applied over recent years); scope for further negotiation at lower levels (considerable in Denmark, less so in Italy, highly constrained in France); and arrangements for private hospitals engaged in public provision. On the last, the situation in Germany – where growth in the private hospital sector is associated with the emergence of single-employer bargaining – differs from that in France and Italy, where (different pillars of) the private hospital sector have their own sector agreements.

Drawing on Bordogna (2008a), the three countries on which this paper focuses are associated with different clusters of countries[1]. 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 of countries 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. Bordogna (2008a)

[1] Bordogna (2008a) 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.

suggests that for the wider public sector, 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 of 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.

Empirical evidence for the wider public sector provides a mixed picture in terms of the emergence of private-sector type forms of workforce governance, and associated adoption of more individualised employment practices, under the pressure of NPM-inspired reform measures (Bach 1999; Bordogna 2008a, 2008b). In accounting for this, Bordogna raises some inherent limitations of the NPM doctrine. Central to these is the assumption that 'by changing organisational and contextual factors it is possible to eliminate any political orientation of, and influence on, the logic of action of the public employer' (p385). However, the continuing salience of the 'political contingency' (Ferner 1988) – 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. Reforms inspired by the 'rhetoric' of NPM can also conflict with the reality of actual governance arrangements amongst hospitals. For example, the creation of additional, lower level bargaining arrangements can generate increased transactions costs as well as scope for local variation; and unless budget responsibility has also been devolved, local level bargaining may have perverse consequences as a result of collusion between the local parties involved. In short, these and other tensions suggest that imposition of reform measures which flow from an NPM agenda may not prompt the outcomes intended.

Notes on Method

National health services include a wide range of organisations and institutions dealing not only with health provisions, but also laboratory activities, research centres, social services, often collaborating together. Our research focuses in particular on hospitals (falling under the 86.1 Nace definition 'Hospital activities'), and the 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 Italy). Doctors and managers, whose terms and working conditions are governed separately from that of 'health staff', are excluded from our study.

The basis of the present work rests on a qualitative reconstruction of the main changes that characterised the health sectors and the relative workforce in the three countries of comparison. This preliminary research took place in 2010 and was based on the collection of documents, analysis of the literature in the fields of social sciences and industrial relations and interviews with experts of health sector employment relations in the respective countries.

The preliminary phase was used to inform the field work, based mainly on semi-structured interviews to representatives of employers' and workers' organisations, at national (for all the three countries) and regional (Lombardy and West Midlands in the cases of Italy and the UK respectively) levels. The interviews, carried out between September 2010 and May 2011, were recorded and transcribed. The meetings with representatives of the organisations were functional also to access

further relevant documentation, particularly in the form of employment accords, figures and data contained in the agreements. The interviews (between four and seven for each country) focused on the trends of collective bargaining in the 2000s. Various aspects were considered and the questions designed according to the specific national situation. Common topics of the interviews would range from relationship between public and private providers in the national health services to questions on procedural changes and substantive outcomes related to collective bargaining.

Main reforms in the governance of hospitals

While many of the health reforms of the 1990s and 2000s were aimed at containing costs while increasing efficiency of health service provision and quality of health care, there is less uniformity in the choice of instruments towards realising this purpose implemented in the different countries.

The United Kingdom

The UK, with some degree of continuity between different governments (Buchan 2000; Bach 2004), has seen a number of important reforms of its universal public health service, the National Health Service (NHS), over the past three decades. Until the mid-2000s, publicly-funded hospital health care was provided entirely by publicly-owned and operated hospitals, although the involvement of private contractors in provision of ancillary services dates back to the 1990s. The reforms started with the introduction of techniques of 'new public management' in the mid-1980s, replacing those based on the 'consensus management' principle, following a government-commissioned report. The late 1980s saw the first introduction of elements of competition among the organisations operating in the health service, of devolved budgeting and of performance management systems based on targets (Kessler and Purcell, 1996). In the 1990s managerialisation 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 most prevalent form of contractual arrangement which resulted was a 'block contract' between purchaser and provider which specified only the total amounts involved, without detailing the volume of specific treatments to be provided. The effect on relationships between purchasers and providers seemed, in many cases, to be 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 shift away from a predisposition towards the private sector in favour of encouraging 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 forthcoming). A sustained commitment to increase expenditure on health included a major hospital-building programme financed through the public finance initiative (PFI), introduced across the wider public sector in the late 1990s, under which private contractors build hospitals (and other NHS facilities) under a long-term cost-plus (i.e. profit) arrangement and which

are then run by the hospital Trusts (and other NHS organisations). 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 organisation of health provision and the governance of workforce. Out of 290 hospitals in Britain, 137 had acquired Foundation Trusts status by 2010.

To summarise, the trajectory of reform of the NHS has been shaped by all four processes. Managerialization appeared first followed by a sustained series of marketization measures under which hospitals provide health care through a quasi-market. This has grown in scope and increasingly moved away from block contracting arrangements to ones specifying the volumes of particular procedures. More recently, corporatization has been formalized with the introduction of Foundation Trust status for hospitals, whilst the independent sector treatment centres have opened up hospital health care provision to private providers. 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. Further reform proposals by the present Government, if implemented, would reinforce the second, third and fourth of these in particular.

Italy

Though the Italian SSN has a long tradition of dual presence of public and private hospitals, the public organisations account for the dominant share, with the private ones being 'complementary' in the overall national health provision through the accreditation system. With the strong push towards restructuring, and the following reforms of 1992 (law decree n. 502) and 1993 (law decree n. 517), there has been a significant decrease in the overall number of beds, both public and private, amounting to -29% between 1996 and 2002 (Neri 2006:178). The majority of the decrease has been borne by public hospitals with the concomitant - though far from equivalent - increase of private beds. Recent trends show that private hospitals are increasingly taking on specific operations, like rehabilitation. For example, while in 1997 only 5% of post surgery rehabilitation was managed by private actors, it was 73% in 2008. Regional differences, then, indicate a varied concentration of private hospitals across the national territory (Anessi Pessina et al. 2010).

The regionalisation of the national health system has been perhaps the most prominent change occurring over the past two decades. Starting with the 1992 reform, and further finalised 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 of regional 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 took charge of deciding how public and private providers should interact, for example, therefore establishing different regional health systems. The reforms outlined apply equally to all regions, analysing the consequent trajectories at the national level, different regional outcomes will be highlighted.

Corporatisation features as a prominent trajectory variable that accompanied the changing governance of health provision. In 1992, local health units (*Unità Sanitaria Locale, USL*) were transformed into local health organizations (*Azienda Sanitaria Locale, ASL*) [2]. 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. As a first result, there has been a reduction of the 659 USL in 1992 to 183 ASL in 2005, obtained through mergers of organisations and an enlargement of their territorial remit. Both ASL and AO are based on management principles of efficiency deriving from the private model, as they are obliged for example to break even as well as entitled to manage bids for the provision of services.

In 1999, another reform (law decree n. 229) further stressed the 'private model oriented' vision through two main instruments. First it explicitly encouraged a system of quasi-market (or 'administered competition') that the regions would eventually develop individually according to the local context. However, with the exception of Lombardy, where competition between private and public providers was achieved, the most common approach adopted by regions, though in different ways, has been that of making public and private providers 'cooperate' with each other (Emilia Romagna being a significant example in this sense, analysed in Neri 2006). Secondly, the 1999 reform aimed to enhance the entrepreneurial autonomy of ASLs' general directors. However, this movement towards managerialisation 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 typically applying to private sector's managers.

The main outcome of the territory-based 'organised decentralisation' of the various reforms was, as mentioned above, a national health systems 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, among others, the CSR ensures that minimum standards are respected and expenditure is under control. Because of persistent failure from a number of regions in the latter objective, in 2005 the Conference and the Ministry of Health imposed on them 'recovery plans'. Similarly to what happens in case of bankruptcy in the private sector, eight out of 20 regions are now under controlled administration, implementing measures to re-establish a balanced budget under the supervision of 'liquidators' (usually appointed centrally by the government and often coinciding with the presidents of the regions, as in Campania and Lazio). Measures include, as we will see in the next section, mergers, closures of hospitals, downsizing, etc.

Even if marketisation and managerialisation appeared on the agenda of the reforms, they did not feature as prominently as corporatisation. The former has been displaced in many regions by the cooperative approaches fostered among the organisations which were supposed to compete. The latter has been affected by the 'political contingency' still prominent within the Italian SSN. Corporatisation, by contrast, has been pursued successfully, with ASL and AO being the main providers of the health system and showing common characteristics with private companies. Privatisation is gaining ground in specific areas of the hospital activities, but appears, at least to date, only limited.

France

In France, the hospital sub-sector 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 within establishments in order to secure control of costs. The

[2] The translation of *azienda* as 'company' seemed not appropriate and possibly ambiguous. We use the term 'organization', which indicates the potential diversity of forms of health providers.

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 health public service ('*participant au service public hospitalier' - PSHP*) may be either publicly owned and financed, or privately owned and operating on a non-profit basis. The former comprise large units in urban areas and local hospitals, mostly in rural areas and linked to local authorities. Non-profit hospitals are often linked to charities or religious organizations. On the other hand, privately owned hospitals, usually referred to as clinics ('*cliniques*'), operate on a profit-making commercial basis. For patients, healthcare in the private sector is covered by national public health insurance generally up to the same fixed level as in the public service. 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 aimed at reducing the costs. In 1995, with the Plan Juppé, there has been a move towards a 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. Subsequently, several reports published in 2002 contributed to building an agenda for a major reform of the internal organisation and financing of French hospitals, leading to a change of administrative and medical governance.

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).

The last legal step, the 2009 law on hospital modernisation, patients and territory attempted to address geographical inequalities in health (and hospital) provision, by complementing ARH with the establishment of new regional health agencies (*Agences régionales de santé- ARS*) with an extended health care remit, and promoting coordination within the hospitals sub-sector and also restructuring when hospitals are too geographically close.

More importantly, the 2009 law 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 (i) an executive body (directoire), which supports the general director in the management of the establishment; (ii) a surveillance council replacing the former 'administrative council' giving an opinion on stratey and exerting a management control function, including screening the financial accounts and results; (iii) a pluriannual contract with the Regional Health Agency (ARS) linking objectives and budgetary resources granted to the hospital; and (iv) a hospital director who is accountable to the ARS with respect to the hospital's objectives and targets. Overall, these measures provided instruments and measures aiming to initiate a major restructuring of the hospital sector and give local health organisations a stronger management (Jacquin 2009).

The changing governance of hospitals in France in recent years is a clear case of managerialisation. 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 formal legal status of public hospitals remains unchanged, and there has been little change in the balance between of activity between public and private providers over the recent period. Corporatization and privatization have not been part of the reform agenda.

Changes in collective bargaining and employment conditions

This section focuses on the trends in the institutions and mechanism of governance of health workforce resulting from the reforms and on the impact on employment conditions in the three countries.

The United Kingdom

Unlike the decentralised, company- or site-based 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. Although scope for local, hospital-based negotiation has grown it remains relatively limited in extent. The current national framework determining pay and conditions entails the co-existence of two main governance mechanisms. 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, including nurses, other health professionals, nursing assistants and ancillary staff. Originating with the establishment of a PRB for nursing staff in 1983, following national industrial action by nurses, the PRB arrangement – under which NHS employers, trade unions and professional associations and the Government each submit evidence to the independent body ahead of its periodic recommendations - was subsequently extended to other non-medical groups (in 2004 and 2007). Other issues, such as pay grades, supplementary payments, non-wage benefits and most core working conditions, are nationally negotiated under a series of national agreements which also cover all non-medical staff. According to employers' organisation and trade union officials interviewed, local negotiations in recent years have mainly focused on supplementary payments not detailed by national agreements, such as 'on call' payments, the workforce implications of restructuring at hospital level and – since the recasting of the national pay grading agreement in 2004 (see below) – implementation of the new system.

In considering the changes to collective governance arrangements which have occurred, or were attempted, over the past two decades two main phases can be identified. The first corresponds to the reforms introduced under Conservative governments in the first half of the 1990s, whilst the second were introduced by Labour governments in the 2000s. Three main developments characterised the earlier period. First, under their newly-attained Trust status granting them a measure of autonomy, 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 the development of 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 of pay increases. Moreover, only a minority of Trusts had opted to negotiate local variations to national terms and conditions on other matters such as pay supplements and annual leave (Bach 2004; Thornley 1998). Several reasons lay behind the relative

failure of the 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 absence of in-house capacity at hospital level in terms of the necessary HR resources and expertise (Bach 2004; Kessler et al. 2000). Second, 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 from the start of the 1990s (Grimshaw 1999). HCAs, however, fell outside the scope of existing national agreements, and their terms and conditions were determined – not always negotiated – locally by hospitals utilising the scope afforded by their Trust status. Third, 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 far from being always the case; moreover, any 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 more recent period has been characterised by a different, contrasting trajectory. Change has entailed a double shift in which the framework of national collective bargaining was substantially recast and renewed, to simultaneously consolidate pay grading arrangements for all groups of staff under a single scheme, thereby address structural issues surrounding equal pay 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. The most 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 within the NHS. The AfC arrangements swept away almost 650 different job grades, and multiple different allowances and working conditions for different staff groups, 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 an important arena for local consultation and negotiation. This direction of travel towards 'organised decentralisation' was reflected in other developments under AfC, including the accompanying employee development scheme which – following a recent (2010) revision – establishes six core principles governing the training and skills required for staff to move along career pathways, with implementation to be determined locally. 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, HCAs also became covered by national pay determination arrangements when the remit of the PRB was extended to cover all workforce groups within the NHS. 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 such workforces (Grimshaw et al 2010).

However, according to both the employers' organisation 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. So far, just one hospital has 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. In short, tensions are apparent between the AfC national framework and enhanced autonomy in hospitals' governance arrangements. In addition, recent developments underline the continuing importance of the role of the state. First, as part of its programme of austerity measures the Government announced a two-year pay freeze for all but the lowest paid staff in the public services, including health, as from 2011. Second, it 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. This coincides with current government proposals which, amongst other things, envisage a further and significant increase in private sector provision within the NHS.

Employment conditions

As established earlier, basic pay and pay increases continue to be largely determined nationally through the decisions of the Pay Review Body. Even with the encouragement of devolved bargaining over pay during the 1990s, the local pay-increase supplements negotiated in a majority of Trusts remained small when compared to the nationally-determined element of pay increases. Some specific pay supplements have long been negotiated locally, as is the case with on-call payments. The AfC national agreement formally provides the scope for the payment of local retention and recruitment premia to specific groups which must be justified on objective criteria. Beyond this, such premia are triggered and specified through local negotiations. Although a new provision, the effect is to formalise previous informal practices rather than encourage the development of a second tier of negotiations.

The payments issue which appeared as the most contentious at the time of the research (winter 2010-11) concerned pay protection for workers who, as a result of restructuring, are re-deployed to jobs on inferior rates of pay. The national agreement lays down procedural requirements, including that agreement should be reached locally, but does not specify substantive provisions. In a context of ongoing restructuring and reorganisation amongst hospitals and concerns to contain costs, local managements have pressed for a reduction in the period of pay protection (often in exchange for concessions on other issues to unions in local negotiations). The result, according to both employer and union respondents, was that pay protection has tended to be reduced from 5 to 3 years, and there are instances where management has tabled a further reduction to 2 years. The wider effect is that the income security of the workforce affected is weakened.

The AfC national agreement retains automatic, incremental progression within the nine pay bands. The accompanying Knowledge and Skills Framework (KSF) specifies pathways for career progression into jobs on higher pay bands through the attainment of specific competencies by individuals; its role is to 'move people up through the system' (employer interview). There are of course limits to upward mobility in the shape, for example, of the professional qualifications required for entry to nursing grades. More generally, even if KSF appears as individualistic and differentiated it did come

in the place of a previous system which was collective and automatic. Rather, it for the first time formalises the modalities of career progression, thereby potentially contributing to the employment security of staff.

In terms of enhancing internal forms of flexibility, two developments have been prominent. The first concerns changes in skill mix associated with the widespread employment of HCAs (see above) on less skilled tasks previously undertaken by nurses, a development which dates back to the early 1990s and which was originally prompted by the twin concerns of nursing shortages and cost containment. According to both our union respondents and earlier studies, the density of HCA staffing levels as compared to that for nurses, as well as the range of tasks which they undertake, vary considerably across Trusts (Bach, Kessler and Heron 2008). One consequence of such variation, but also of the increased incidence and frequency of restructuring and reorganisation, is that work organisation has increasingly become a focus for local negotiation.

The second is working time arrangements, traditionally determined at sub-hospital, departmental level. Union respondents reported a tendency amongst line managers to streamline rostering arrangements so as to more effectively utilise resources in terms of available working hours, including the introduction of electronic in place of previous manual systems. Such initiatives had served to exacerbate tensions between the flexible hours requirements of individual employees, for example in the context of childcare commitments, and those of the organisation. In addition, problems were identified with electronic systems in generating rosters which met informal requirements of a mix of skills and experience on a shift. In a few hospitals, a new development is more formalised hospital-level negotiations on reconfiguring working time arrangements. One early agreement reduced the standard length of a shift so as to introduce a provision under which staff could be required to work a small number of their weekly hours wherever they are required.

Concerning external forms of flexibility, the extensive outsourcing of ancillary services – which were subject to compulsory competitive tendering during most of the 1990s and until 2004 remained a requirement for hospitals submitting major building plans under PFI – resulted in substantial numbers of workers moving from the NHS into the private sector. As noted above, whilst formally their main terms and conditions were statutorily protected, in practice this was not always the case. Such protection does not apply to newly recruited staff, which the recently rescinded 2005 two-tier code subsequently addressed. Overall, income security is likely to have been eroded for ancillary staff, although it is difficult to assess whether job security has also been weakened. Within the NHS, the 1990s brought growing use of contingent employment amongst nursing staff as a response to shortages, through increased reliance on both agency and bank nurses. Yet the result was also an escalation in costs (Tailby 2005), which prompted the Government to establish a temporary agency within the NHS with the aim of meeting continuing demand in the face of continuing shortages whilst containing costs. This was only partially successful (Tailby 2005), and union and employer respondents underlined that cost containment issues continue to surround the use of bank and (in-house) agency nurses. They pointed to the role of local consultation in a range of innovative initiatives aimed at minimising their use and at the same time promoting the employment security of existing staff as hospitals face up to a period of retrenchment.

In sum, there is little evidence of a systematic shift from collectivist and automatic to individualistic and differentiated criteria in determining pay and career paths. If anything, AfC and the accompanying KSF, have introduced greater formality into aspects of pay (certain supplements) and the issue of career progression than existed hitherto. At decentralised, hospital level, the outcome of

developments – negotiated or managerially determined – on the balance between forms of flexibility and security is complex. Income security has been weakened, as a result of negotiated changes to the duration of pay protection and the consequences of transfer of ancillary services to the private sector. The implications for job security of outsourcing are less clear. The cost implications of reliance on bank and agency nurses have limited any rise in job insecurity associated with such contingent forms of employment. Current retrenchment will, however, have a negative impact.

Italy

Introduced in 1993 and known as the 'contractualization' of public employment, collective bargaining is today the primary mode of governance of the hospital workforce in Italy. It is a multi-employer bargaining system articulated in two levels: a national level and a decentralised one taking place at the organisation level (ASL or AO).

The national collective agreement is highly detailed. This is partly due to the past model of regulation of employment relations for civil servants, until 1993 determined by the law, which used to be applied directly to all employees, without any decentralized level, therefore covering all aspects of the employment relation (Bordogna 2007). Its contents range from professional profiles, to union rights, to training and flexible employment contracts. At the decentralised level local representatives of workers and management regulate through collective bargaining working shifts, organisation of work, incentives, guidelines for the improvement of the work environment, eligibility criteria for part time, overtime payment and variable pay distribution criteria, including management of the productivity funds.

This complementary relationship between the two levels has been subject to fluctuations over the years (Bordogna 2007; Carrieri and Anastasi 2009). It proved to be working well in particular in the first phase of implementation, until the beginning of the 2000s, with the achievement of objectives like inflation control, introduction of flexibility, 'responsabilization' of the local level for career progression. In this phase a central level of collective bargaining prevailed over a decentralised level in particular because of the need to control the expenditure. With the renewals of the national agreement in 2002 and 2006, delays and a revival of the 'political contingency' affected the outcomes of collective bargaining.

Significant of the difficult process of decentralisation is the case of variable pay determination. According to the 1993 reforms, looking at the private employer model, individual productivity and performance related pay were to be measured and rewarded at the local level, as means of incentive as well as regulation of variable pay. This was consistent also with the then starting process of corporatisation of the health organisations described earlier. In practice, though, this was hardly achieved and the local resources were instead distributed collectively at the organisation level, considered as a local top up of the poor national level wage increases (Bordogna and Ponzellini 2004).

By sharp contrast, there is little collective bargaining at the decentralised level of private health organisations, except in some cases in Lombardy. Workers in private health hospitals are covered by three different national collective agreements, reflecting the distinctions of the organisations they belonged to. There are private hospitals represented by the employers' organisation Aiop (*Associazione Italiana Ospedalità Privata*); religious not-for-profit hospitals, represented by the employers' organisation Aris (*Associazione Religiosa Istituti Sociosanitari)*; and a group of religious private hospitals separately represented by the Don Gnocchi Foundation. The first CA for the private health sector was signed in 1995 by all the three employers' organisations and the same federations of the three main trade unions signing the CA for the public health sector.

A coordination approach was pursued since then, with public health sector CA being usually signed first and representing a benchmark for the private and religious hospital sectors. The pay gap existing in the nineties was cleared within two bargaining rounds (in 1995 and in 1999) bringing private health workers pay to the level of the public health sector. However, this direction was reversed with the most recent renewal of private health CA. This was signed by unions and Aiop in September 2010 after a five-year delay. Wages were eventually updated, but given the difficult negotiations a solution for all the due back payments (since January 2006) was not found[3].

Though CB is the main mode of governance of employment, the State is still pivotal in the employment relations of the health sector. The governments' yearly budget law defines the resources for the health service, therefore shaping the boundaries of negotiations, and sometimes intervening on the criteria and quotas of resources to be dedicated at the regional level, for example, to training, as happened during the 2011 centre-right government. In 2009, the minister of public administration issued two reform bills[4]. From the economic point of view, some savings have been quickly achieved through a collective bargaining freeze for the round 2010-2012. Decentralised collective bargaining can still take place, though there were ambiguities at the time of our work on the resources available for it. From the point of view of the contents, the reform aims at further enhancing the scope for unilateral managerial intervention at the organisation level on work organisation issues and on appraisal system. In line with the NPM 'precepts', the reform does so, for example, by limiting collective bargaining at the decentralised level to 'duties and rights strictly related to the employment relations', HRM practices will be excluded. Moreover, the reform allows managers to unilaterally decide on subjects that haven't been solved through collective bargaining in case negotiations do not lead to an agreement in a reasonable time (Bordogna 2009).

Though the system of IR does not formally recognise the regional one as a level of CB, from what we observed, regions are increasingly playing the role of 'third actor'. In the regions with recovery plans, 'normal' organisation CB level struggles to act as complementary to the national level CB, because of the serious economic constraints and re-organisation processes imposed by the regional governments (and ultimately subject to State approval). Unions are involved at the organisation level mainly to deal with transfer of employees, mobility, dismissals. By contrast, in other cases a more proactive role has been taken by the regional government in the employment relations of the health sector. The case of Lombardy is an example. Health provision is one of the priorities of the regional government, which addresses to it significant additional resources, explicitly aimed at, for example, stabilization of temporary workers, incentives to face the nurse shortage (through for example provision of accommodation facilities to nurses from outside the region).

Moreover, regions, more than the state, proved active in the dispute for the renewal of the private hospital CA. During the five years of negotiations, some pre-agreements were signed at the regional level with the private hospitals organisations to update pay levels (Neri 2010). In regions with a relatively 'wealthy' position, like in Lombardy, there is a demand from private hospitals to apply different sectors' CAs, like that of the cooperatives or to the one including social assistance, education, charity and assistance institutions (Uneba, *Unione nazionale istituzioni e iniziative di assistenza sociale*). The reasons recalled by the interviewees are mainly related to greater scope for forms of various flexibility of work (in terms of pay, length of employment contracts, working hours, etc) and, in general, to the perception of a less constraining general framework of rules compared to that of the public sector.

Against an actual regionalisation of the health system within a framework of IR that does not yet foresee a regional level, the national CA of the public sector has proved important to maintain

[3] In the regions with recovery plans, private hospitals have been hard hit by the cost containment measures. Nonetheless, they rarely declare bankruptcy and therefore no 'social shock absorbers' can be claimed by the unions, as reported by a union representative.

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

coordination between the 'good' and the 'bad' performing regions, ensuring employees with a minimum common level of terms and conditions. By contrast, the private health sector seems more exposed to uncertainty posed by lack of coordination. It seems reasonable to expect this tendency towards fragmentation between private and public organisations to be consistent with the increased differentiation on regional basis of the health provision, which might have challenged the negotiations for private hospitals at the national level. Along with a growing, though contained, presence of private actors in the health sector, the trajectory is that of an increasingly fragmented situation pushed for in particular by the employers, to the detriment of the former trajectory towards coordination between the different pillars.

Employment conditions

The health sector has been going through various reforms and, recently, an increased intervention from the State. On one side, the recent reforms affected the organisation of work and its governance, on the other it had a direct impact on pay conditions. With regards to the former, managerially imposed solutions are now allowed at the decentralised level in the area of work organisation and 'managing human resources' in case of prolonged negotiations. As far as the pay conditions are concerned, with the freeze of CB imposed by the government as measure of cost-containment, pay increases have been put on hold until the next CB round, due at the end of 2013 and it is still unclear whether regional resources can be spent to upgrade wages.

We find here traits of the trends identified when looking at the past decade, in particular towards decentralisation and renewed difficulties in pay negotiations. What were regarded as 'poor' national level wage increases over the years, were 'topped up' at the local level using what was introduced as element of variable pay linked to performance. Appraisal systems did not develop and, where present, were based on criteria such as availability to cover colleagues on sick leave, levels of absence and other elements not exactly related to the content of the performance.

Internal forms of flexibility were attempted in the sphere of working time and two opposed outcomes of the CB on this issue can be found in the first and second half of the 2000s. In the renewal of the national collective agreement of the years 1998-2001, flexibility in the arrangements of working time was delegated to the decentralised level. In some cases, the local level CB managed to re-organise shifts and reduce the working week of up to 40 minutes (see Bordogna and Ponzellini 2004). In most of the organisations, however, according to the interviewees CB never managed to implement particularly original working time arrangements. Interestingly, by contrast, what the latest national renewal did to enhance working time flexibility was to allow greater scope for the decentralised level to increase overtime (by extending the period over which one calculates the average worked hours).

Working time and the organisation of shifts remain two of the most prominent and problematic issues raised by the social partners interviewed. This was regarded as linked to the high demand for part time work which, unless justified by temporary needs of family care duties, was described as a privilege for workers. The national CAs of all public sub-sectors establish that a maximum 25% of the total workforce can work part time. This can be raised by an extra 10% through local level collective bargaining in cases of strongly motivated needs. Once again, recent state labour reforms (*Collegato lavoro*) made it easier for the management to reject part time requests on the basis of organisational needs.

External numerical flexibility is not a prominent phenomenon. This is hardly surprising given that, in the case of agency workers for example, the sector collective agreement establishes a maximum of 7%. Again at the national level, CA conditions the hiring of temporary workers or collaborators to temporary needs.

Outsourcing operations regarded mainly non-core functions such as catering and cleaning and, recently increasing, post-surgery rehabilitation. In these cases, employment conditions for the workers concerned (outsourced) can vary according to different scenarios. Under the 'transfer of undertaking' regulation, transferees are entitled to maintain the same terms and conditions of employment with the new employer until the contract expires. After that, economic conditions and terms of employment will be established according to the national CA of the industry to which the new employer belongs. CB would usually deal with the transfer, but according to one of our respondents, communication about outsourced services is often handled incorrectly or when it is too late for union representatives to intervene and negotiate further improving employment conditions of the transferees.

As for post-surgery rehabilitation, usually the transfer takes place from the public to the private health sector. What emerged from our research is a lower CB coverage in the private health industry compared to the public one and, more in general, conditions of employment less advantageous (less stability, lower pay).

When looking more in details at the outcomes of CB at the decentralised level, we found that employment conditions can be conspicuously affected by the practices in place in the different regions. To stick to the example of agency or temporary workers, in regions with recovery plans, the objectives of stabilization of precarious workers encouraged by the national CA were dismissed on the basis of financial viability. In better performing regions, these objectives of stabilization are further reinforced and monitored by social partners at the regional level. Other policies are then applied to ensure continuity and protection of employment in the case of private actors managing public hospitals, like in case of Private Finance Initiatives. In Lombardy our respondents reported that the institute of secondment in these cases is 'automatic'. Compared to the regulation of the transfer of undertakings, secondment ensures the application of the public health sector CA on a permanent basis.

Since the 'regionalisation' of the organisation of health provision, the function of the national level of CB has been that of guaranteeing a minimum level of employment conditions across the country, regardless the regional wealth. An example is wage setting through Cb at the national level, or the provision of training. 'Life long learning' policies were encouraged via law and taken up by the CB at the national level, which established and monitored compulsory training for all public health workers. While the first half of the 2000s have been innovative and proactive in this field, with improvement in the contents of courses and selection of the training providers, the second half was recurrently described as 'of maintenance' with regards to a number of issues.

In terms of effects on the employment conditions, regionalisation seems to have played almost a greater role than that played by corporatization and the reinforcement of the organisation level of CB. On one hand, the organisation level of CB ends up being more or less favoured by to the overall performance of regional health system it belongs to, and the consequent amount of resources available to, for example, stabilize temporary workers or implement projects to improve work organization. On the other, good regional industrial relations functions as monitoring on the allocation of those resources and on managerial discretion. Ultimately, beyond the nationally established minimum standards, the regional wellness of the health service seems to have direct implications on the job and income security of some groups of workers, in particular staff of outsourced or privatised services and short-term employees.

France

In France, the state has traditionally been, and remains, more present than in other countries. State regulation and administration prevail over collective bargaining in the governance of the health sector workforce. Public hospital staff belongs 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, employment relations are governed primarily by administrative law and statutory regulations. 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 especially in recent decades. 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 all the 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 organisation at various levels, which in effect gradually transformed into a right to enter negotiations on these issues (Rehfeldt & Vincent 2004:15). Wages set aside, branch unions and employer organisations are consulted by the Minister of Health on certain issues, most often in an ad-hoc manner, for instance on pay, staffing, working time; funding, organisation and governance of hospitals, also with respect to the reforms in the past decade. Unions that are considered representative and included in these consultations are determined according to the results of workplace elections[5]. 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. It is important to note that growth in the role of collective 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 at the beginning of the decade, 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

[5] In practice, they are eight: CFDT, CFTC, CFE-CGC, CGT, FO, SUD, UNSA and SNCH.

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, it seems to remain highly centralized overall and closely linked to legal regulation. The new recognition of collective bargaining in the governance of public service employment has not as yet led to significant negotiated outcomes.

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 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.

Employment conditions

Hospital employment forms a public sector branch on its own, and as such is covered both by the general civil service staff status and by sector specific regulations. Employment in public hospitals is governed primarily by the Law of 1986 on the hospital civil service. Central to this status is the classification of professions, which was revised in 2008 at the initiative of the government as part of a wider wave of measures designed to improve human resource management in the public sector. It provides a description of functions and competences attached to 201 professions involved in care missions. The establishment of the new repertory of health professions was the outcome of a participatory process in which unions and professional organisations largely took part. However, it turned out to be merely a technocratic exercise, which reinforced professional and occupational legitimacy at the expense of unions (Tallard and Vincent 2010:1173). The characteristics of occupations described in the repertory provide a benchmark against which individual competencies can be evaluated but this has only been done on a voluntary basis so far. More importantly, the new repertory fed into a reflection on the adequacy of existing training, the content of state diplomas and professional recognition, first and foremost for nurses. In view of the tensions in the profession (an expected wave of retirement, a relatively high level of job dissatisfaction and a general need to improve staff retention), the attractiveness of work in public hospitals has regularly appeared on the collective bargaining agenda. In 2010 a major agreement was signed to improve the recognition of nurses qualifications: they now belong to the highest (A) staff category and their salary conditions were aligned accordingly.

Wages, other forms of compensation and social rights as well as wage progression and advancement are governed almost exclusively by statutory and professional regulations. Public sector wages - in hospitals as in other sectors - are calculated on the basis of the civil service wage index point, to which a multiplier is applied. The individual pay multiplier depends on a fixed wage scale taking into account statutory grade, which is in turn determined by one's occupation and career position within a generally uniform career track. Standard salary advancement in the grid (i.e. within the grade) is based on seniority according to rules that apply to all employees in the same occupation and level of qualification in a uniform manner, while promotions tend to be awarded through internal competitions or through bipartite decision by peers in the "*commission paritaire*", a local body of social dialogue.

In this context, the scope of peak collective bargaining is limited and tends to restrict itself to discussing marginal increases of the wage index point. Collective bargaining between public sector unions and the state has only led to two agreements in the past two decades: one in 1998 (increase

of wage index point +1,3 in 1998 and +1,3 in 1999, more improvement for lower wage categories) and one in 2008 (increase of 0,8% of index point). The renewal of collective bargaining in the public sector made wages a new explicit agenda; both three-year negotiation cycles on the index point and annual negotiations covering the review of previously agreed measures, the presentation of categorical measures by the government, purchasing power, variable pay options related to service performance and individual merit[6] (2008 protocol agreement). The evolution of the index is thus regularly discussed with the unions but in practice determined solely by government unilateral decision. Marginal wage increases in the form of index revaluation have been implemented regularly until July 2010, but they tended to be inferior to the rate of inflation, resulting in a slight decline of real wages since 2008. Public sector wages have been frozen for 2011 and 2012, while wages offered to contract workers, to which no binding regulation or collective bargaining apply, have tended to decline, thereby providing a minor degree of wage flexibility.

Working time arrangements have featured prominently in the development of internal flexibility. The implementation of the 35 hour workweek imposed a decrease in annual working time and provided an opportunity for greater flexibility in working time management, especially with the introduction of a possibility to convert supplementary working hours in additional paid leave that can be used in various manners (holidays, individual training) – or in part paid at a later date. The implementation of this scheme is negotiated at the establishment level. Given staff shortage and financial constraints, supplementary hours are widely used but employers are reluctant to pay them, which unions repeatedly demand in light of the accumulated extra hours on the time saving accounts. It is a contentious issue and a regular issue of discontent related to earnings in the public hospital.

Statutory employment provides little space for external flexibility, although it allows for internal mobility across employers in the public sector and part-time on a voluntary basis. In practice, in public hospitals, flexibility is organised primarily at the establishment level at the expense of the security of some employees. For years, public employers have found flexibility at the margin of statutory employment, most often by relying on a proportion of flexible non-statutory workers on temporary contracts that can be renewed when and if necessary to accommodate activity fluctuation. What appears is a highly segmented workforce with a divide between a (large) core of statutory employees and a (minor) peripheral workforce, mirroring the divide between standard and non-standard work in the private sector. This is especially observed for low qualified work in both care and non-care functions such as assistant nurses or service assistants (Mossé et al. 2010: 187-188). While there are strict regulations to prevent contract workers to substitute statutory employees in permanent jobs, these flexible workers are by and large not covered by the favourable statutory regulations governing pay, additional benefits and career advancement that civil service staff enjoy. Until recently, they were also de facto largely excluded from employee representation and collective bargaining.

Two recent events signalled a turning point. First, a collective agreement specifically addressing the issue of precarious work in the public sector was signed in March 2011. The main point is to offer contract workers who have a certain number of years in the job and fulfil relatively strict eligibility conditions a path to greater employment stability and income security by opening specific access to either undetermined contracts governed by regular labour law or to statutory civil service employment. For this to take effect, the agreement is expected to translate into a law, the implementation of which is still pending at the time of writing (November 2011). Secondly, contract workers were granted similar voting rights as statutory workers in the elections of employee representatives in October 2011, which significantly increased the electoral basis but left the relative weight of the various unions mostly unchanged. It is likely that these developments are not

[6] Variable pay based on performance has not been implemented at the time of research (autumn 2011), although a performance-related element has been introduced for hospital managers in October 2011.

unrelated to the government agenda of reform aiming to reduce the rigidity of statutory employment and to diminish public sector privileges.

Discussion and conclusion

Reviewing the trajectory of reforms in the governance of hospital health care in terms of the four main trends identified earlier, some similarities as well as differences are evident across the three countries. Manageralisation features strongly in all three, with senior management at hospital level being accorded greater authority and discretionary power and formal systems of performance measurement and 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. Marketisation 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 becoming players. Moves towards marketisation vary between Italy's regions, reflecting their role in co-financing and organising health care including hospital provision. Although encouraged by central government, implementation of marketisation 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 marketisation, but so far there has been no initiative to introduce a competition through a quasi-market. Corporatisation 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 substantially augments the greater governance and operational autonomy that hospitals had obtained when acquiring Trust status at the beginning of the 1990s. In Italy, the introduction of *azienda* status in the early 1990s for the ASL and AOs, gave larger hospitals independent status in respect of local health authorities. Concerning privatisation, the private sector has a long-established role in the provision of hospital health care for the public system in both Italy and France. With the important exception of the Italy's Lombardy region, there has been no substantial 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. This has changed, and from the early 2000s onwards the possibility of private provision has been introduced and subsequently grown, notably through the opening of independent sector treatment centres. In summary, reform has travelled furthest in the UK, where each of the four main trends is apparent. It has travelled least in France, where managerialisation has been the predominant trend. Italy lies in between, with clear evidence of both managerialisation and corporatisation. Marketisation and privatisation vary according to region, with Lombardy standing out from the other regions as embracing both.

The budgetary context varies between the three countries and over time within (some of the) countries. 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 as a result of incurring substantial financial deficits have been required to implement recovery plans, involving significant restructuring, in order to achieve financial solvency. 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 salient 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. The timing of the main health care reforms is also a consideration, since their effects on collective bargaining and other workforce governance arrangements may be lagged. Reform initiatives came earliest in the UK, with impetus towards managerialisation dating back to the mid-1980s and the first measures promoting marketisation and corporatisation being introduced in the early 1990s. Italy's first measures promoting managerialisation and corporatisation were also introduced in the early 1990s. Whereas in France, the main measures promoting managerialisation are more recent, only being introduced in the early 2000s.

Overall, this suggests that pressure for changes in the institutions and structures for workforce governance would be greatest in the UK and least in France, an expectation that we now turn to investigate.

Changes in collective bargaining and other administrative mechanisms of workforce governance have occurred in each of the three countries. Moreover, as proposed by Bordogna (2008b) these changes are connected to the extent and nature of the reforms introduced in each. A recurrent mechanism adopted by the respective IR systems is that of an 'organised decentralization'. It takes different forms, as we saw, with a more 'organisation' based criterion in the case of the UK, and a combination of territorial and organisation criteria in the case of Italy. In France, decentralisation has been limited: to the extent that it has occurred it is according to an organisation criterion.

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 are also important, as the findings from the three countries underline. In France, the 2000s saw the opening up of greater space, and an enhance role, for collective bargaining in the public hospital sub-sector, as compared to administrative regulation which was the established mode of governance given the public servant status of the majority of the workforce concerned. This 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 managerialisation. It can also be accounted for in terms of an accommodation to widespread, organised workforce discontent evident in increasing resort to industrial action at the beginning of the decade.

In Italy, the trends towards managerialisation and corporatisation might be expected to be reflected in a growing role for lower-tier bargaining at local area and hospital levels under the two-tier bargaining arrangements which characterise the public service in general, and hospitals in particular. 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. Following Bordogna (2008b), such an attenuated effect might be attributed to the fact that budgetary responsibility has not been devolved to hospital level, meaning that incentives to improve performance for either of the negotiating parties is weak and the scope for collusive behaviour between them correspondingly strong. The emergence, however, of a regional level of collective negotiation – uneven between regions and generally not formalised – is almost certainly a reflection of the enhanced role of the regions in the financing and organisation of hospital health care.

In the UK, reform measures promoting managerialisation, marketisation and corporatisation 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. This underlines the scope that exists for the exercise of political choice, and also the need to take account of the capacity of organised actors – employers and trade unions – to frustrate change initiatives which are perceived to threaten their

interests. 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, referred to above, was employer caution over the potential negative consequences of a full-scale embrace of local bargaining - relating for example to the capacity of a well-organised workforce to engage in comparison-based bargaining, as well as union resistance (Bach 2004). In contrast, the thrust of the subsequent initiative in the 2000s has been to effect a 'controlled' or 'organised' 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 the Agenda for Change reform of collective bargaining structures and agreements on key issues 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 have occurred in all three countries, and whilst these are connected to, but not determined by, reforms in hospital governance, 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 (Bordogna 2008b) seems, however, to be wide of the mark. The formal two-tier bargaining arrangements which cover hospitals in Italy parallel those which prevail in the private sector. But the detailed provisions specified in the sector-level agreement, which echo the administrative regulations which applied up until 1993, set the agreement apart from its private sector counterparts, whose provisions have become more framework in character, and less detailed, over recent years (Baccaro and Pulignano 2010). In addition, the local bargaining over pay related to performance or productivity which characterises larger organisations in the private sector, has not really developed as such in the hospitals sub-sector. Insofar is there is local bargaining over an element of pay, any connection with performance has largely been confounded. Furthermore, coordination of collective bargaining developments across the different, public and private, pillars has weakened in recent years, indicative that if anything the pillars are becoming more – not less – distinct from each other.

In France, although the role of collective bargaining for public hospitals has grown it nonetheless remains secondary to legal and administrative rules emanating from the state which are in essence unilateral. The centralised nature of these rules continues to mark out mechanisms of workforce governance in public hospitals, as in the wider public services as different from those found in the private sector. In contrast to Italy, coordination between collective arrangements covering the public and private pillars has intensified, with the 2002 agreement[7] covering the profit-oriented private sector which set the objective of moving wages upwards towards the level of those in the public sector.

The most explicit initiative amongst the three countries to render workforce governance arrangements more like those in the private sector occurred in the UK. This was the explicit attempt in the 1990s to devolve bargaining to the local level, and simultaneously undermine national arrangements. But, as detailed above, it 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 ones. In this respect, the reform of collective bargaining arrangements for hospitals 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.

[7] *Convention collective de l'hospitalisation privée* of 2002. The non-profit tier has its own framework branch agreement.

The focus on the changes in the employment conditions of health workers across the countries showed a striking number of similarities strictly. Because of the nature of the nationally defined health expenditure, pay remains in all countries subject to central definition. In some cases, there has been scope for implementing local retention premia, like in the NHS for professions that have a market outside the health sector, or regional pay top-ups like in Lombardy to retain nurses. Performance related pay, linked to productivity, has however not been successfully implemented in the cases analysed.

Another common concern relates to the attractiveness of the health professions. The UK has experienced waves of shortages that have been addressed, among other instruments, through overseas recruitment policies. In Italy the respondents in Lombardy mentioned the need to design retention policies of nurses often trained in the North of the country but willing to move back to the Southern regions of origin. In France a re-definition of the professional profile of nurses was partly meant to make it more attractive for future applicants. Responses to the problem have been similar in other regards. In all the three countries there has been an enhancement of the level of education required to access some health professions of nursing, midwifery, physiotherapy, only to mention some. Similarly, this was accompanied by a consequent upgrade of the professional profile, in consultation and dialogue with the social partners and the professional associations involved, and then implemented through local CB in the UK, through the incorporation of the new grading system in the national CA in Italy, and statutory regulation in France.

Working time features as another prominent common issue. Given the difficulties to predict 'peaks in the demand' across the working day, organisation of shifts, need for overtime, replacement of sick leaves, the high number of part time requests from a mainly female workforce are some of the elements that contribute to make working time one of the issues regarded as most problematic. Once more, the responses are similar and within nationally defined boundaries on working hours, flexibility was found to be organised at the local, organisation or even ward, level, often in a informal way.

Though at various extents in the different countries, external flexibility has relied mainly on temporary and agency workers. In the UK there has been government intervention to address the high costs that the NHS was facing in order to have flexible temporary workforce. The government set up a 'controlled' temporary agency for the NHS with set fixed pay rates and common employment conditions. Centrally defined also was the two-tier code, aiming at harmonising the terms and conditions of personnel from different organisations working within the same hospitals. The two-tier code, however, has been reversed under the current government. In Italy, though the phenomenon of temporary and agency workers is less prominent, the national collective agreement has explicitly encouraged the progressive stabilization of temporary workers. Actions have been taken in this direction at the regional level, but with differences in the actual stabilization of workers related to the wealth of the regional health systems. In France, the harmonisation of working conditions of temporary workers with those of the permanent public sector workers is on the agenda. A collective agreement has already been reached and it is waiting to be translated into law to have full effect.

Overall, the changes which have occurred in the mechanisms of workforce governance, including collective bargaining, cannot be said to be driving the employment relations in public hospitals towards those which characterise the private sector. Our findings on hospitals are consistent with those of Bordogna (2008b) for the wider public sector. Proponents of 'new public management' have overplayed their hand when predicting that the consequence of reforms inspired by the doctrine will be the displacement of distinctive modes of workforce governance in the public services. This is not to conclude that established mechanisms of administrative regulation and collective bargaining have not come under pressure, and have not undergone changes as a result. But the logics which have shaped these changes are multiple, and not just the imperative of emulating the private sector.

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