# Modified management thinking in healthcare: impact of centralization

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## Abstract

In health care systems, scarce resources and continuous rise of debts usually cause a stronger cost control and cost containment. In this context the Hungarian government tries to stabilize the sector with (re)continuous centralization and nationalization. This environment would require, in organizational level, a better management support systems and devices. The paper shows that centralized health care environment affects the decision support, and even modifies the attitude of managements. It focuses on characteristics of hospitals management; specifically the interpretations, tools and daily practice of the management and incorporation in decision-making were examined. Research question is *what kind of tools do top managers use for decisions?*

With tools of qualitative research, I defined the management devices in hospitals and highlighted the influence of external factors. Therefore, top managers of hospitals, external experts/consultants and governmental managers were interviewed and decision supporters were asked in homogenous focus group in semi-structured interview situation. Additional questionnaires were used before the focus group discussion for better understanding of the research topic and the respondents' views. The typed interview texts were coded in MAXQDA12 software.

The result of the research shows that top managements of Hungarian healthcare organizations face unique challenges caused by performance volume limitation, debt accumulation, consolidation and centralization/nationalization. These elements have a significant impact on the internal systems of hospitals and on the interests of stakeholders. This environment would require a better use of management support devices however the result of this qualitative research shows the opposite. I identified three different management tools of which the most significant is the financial perspective: hospital top managers try to achieve economic stability with monitoring of liquidity and lobbying for bailout and to maintain the soft budget constraint.

## Renaissance of centralization

Nowadays, all over the world, healthcare is facing intense challenges owing to increasing healthcare needs, aging population or exponentially developing medical technology. The governments try to use stronger cost control and transform the healthcare structure with the device of re-centralization, consolidation, mergers of institutions or privatization. In contrast some decades ago, the dominant trend was the decentralisation, because it 'brings government closer to the people and so the political process becomes more tangible and transparent and more people can become involved' [Hadenius, 2003]. Concerning the healthcare, the improvement of health performances and quality, alongside some other as process of democratisation, minimising inequalities and ethnics disparities or tension were the main reasons of 'redistributing central authorities and responsibilities to local governments' [Regmi, 2014].

Byrkjeflot – Neby [2008] defined the periods and the typical model of country with different healthcare systems: (1) the making of the decentralised model (before 1970), (2) the heyday of the decentralised model (1970-early 2000s) and (3) challenging the decentralised model (after 2000) when even Scandinavian countries are arguably becoming more centralised.

| | decentralised model | challenging the decentralised model |
|---|---|---|
| tax-funded health systems in Nordic countries | most administrative and managerial responsibility as well as substantial political (policy) and fiscal decision-making control has been decentralized inside the public sector | *Norway*: government took over political and administrative/managerial responsibility for all hospitals and transferring the administrative role to five newly created regional bodies<br>*Denmark*: fiscal and most political responsibilities were centralized back to the national government, regional governments was reduced<br>*Finland, Sweden*: number of regional level governments or municipalities was reduced |
| tax-funded health systems in Southern Europe | most administrative and managerial as well as many political (but not key fiscal) responsibilities were devolved from national to regional governments | ***continued regional decentralization*** of health sector decisions<br><br>designing new national programs to monitor performance or set standards for quality and outcomes |
| social health insurance funded countries in continental Europe | most administrative and managerial as well as many fiscal (but not key political) decisions have long been delegated to private not-for-profit bodies | move toward centralizing fiscal responsibilities away from the private not-for-profit funds and into the hands of a national government body |
| state-based social insurance systems | decentralized ownership of hospitals from national to regional and local governments or municipal governments as 'privatization' | pull operating control over its social health insurance system away from regional funds and back into the Ministry |

*1. Table: Process of decentralization and re-centalization in Europe (own table, based on Saltman, 2008)*

Saltman [2008] summarize that it appears that only administrative and managerial authority will remain decentralized to lower level and/or non-governmental organizations, because of the worry about the aging of population, the rapid growth of expensive new clinical technologies and the economic constraints on health sector. Beyond centralization (or as an expectation related to centralization), rationalization (decrease) of hospital bed capacity also arises: "the broader re-organization of hospital care provision involving ways of centralizing hospital care

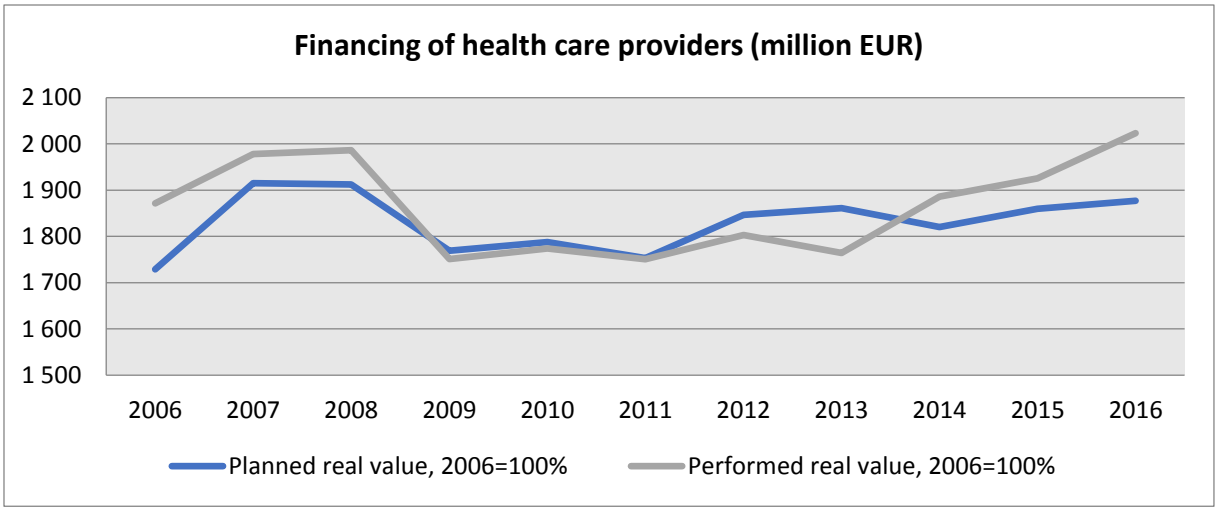
provision and of reducing hospital infrastructure has also been a reform target." [Clemens et al., 2014]

Xu et al [2015] highlights that hospital consolidation (understand as merger of institutions) has increased substantially but it has some benefits: increased quality control, particularly lower patient mortality, improved outcomes achieved by concentrating patients in high-volume centres. But increases in hospital market concentration lead to increases in the price of hospital care [Gaynor, 2012]. In tax-funded countries, the expenditures of health insurance funds are also rising and deficit has become constant. Furthermore, budget deficits were seen as a means of getting more resources from the owner and were in reality, considered as flexible budgets [Nyland – Pettersen, 2004]. The overall approach of soft budget constrain originates from Kornai [1978, 2009], who was examining the behaviour of the socialist companies (nowadays this phenomenon is already noticed in each country in public and private sectors.). The political and social environment creates it with the (low) definition of budget or prices (fees of medical interventions), as examples from the hospital sector. Another definitive factor is the motivation and behavior of the institutions. Kornai [2009] says that the decision-maker is waiting to be saved in case of a low ex-ante budget and then the excess of expenditure will be paid by some other institution typically by the State. As he composes 'the stronger the hospital manager's position is in relation to the hospital's superior organizations, the insurer providing the funds and the institutional owner providing the subsidy, the greater the hope of rescue' [Kornai, 2009]. As well as Dózsa [2011] demonstrates that hospital indebtedness depends on macro level of the financing situation and on management decisions. He proved that indebted and financially stable institutions could be found among hospitals with the same characteristics.

## Context of Hungarian healthcare system

### Trends of debt settlement and consolidation, as certainty of Soft Budget Constraint

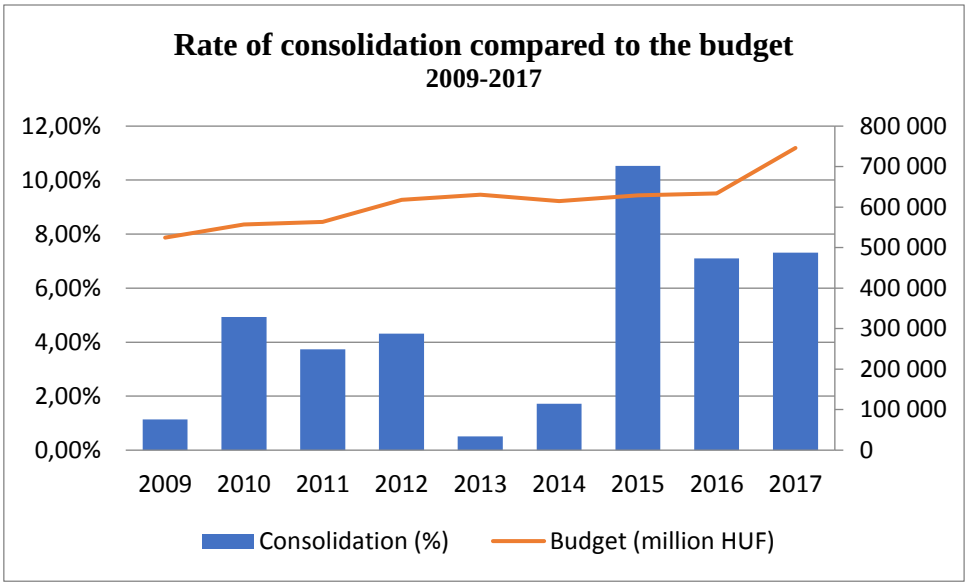
Constant healthcare deficit is a worldwide problem, due to expenditures rising over incomes. Healthcare providers do not pay their suppliers and they lobby at the government for support even though optimal distribution decisions are not supported by debt settlement [Langenbrunner et al., 2005]. Since the mid-90s, the Hungarian healthcare moves in 'vicious circle' because the continuous decreasing resources in healthcare sector is insufficient to resolve the structural problems of healthcare [Bodrogi, 2010]. The fund of Hungarian healthcare is constantly narrowing as in other countries; in numbers: the health spending of GDP is currently 7.4% (average of the OECD is 8.9%) [OECD, 2015]. The average drop in GDP – generating the economic crisis – was almost twice in Central and Eastern European countries as the drop in the euro-zone [Baji et al. 2015], which is caused the low healthcare resources even further reducing.




*1. Figure: Financing after accounting for performance between 2009-2015 (own figure, based on data of NEAK)*

As an effect of the economic crisis, between 2009 and 2013, the performed health insurance payments to hospitals were lower than budgeted payments. From 2014, insurance payments exceeded budgeted amounts by 3-8%, but that increase was paid only at the end of the year. Moreover, the deficit has been continuously generated and the financing amount has not been corrected by the increasing employee wage, inflation and VAT rate in the past period.

According to the practice in recent years, resources are provided by the financier (owner) for the settlement of hospitals debts and for the reduction of supplier debt services and waiting lists. As Kornai [2009] said ‘we are up against a self-inducing process’: ‘if many await saving and hospitals will actually get saved then even more will be expecting the same’. Lenient budgets are a state of mind: the decision-maker is waiting to be saved and is acting accordingly. There was a massive consolidation throughout the entire Hungarian healthcare sector in 1996 and in 2002 after which the reduction in numbers of hospitals with debts had only been temporary – overspending restarted a while ago [Kornai, 2009]. By now supporting hospital debts has become taken for granted in this system, where hospital leaders expect their bail-out at the end of year.




*2. Figure: Consolidation amount compared to the total amount of hospital funding (own figure, based on data of NEAK)*

In the last decade, the monthly funding amount was less than the twelfth of the annual amount, so there was possibility (and expectation too) for year-end payments. Thus the government created the institute of 'end-of-year consolidations', as the hospitals called 'the sweep out of health insurance cash'. From time to time, suppliers of hospitals raise their voices about the magnitude of debt hospitals owe them and they reinforce the need of consolidation. Later the debt settlement financing have appeared beside 'the sweep out' in an amount of 59, 45 and 54.8 milliard HUF (189, 145 and 177 million EUR). The cash-sweeping and then a significant amount of debt settlement was divided between the hospitals by an unknown or non-existing algorithm till last year. According to the recent published law, the ratio of debt financing depends on the expiration (30, 60 or 90 days) of the debts. Although it has also been added that the hospitals may ask individual aid for institutional renewal, investment and/or development.

**Ownership: nationalization, as a process of centralization**

Due to change of socialist system (in 1989), in healthcare sector the central government control has been replaced with decentralization and local governments remained, with a minor change, till 2012. The healthcare reform started with a huge change in politics, the Ministry of Health had been merged into one "giga-ministry" together with education, social care, culture, and sport), headed by state secretary of health. Then the health policy program described the main goals of a proposed new healthcare governance system, envisioning coordination bodies at country, regional and local levels. As regards the ownership of hospitals, the policy document set foot clearly against private for-profit hospitals and also proposed to reach an even higher autonomy of hospital managers. In several steps, the ownership of previously county-owned hospitals was transferred to the central government (both local and county-level governments were affected). The healthcare institutions (after carrying out several hospital mergers as well) have moved under a centralized professional managing institution (Hungarian National

Healthcare Services), the largest supplier and supporter of healthcare services. It has many authorities, such as budget, control and asset management, consolidated public procurement and care management. A few (but significant) hospitals were continued to be supervised by other bodies of the central government (e.g. university hospitals directly by the ministry, or one of the biggest community hospital by the Ministry of Defense). In the new structure, numerous tenders were announced for top manager positions and most hospital managers were changed.

The structural change resulted in a national decrease of number of active beds. Instead of the eliminated active beds, institutions could apply for a one-day daily hospital and outpatient conversion. According to the latest statistics (31 December 2016), 167 health institutions provide services financed by Social Security, with the maintainers and size demonstrated in Table 2.

| **Institutions by maintenance** | **2016.** | | **2011.** | | **2003.** | |
|---|---|---|---|---|---|---|
| | **Number of institutions** | **Number of beds** | **Number of institutions** | **Number of beds** | **Number of institutions** | **Number of beds** |
| Healthcare institutions maintained by local government | 15 | 93 | 112 | 55.404 | 117 | 60.747 |
| Healthcare institutions maintained by central government | 96 | 58.187 | 15 | 6.492 | 26 | 9.846 |
| University | 4 | 7.328 | 4 | 7.359 | 4 | 7.446 |
| Enterprises | 27 | 1.906 | 12 | 187 | 1 | 68 |
| Religious institutions | 6 | 1.432 | 7 | 1.463 | 9 | 1.609 |
| Others (foundations, etc.) | 18 | 561 | 21 | 592 | 19 | 526 |
| Hungarian Prison Service | 1 | 311 | 2 | 608 | 2 | 608 |
| **Total** | **167** | **69.818** | **173** | **72.105** | **178** | **80.850** |

*2. Table: Number of institutions and beds, presented by mainenance (own editing, Source: NHIF)*

The Table 2 clearly shows the process of centralization in Hungarian healthcare services, financed by social security. Private-funded care currently has only a marginal part of the number of beds, and these are mostly found in state-based social insured institutions [Gyenes et al. 2016].

In the public healthcare system, the state secretary wants to introduce a chancellor system since the year 2016, but it generated a large refusal of hospital managers, health workers and experts, so the introduction was postponed to April of 2018. According to the state secretary, the model can improve the control, the transparency and contribute to reducing human resources crises: ‘the chancellor is a position of power that will be appropriate to implementation of management decisions and hospital should not serve themselves, but patients’.

## Research method

The research focuses on characteristics of hospitals management; specifically the interpretations, tools and daily practice of the management and incorporation in decision-making were examined. Research question is *what kind of tools do top managers use for decisions?*

For presenting how Hungarian healthcare system modifies the management tools in hospitals, qualitative research method was used. The research question was examined from the managers' point of view, for deeper recognition and detailed presentation, individual and focus group interviews were made, top managers, healthcare experts and decision supporters (chief financial officer and controller) were asked from different hospitals. The sample includes different types and sizes of institutions and private hospitals, paying particular attention to the response of universities. Community health centres, regional hospitals, national institutions, universities and rehabilitation centres are in the sample. For the selection of the institutions, the statistical analysis of healthcare management control system was taken into consideration [Krenyácz, 2015]. The Table 3 shows the interviewees' information about different hospital, three profit-based and two state-owned enterprises, financed by social insurance.

| Owner of the institution | Total number of institutions | Ratio of interviewed institution |
|---|---|---|
| Municipal health institution | 14 | 0,0% |
| State health institution | 100 | 11,0% |
| University Hospital | 4 | 25,0% |
| For-profit institutions | 24 | 12,5% |

| Role of institution | Ratio of interviewed institution |
|---|---|
| Community health center | 5,9% |
| Community hospital | 6,3% |
| National hospital | 33,3% |
| Specialized hospital | 12,5% |
| Regional center and co-center | 33,3% |
| Multi-profile hospital | 17,4% |

*3. Table: Ratio of surveyed institutions according to the role and the owner of the hospitals*

A total of eight personal interviews were made with managers of hospitals (citation with MI notation) and one homogeneous focus group interview (FGI) with decision supporters. To the better understanding of management information, experts (EI) who know whole healthcare sector were also asked.

The advantage of the focus group interviews is the more efficient data collection, except the careful preparation [Becker, 2006] and more information can be gained by using synergies between group members [Héra – Ligeti, 2006]. Focus groups have a strong social influence on group [Vicsek, 2006], which is more dominant in the homogenous group of decision supporters (mainly controllers). The implementation of the focus group research unit was enormous challenge because of the overladen hospital managers; some colleagues' skype accession solved the problem for the second occasion. But the focus group study was indispensable: 'the deep understanding and knowing of potential features may offer and it may reveal such aspects that the researcher does not think' [Vicsek 2006]. The focus group was small (five persons), as the

interviewees have experience from several institutions. Moreover, they are – according to their self-declaration – highly motivated and committed to managerial decision support. Characters of the focus group:

- homogenous group with two represented areas (finance and controlling), which are closely linked;
- participants have experience from various hospitals (different location, size, structure, management);
- dedication and forming strong, definite opinions have all been assumed based on the questionnaire;
- open and inquisitive team, but with participants typically women (this may be true in the profession as well).

During individual and group interviews, semi-structured interview situation was generated and 'technique of funnel' was applied – structure was increased thus using the advantages of strong and weak structured questions. The interviews were built on each other: starting with expert interviews (1.5 hours) followed by a focus group (1.5 hours). With the expansion of this knowledge, the interview questions of hospital managers were specified. The length of interview decreased from 1.5 hours to 1 hour, due to recurring information. The interviews were typed, after having read them several times a quick report was prepared to keep as a guideline during the final analysis.

Based on the text from the experts' interview major categories were marked with open source coding in Verbi MAXQDA 12 software, and then these were divided into subcategories during the encoding.

## Results: used management devices and attitudes

The Hungarian law names the members of the hospital top managers: the general director (hereinafter the manager or top manager), finance director, medical director (supervises and coordinates the medical and pharmaceutical activity, controls the operation of departments), and the nursing director (monitoring and coordination of care activities). The manager is responsible for the optimal (professional and economical) operation of the hospital. My research highlights that the managements of the examined hospitals use different systems for managing their institutions, which can classify in three categories.

| | |
|---|---|
| **No management tool:** leader manages from 'heart-pocket-booklet' | category from experts' interview, 'managers do not like to admit it' |
| **Special financial tools:** liquidity and debt balance, special budgeting rows monitoring and performance allocation | very typical, almost every interviewee mentioned |
| (operating) **management control system** | used by few institutions, typical before changing of healthcare financing role of year 2004 |

*Table 4: Sumarizing table of hospital management (own table)*

The device of management control system (third tool) is basically an approach, an analysing method of the organization. In the thinking of public hospitals, it is a tool for retrospective analysis, not for providing rapid response; practically its tasks are rather the registering and processing of data than the planning, forecasting and feedback. Because of this misinterpretation of management control system, the two other devices (management without tools and special financial tools) are deeper examined, but the presenting of public healthcare and management thinking's relationship will include the experiences of management control system.

**Managing from 'heart-pocket-booklet'**

The management is formed specifically in many institutions. Some of the managers do not apply decision support systems – information is in the head of the top manager. According to the interviewees the managers use less data for decision due to the lack of IT system and/or knowledge of management, the questioning of data validity (most importantly in terms of cost) and/or other problems. Experts added that:

> *'At many hospitals, I can see the leader managing from 'heart-pocket-booklet' and it would be difficult to say how many - obviously top managers do not readily admit that of course ... in certain areas there are calculations and data… but with a lot of improvisation.'(EI)*

According to several interviewees, the reason of managing from 'heart-pocket-booklet' is the underdeveloped IT systems and the lack of data validity, however the solving and eliminating of these tasks is the responsibility of the manager. Therefore, we can conclude that this management style is generated by the lack of managers' knowledge and/or the importance of 'leadership status symbol' (MI).

> *'The manager is elected politically and this is the symbol of power and status honor ... „he/she is engaged on the base of power and not value' (MI)*
>
> *'For the general director, the main motivation is the status' (MI)*
>
> *'The manager manages from booklet because they do not have management science knowledge, managers vein or not aware of what he/she can do.' (MI)*

'With applying management control system, not only the fault of organizational operation can be discovered, but it shows the managers' mistakes, as well'. They can only be corrected by exploring conflicts and tensions and it is difficult to estimate the consequences of undertaking conflict, e.g. a decision could paralyze the operation of hospital, and can even affect the top manager status.

> *'after defining the expectation of performance, 40% of physician left the hospital, causing a three-month loss' (MI)*

*'the medical staff itself is actually operating wrong when it is not working as an organization ... for example it took me three years, to achieve that the consilium really could work according to the intended purpose.' (MI)*

Another reason for the legitimacy of this management type is the continuous decreasing of managerial room for maneuver e.g. with the implementation of the chancellery system in healthcare (as in other public sector). It is a vicious circle, which further devaluate the hospital management device. The introduction of the chancellery system to healthcare reinforces this process by 'argue the responsibility and competence of general manager' (MI). It could also carry the demand of management and control activities in sectoral level, which is progressively outlining by the centralization.

**Use of special financial management tools**

The majority of the surveyed institutions use specific instruments to manage the economic balance:

(1) limitation of performance in each medical department and its continuous control,

(2) special row budget divided to departments,

(3) liquidity and debt monitoring and managing.

The main reason of these financial management tools is the underfinancing and the existence of performance-volume limit (hereinafter PVL) as a specific phenomenon of the Hungarian healthcare [Dankó et al., 2006a,b]. The hospitals could account their performance until a fixed amount in the budget: the social security financing revenues are maximized at the beginning of the year. Therefore, the available performance of hospitals are divided into professions/medical departments, as PVL 'quota'. This restriction of funding requires the limitation of hospital performances in active and outpatient care (with the exception of some major illnesses and chronic care.). Managers can reach the maximum financed revenue by continuing controlling and reallocation institutional PVL. This mechanism is largely explained by the strong revenue focus of hospitals: in this context, the main managing role is to achieve the maximum. And so the reported performance to health insurance fund is always monitored:

*'Rule of thumb: make as much performance as is needed to achieve the corrugated PVL ... of course it is a bit more refined ... '(MI)*

*'They are able to define the gap above the level of PVL, where it can perform without much deficit. Obviously, they can find interventions in the narrow digression gap, which is to cover the fix cost and it is worth to perform. But, above the gap, zero percent financing guarantees the deficit. The question is: how much is the deficit? Because of interest in patient care ... we provide care to patients, free for some, and, if we balance well, the hospital won`t be bankrupt. '(EI)*

This financial management tool contains the achieving of maximum performance (maximization of healthcare revenue) on minimum cost level. The cost of human resources is about 70% of the budget, but managers think that the only limitable cost is the special medical row of the budget: professional material, medicines, blood utilization, and laboratory and CT budget. But ultimately those budget which associated with the use of direct patient care cost is more flexible than the other (e.g. blood and medicines).

> *'To tell the truth, even the budget is not a budget; because it may be exceeded, with perhaps an awfully confusing administration belonging to it.' (EI)*

> *'In principle, the department could not exceed the budget, but in healthcare it is very difficult to keep to it. If a department runs out of medicine, I can only ask to tell me why. It is so infantile.'(MI)*

The third element of financial management tools is the liquidity monitoring and debt managing; the financial processes are reflected in handling of bank accounts and settlement of debts. Hospitals must report stock of cash and suppliers on a monthly basis to the maintainer. The financial director monitors the cash balance on a daily basis and decides to pay the bills. This is a key for lobbying because the timetable and the balance of the debt settlement define the amount of future consolidation.

**Relation of public healthcare and management thinking**

After the introduction of performance-based financing in 1993, hospital management was regulated by managers enhancing performances.

> *'Since 1995, from the first cases of controlling to the appearance of PVL, the easiest and most popular tools enhancing management were all offensive – all based on revenue growth, and not on restrictions on expenses or cutbacks. As a stoppage to that, they introduced PVL, a revenue stopper, and by that and thus cutting back expenses, in-house results, coverage and institution-wide results could be enhanced.' (EI)*

The performance limit turned financing into base-financing and generated a new way of thinking and management, pushing controlling tools into the background. Handling PVL and distributing them between professions became the main focus.

> *'With the appearance of PVL financing immobilized in the system, compromising the otherwise so strong controlling.'*

> *'Due to patient care being the main interest of hospitals, if need be, they can go above; and they do. This means patients are cared for, some of them for free actually. If they kept the balance in the meantime, bankruptcy would not occur.' (EI)*

In a hospital, knowing the costs, fixed or varying is essential. This however was only recognized by only some of the state-owned institutions with enhanced controlling systems. So these institutions

*'tend to do expensive activities less because the more they go above the PVL, the more deficits these activities cause.' (FGI)*

*'More expensive professions based on cases, i.e.: optometry, surgery or orthopaedics induce higher costs over PVL, while in cases of fix rate medicinal or psychiatric professions, otherwise expensive due to HR expenses, it does not actually matter if 100 or 110 patients are treated since those few extra cases make no significant difference in expenses.' (MI)*

The amount remaining in the National Insurance budget at the end of the year is distributed in order to settle outstanding debts at year-end or to reduce waiting lists, etc. This amount had been distributed between institutions based on performance in previous years however recent years' experiences indicate that the bailout amount depends on debt service of individual hospitals and their ability to lobby.

*'Is there any outstanding debt of the hospital older than 60 days? … They all had it … they started to compensate suppliers in a different manner.' (EI)*

*'this is bad practice since they are kept in a state where they are not interested in keeping liquidity. Thus there is no retaliation if supplier debt service overruns … the government rather injects a single amount, not believing at all in the possibility of reproduction in case of a 100 billion raise in financing.' (MI)*

Debts make heads of institutions concerned but they do not incite them to a more effective management because their message is such as this: 'due to debts my losses will be compensated so why should I make an effort to stand against the clinic and so on… ' Operational budgets, economics and other features were much more transparent in the decentralized municipal system.

*'as a head of an institution I was completely aware of the fact that if I became indebted and bankrupt then someone would have to stand up … but I was completely aware of its relations with the hospital and also with its financial situation. I could actually influence this too. But only as far as that: if I become bankrupt then no more care. No care means scandal. In case of a scandal I become headlines. Headlines mean replacement and so on… There once was some kind of a red line up till which the owner could have helped but only to a certain limit.' (EI)*

*'In the past decade, if financing changes happened only three times a year, it was a quiet year.' (FGI)*

The uncertainty, legislative changes, under-financing and year-ending extra financing, all of them are justified the need and use of financial management devices.

## Conclusion

Even though the theory of decentralisation in healthcare sector unfolded in Europe only two or three decades ago, the governments start to use the device of recentralization with the aim of improving health performances and quality or minimising inequalities and ethnics disparities. In Hungary the decentralization started after the socialist regime change, which remained until 2012. With centralization, the institutions got under state property and supervision, more hospitals have been merged and rationalization (decrease) of hospital bed capacity also arose. The current government has continuously extracted resources from healthcare, reduced funding and the actual health insurance payments to hospitals were lower than budgeted financing. Thus, the year-ending funds became regular and expected. In the last three years, the debt settlement financing have appeared in a significant amount. This soft budget contains, called by Kornai, and the centralization has a strong influence on the managers' thinking.

The managers interpret these changes as a serious issue, as a *sensitive area driven by politics and personal relationships, with common unsolved problems and untold or hidden expectations.* The debt of hospital do not incite the heads of hospital to a more effective management because their message is such as *'due to debts my losses will be compensated so why should I make an effort to stand against the clinic and so on… '* Operational budgets, management, control and other features were much more transparent in the decentralized municipal system; so the idea of Hadenius [2003] was confirmed: the 'decentralisation brings government closer to the people and so the political process becomes more tangible and transparent'. In this period, the tools of management control (reporting by controller, coverage calculation, analyses of capacity, etc.) were rather used. As a result of the centralization and the phenomenon of debt consolidation, financial perspective is in the thinking of hospital top managers – they try to achieve economic stability with monitoring of liquidity and lobbying for bailout. This is the most common management tool for top managers. But some of the managers do not apply decision support systems, the information is in his/her head because of the underdeveloped IT systems, the lack of data validity and last but not least because of the lack of managers' knowledge and/or the importance of 'leadership status symbol'.

Due to the end-of-year consolidations, the phenomenon of soft budget constraint [Kornai, 2009] modified the attitude of hospital managers to a special financial perspective: the managers prefer to lobby for extra-funds instead of avoiding deficit and improving efficient.

Even though the change of financing or the introduction of performance limitation has a powerful effect on healthcare system, the interviewed managers and experts perceive that centralized restructuring and the bail-out phenomenon modified their thinking. Since the debt settlement is regular, it became expected and built in the managers' repertoire.

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