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**Article**

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# Staff councils in hospitals as co-managers? A blind spot in co-determination research<sup>\*</sup>

Stefan Bär, Sebastian Starystach, Heike Hess<sup>\*\*</sup>

**Abstract** New Public Management (NPM) has triggered far-reaching transformations within hospital sectors worldwide and professionalized hospital management has put employee representation under pressure. In this context the current state of research points out that co-determination actors are taking increasingly over the role of co-managers. To test this hypothesis, the cognitive and normative structures in the mind-sets of staff council members at four German university hospitals have been reconstructed on the bases of problem-centered interviews. The results show that the structural change in the German hospital sector affects employee representation in university clinics extensively. However, there is no clear-cut development towards a co-management orientation within the mind-sets of the staff council members. On the contrary, co-management is rejected in varying degrees. The reason for that being is that staff councils in German university hospitals, in addition to their institutional co-determination function, see themselves closely linked to the institutional mission of providing a public good. This is firmly embedded in the cognitive and normative structures of the mindsets. Although the study focusses on a very specific area of co-determination, it exemplifies how the political agenda of the NPM can irritate and break institutionalized patterns in industrial relations.

**Keywords:** Public hospitals, commodification, staff councils, co-management, New Public Management. JEL: J53; L39

## Agieren Personalräte in Krankenhäusern als Co-Manager? Ein blinder Fleck in der Mitbestimmungsforschung

**Zusammenfassung** Das New Public Management (NPM) hat weltweit weitreichende Transformationen innerhalb des Krankenhausesektors ausgelöst und mit einem zunehmend professionalisierten Krankenhausmanagement ist seither die Beschäftigtenvertretung neuen Herausforderungen ausgesetzt. Im gegenwärtigen Forschungsstand wird darauf verwiesen, dass sich Mitbestimmungsakteure in diesem Zusammenhang zu Co-Managern entwickeln. Um diese These zu prüfen, wurden problemzentrierte Interviews mit Personalratsmitgliedern an vier deutschen Universitätskliniken geführt und mit Hilfe der Collective-Mindset-Analyse auf kognitive und normative Strukturen hin ausgewertet. Es zeigt sich, dass der Strukturwandel im Krankenhausesektor umfangreiche Auswirkungen auf die Arbeitnehmervertretung

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hat. Eine klare Co-Management-Orientierung zeigt sich jedoch nicht. Im Gegenteil, sie wird in unterschiedlichem Maße abgelehnt. Das lässt sich dadurch erklären, dass sich Personalratsmitglieder in deutschen Universitätskliniken neben ihrer institutionellen Mitbestimmungsfunktion eng mit dem institutionellen Auftrag der Daseinsvorsorge verbunden sehen. Dies ist kognitiv und normativ fest in den Mindsets verankert. Auch wenn sich die Studie lediglich auf einen kleinen Bereich der Mitbestimmung konzentriert, verweisen die Ergebnisse darauf, dass die politische Agenda des NPM institutionalisierte Muster in den industriellen Beziehungen irritieren und aufbrechen kann.

**Schlagwörter:** Öffentliche Krankenhäuser, Ökonomisierung, Personalräte, Co-Management, New Public Management.

## 1 Introduction

Against the background of change in the industrial relations towards a neoliberal direction (Baccaro & Howell, 2011, 2017), research on employee representation and co-determination is of high relevance. However, co-determination in hospitals is a largely unexplored subject (Brehmer, 2014; Glassner, Pernicka, & Dittmar, 2015). This is surprising, considering the pervasive restructuring and reorganizing efforts within the hospital-sector worldwide, which affect employees' interests negatively, especially concerning working conditions (Aiken, Sloane, Bruyneel, van den Heede, & Sermeus, 2013; Griffiths et al., 2014; McGowan, Humphries, Burke, Conry, & Morgan, 2013; Tokuda et al., 2009).

Since co-determination laws guarantee employees' participation concerning working conditions and business-related decision making, co-determination by its very nature is closely connected to corporate governance. In the last decades "councils had to learn the rules of co-management by transcending their collective-voice function and taking responsibility for productivity and economic success" (Müller-Jentsch, 1995, p. 55). Hence, current industrial relation research points to the emergence of a new type of co-determination: co-management (Hälker, 2004; Jung, 1999; Rehder, 2006; Rüdert, 2007).

In theory, reorganizing hospitals should increase the importance of employee representation and the institution of co-determination as part of the governance structures. It might as well change how works and staff councils ("Betriebsräte" and "Personalräte") operate. Therefore, the study examines the impact of the increasing incorporation of modern management methods in the hospital sector on the institution of co-determination.

New-Public-Management (NPM) has triggered far-reaching transformations within the hospital sector (Dent, 2003; Mosebach, 2009). The neo-liberal idea of NPM (cf. Connell, Fawcett, & Meagher, 2009) gives answers to the dilemma of (1) ever-increasing costs due to changes in morbidity, ageing populations as well as medical-technological progress and (2) the welfare state's guarantee to provide affordable medical treatment. The promise of NPM is: If economic principles take effect in the form of a quasi-market system and managerialism as governance, transparency and efficiency will increase, the dreaded cost explosion can be avoided while at the same time high-quality medical care is ensured.

The institutionalization of competition and modern management methods via laws and reimbursement regulations have strengthened the chances of institutional entrepreneurs (Di-

Maggio, 1988) to change the very form how medical care is organized, resulting in reorganizing and restructuring efforts within hospital-sectors worldwide. There is an ongoing debate, to which extend regulatory changes truly affect hospitals' governance-structures (Lega & DePietro, 2005; Mosebach, 2009; Scott, Ruef, & Mendel, 2000; cf. Starystach & Bär, 2019). Dominantly, changes in the regulatory environment are interpreted as commodification or economization of health care (Imershein & Estes, 1996; Mohan, 2019; Reich, 2014a, 2014b; Simon, 2001; Tonkens, Broer, van Sambeck, & van Hassel, 2013). Commodification theory's main assumption is that medical treatment is currently extensively and increasingly evaluated via economic performance standards on all levels of conduct and that governance-structures first and foremost conceptualize hospitals as market players competing with other medical service providers (Mosebach, 2009, p. 70).

Taking this into account the following hypothesis derives: Due to increased economic constraints and professionalization of hospital management, works and staff councils in the hospital sector increasingly take over the role of co-managers and to that extent, become less of a traditional employees' interest representative. If this is true, not only would this change our understanding of the general functionality of co-determination as an institution, but also would point to a reinforcing acceleration of the commodification dynamic in the hospital sector. With taking over the co-management role, works and staff councils would become corporate actors supporting neo-liberal ideas. Intentionally or not, they would partake in institutional work and become institutional entrepreneurs (DiMaggio, 1988) of the normatively contested idea of the hospital as a for-profit service provider of medical treatment (Schimank, 2008).

Unlike in most other co-determination contexts, the survival of the organization in the case of hospitals has so far not played an explicit role for councils' members in pre-DRG times, especially since the former cost recovery principle and the guarantor liability virtually had ruled out insolvencies. Therefore, we concentrate in an ideal typical approach on how the conflict of interests to the classic configuration of "capital versus labour" is reorganized. We proceed this way even though the relationship between staff councils and employers does not empirically manifest itself in this dichotomous form, neither in the hospital context nor in other constellations of industrial relations. Practically speaking, co-determination is generally institutionalized as a mediator (Müller-Jentsch, 1997). Our argument, however, concentrates on the newly added challenge for the role of staff councils in hospitals and thus show what consequences arise regarding the potential increase in co-managerial orientations.

Therefore, our main question is, if and to what extent we can find co-managerial orientations in the mindsets of council members in the hospital sector. An increase of these orientations would mean that economic principles reshape industrial relations not merely in terms of framework conditions, but rather in form of a paradigm shift in the mind-sets of actors inhabiting the governance-structures of hospitals: In an institutional analysis perspective, "capital and labour" would not be irreconcilably opposed anymore, and the success of the organization as a company would become a dominant interest of both, staff councils and management.

To test this hypothesis, in this paper we focus on staff councils of the four university hospitals in Germany in the federal state of Baden-Württemberg. We restrict our analysis to university hospitals since they are as maximum-care facilities especially faced with corresponding cost structures and therefore prone to managerial control and reorganizing efforts. We focus on staff councils due to specific State Staff Representation Acts (SSRAs) that apply

in public university hospitals. We concentrate on Baden-Württemberg to control for the institutional framework, since Germany's co-determination regulations vary considerably on the level of federal states.

First, we present the background and institutional context of regulations. We then further specify our research question by embedding it in an institutional analytical perspective. After a brief overview of methodology and design, we present findings on the question of staff council members' co-management mindset with the help of 29 problem-centered interviews. We summarize by deriving a hypothesis from the results and naming the limitations of the investigation.

## 2 Background and institutional context

Mainly two components form the specific institutional configuration of co-determination: (a) challenges and changes in the health care sector, and (b) the representation of employee's interests and the respective regulations to which it is subject.

(a) In most developed countries, health care systems are seriously challenged by cost implications of changing morbidity and ageing populations as well as ongoing medical and technological progress (Dent, 2003). Governments in many countries have changed regulations concerning financing health care services to open hospitals to principles of NPM (Dent, 2003; Glennerster & Le Grand, 1996; Mattei, Mitra, Vrangbaek, Neby, & Byrkjeflot, 2013). Consequently, financing of hospital services in many countries is associated with a case-based flat rate system (Busato & Below, 2010; Busse et al., 2013; Chok et al., 2018; Kobel & Pfeiffer, 2011; Koné, Maria Zimmermann, Nordström, Simone Elger, & Wangmo, 2018; Leister & Stausberg, 2005).

Beginning around 2000, the Diagnoses Related Groups (G-DRGs<sup>1</sup>) system replaced the former financing of current expenses via daily nursing charges in Germany (Rau, Roeder, & Hensen, 2009). In contrast to other countries with mixed systems of financing current expenses, Germany took over the DRGs as an exclusive system (Geissler, Scheller-Kreinsen, Quentin, & Busse, 2012). This system does not calculate actual costs incurred in specific cases, but average costs incurred in a diagnosis (Fiori & Bunzemeier, 2009; Simon, 2013, p. 416 ff.), which then become the basis for remuneration. As revenue is linked primarily to the average costs of treatment, cost control has automatically become a major key factor in hospital management. This has led to a major reorganization (Bär, 2011; Bär & Pohlmann, 2016, 2017) with a massive trend towards privatization of publicly owned hospitals as well as implementing management models (Bär & Pohlmann, 2016; Lega & DePietro, 2005) with outsourcing and spin-off strategies.

(b) Workers' representation exists worldwide, but in vastly differing ways (Rogers & Streeck, 1995). The German system is a dual one with trade unions on the one hand and works councils elected by the employees on the other (Waas, 2012). In addition, the interests of employees in state owned institutions are represented by staff councils.

Concentrating on public institutions, the question arises, as to what effect the aforementioned changes will have on these councils. However, it is difficult to assess the dynamics

1 An adaptation of the Australian AR-DRG system.

of change on co-determination within Germany's hospital sector, because of the different areas of application of the Works Council Constitution Act (WCCA) and SSRAs. Moreover, regulations on co-determination are not standardized due to the hospital sector being heterogeneous in terms of ownership structure and legal forms.

In general, the WCCA applies to hospitals managed in the legal form of a limited liability company (*Gesellschaft mit beschränkter Haftung, GmbH*) or joint-stock company (*Aktiengesellschaft, AG*). In contrast, hospitals owned by churches and religious orders and other private non-profit hospitals are subject to their own regulations respectively. In university clinics and other publicly owned hospitals, specific SSRAs apply in the respective federal state.

Greer, Schulten and Böhlke (2013) consider surprising that labour-management conflicts occur in state owned hospitals with public legal form. In our view it is not, since an integral part of state hospital planning, public hospitals are under financial pressure far more than others. The reason for this is that in Germany, hospital financing is a dual system, in which current expenses are refinanced by the health insurances through DRGs, whereas investments should be refinanced by the public sector. However, there is an enormous public investment backlog (Blum, Löffert, Offermanns, & Steffen, 2018). Especially large entities, like university hospitals – which are obliged to treat all kinds of highly complex diseases at all times with highest quality and concurrently to maintain the need for every kind of specialists and infrastructure – suffer from a nationwide uniform flat-rate remuneration model for their services. It is therefore obvious that reorganizing hospitals will have effects potentially resulting in personnel savings or rationalization and that conflicts of interest may arise not only in privatized hospitals but in state owned hospitals as well.

Especially in university hospitals federal-state dependent co-determination rights are weaker. Besides, there is a weak union influence on the governing board (Greer et al., 2013). In addition, in 2006 the former professional association “Marburger Bund” was established as the physician's union (Bär, 2010; Greef, 2012) and since then Germany's main union in healthcare ver.di no longer has a sole mandate to represent employees' interests in hospitals. Therefore, it is of high interest to investigate staff representation in state owned university hospitals.

To summarize, over the past two decades, NPM, reorganization, managerialism and commodification have fundamentally changed hospitals, their working conditions (Bär & Starystach, 2017; Starystach & Bär, 2019; Starystach, Bär, Ernst, & Streib, 2018) and the corresponding industrial relations (Bach & Givan, 2011; Bär & Pohlmann, 2017; Galetto, Marginson, & Spieser, 2014; Glassner et al., 2015). Despite the importance of understanding this nexus in terms of corporate governance, the current state of research does not deliver a complete answer to the question whether and to what extent these structural changes influence co-determination.

### 3 State of research

Co-determination in public service in general and specifically in publicly owned hospitals has a longstanding research deficit (Keller & Schnell, 2003, p. 185; Kotthoff, 2013, p. 324).

Research focusing on works councils has shown their role as potential co-managers (Minssen & Riese, 2005; Rehder, 2006; Rüdts, 2007) and a trend towards professionalism since the 1990s (Kotthoff, 2013, p. 325). In particular, the scope of the co-management hypothesis – although the term is used inconsistently (Kotthoff, 2013, p. 328) – is of importance for understanding changes in governance structure in this context, because it addresses an on-going paradigm shift in the industrial relations.

Co-Management has two main features: (1) Works councils are considered to have almost equal rights in important management decisions that go beyond the legally guaranteed areas. (2) The interests of the workforce and the company tend to merge as the works councils articulate the employees' interests from a company perspective (Rehder, 2006, p. 228). Studies on the co-manager type of works council show that they work more professionally. That is to say, with differentiated work processes, a high degree of specialization, higher employee participation, more intensive contact with the management and a tendency to adapt their practice to the company's decision-making processes (Minssen & Riese, 2007). However, resulting role conflicts can be attributed to the traditional distinction into the three systematic problems of representation, integration, and solidarity (Fürstenberg, 1958). By solving the problem of integration (of interests) via co-management, a collaboration too close with the management might lead to deficits in legitimacy in respect to the workforce and might compromise the solidarity with the unions (Rehder, 2006). When a works council acts as co-manager, it may be forced to support controversial management decisions. Representatives are therefore faced with the challenge of maintaining a balance between co-management and structural conflict (Kißler, Greifenstein, & Schneider, 2011, p. 116). Unlike other authors, Müller-Jentsch (1997, p. 280–281) sees the works council's actual strength precisely in its role as an intermediary institution, with its compulsion to mediate between different interests. According to Kotthoff (1998), co-managers are expected by the management to make concessions in terms of the politics of interests under the motto of "safeguarding employment", which in the past was considered unthinkable (e.g. reduction of social benefits or of wage components). Paradoxically, the increase in opportunities for participation and importance of the works council is linked to a decrease in its effectiveness as a representative of employees' interests (Kotthoff, 1998, p. 78).

Nevertheless, the archetype of co-manager is regarded as the most promising form of modern representation, since they can participate early in operational design strategies (e.g. reorganization measures) and thereby influence operational decisions far beyond the statutory co-determination possibilities of the WCCA (Kißler et al., 2011, p. 133). Particularly concerning economic issues in which the WCCA only grants informational rights (Müller-Jentsch, 2017, p. 103).

Compared to the relevance of these transformation processes, there is hardly any empirical research on co-determination by staff councils, and very few that explicitly deals with the co-management hypothesis (Kißler, Graf, & Wiechmann, 2000). However, staff councils are structurally involved in modernization processes and therefore face new challenges (Schnabel, 2007).

In the light of the "New Control Model" (i.e. the German version of NPM) research on staff councils in municipal administration (Wiechmann & Kißler, 2010) showed, that faced with modernization and restructuring, they are in a quandary between protecting staff against rationalization and co-management (Greifenstein & Kißler, 2002, p. 34). Following Bogumil and Kißler (1995), they distinguish between three different types of interest representation

(traditional, balancing, progressive) and argue that only the progressive staff council can exert a formative influence. In the course of NPM, a shift away from individual case measures and towards a preventive and formative orientation can also be observed among staff councils (Kißler et al., 2011, p. 135). In addition, staff councils have grown into an intermediary role in which they not only represent the interests of employees, but also strive to improve administrative processes (Kißler et al., 2011, p. 136).

For staff councils in hospitals, only an explorative study by Becker (2014) was able to show empirically challenges due to establishing new corporate governance and management structures at the investigated hospital.

Despite these sporadic findings, it is unclear whether staff representatives in public hospitals will react by continuing to defend interests against the outlined dynamic of change, or whether they will seize the opportunities and chances for an improved position of co-determination as co-managers.

#### 4 Conceptual and theoretical approach

To investigate a possible paradigm shift in co-determination, we use an institutional analytical approach. Following Scott (2001) institutions can be differentiated analytically in: a) *regulatory institutions* that govern actors' actions by means of clear, readily formulated laws and instructions. If these are not obeyed, formal mechanisms of social control are available; b) *normative institutions* that denote norms and values that have been internalized by actors. If these are not adhered to, ostracism and other forms of social exclusion are the result; and c) *cognitive institutions* that are socially shared conceptions of the world, its shape, and the mechanisms inherent in it, to gain the ability to act in concrete situations.

The change of hospitals' reimbursement economy due to transferring NPM into health politics, is a major change on the regulatory layer. The corresponding laws and regulations strengthen chances of actors to change the very form of governance structures via applying managerial concepts and principles. Following Schimank (2008, 2010, 2011), we conceptualize them as institutional entrepreneurs (DiMaggio, 1988). These actors are characterized by the fact that they have (1) internalized normative standards of the respective institution and (2) cognitive structures to cope with situational contingency within the body of applicable regulation. Institutional entrepreneurs make use of the opportunities created by regulations by implementing governance structures, which conceptualize, support, and execute changes to the organizational structure.

In case of hospitals, professional management tends to reorganize and rationalize inpatient medical treatment *as if* hospitals are competing and *as if* prospective budgeting is necessary to survive the market-forces. Scott et al. (2000) created the well-known formula for this transition: "from professional dominance to managed care". Institutional entrepreneurs reify the perspective on hospitals as enterprises, i. e. as a specific form of organization, which has to pursue economic goals besides providing medical treatment (Kelly, Doyle, & O'Donohoe, 2015). In this perspective the hospital as an enterprise is a "contested normative fiction" (Schimank, 2008).



In theory, employee representation, which is institutionalized as co-determination, is one of the major contestants to this idea. Works and staff councils are major institutional entrepreneurs and, in theory, will try to reify co-determination as a solution of the conflict between capital and labor.

Referring to university hospitals the question which the co-management hypothesis raises is: Does implementing NPM into corporate governance structures via hospital management also change the cognitive and normative structures of the staff council's members? Do staff councils change their normative and cognitive structure towards a co-managerial mindset due to the exposure to professional management? Does co-determination become therefore an institutional entrepreneur by proxy (via isomorphism) for economic governance principles and reinforce the ongoing process of commodification of inpatient health care?

The current concept of co-managerialism is not clearly defined. Therefore, we propose our own definition, to render the hypothesis testable. For this purpose, we conducted a thought experiment: What would be the normative and cognitive structure within the corporate actor (staff council), if they would fully adapt the normative ideals and management strategies of the current institutional changes in direction of neo-liberal thinking (see Table 1).

On the normative level, being an archetypical co-manager would mean to adopt the principle, that the hospital's corporate success in a competitive environment is the top priority of corporate governance. Interests of employees would be secondary, since a necessary condition of fulfilling their interest lies in the economic success of the hospital itself. Adopting such normative standard should be reflected in liberal arguments that the welfare of the employees is (mainly) achieved via success of the hospital as a market player.

In contrast: If the normative structure would remain traditional, employees' interests should be protected on the basis of formal rules even if it puts the hospital at a competitive disadvantage.

On the cognitive level, being an archetypical co-manager would mean to adopt managerial tools to reduce complexity, while partaking in corporate governance. An example of this would be to analyze conflicts of interests in terms of operating results and to make decisions together with the management based on a shared assessment of the situation in economic terms. Participating in corporate governance should lead to structural manifestation in staff councils, in the form of a formal functional differentiation and corresponding division of labor, which mirrors – in an isomorphic fashion – structures of the modern hospital management. Therefore, we should find a high degree of specialization and an increased cooperative contact with the management.

In contrast: If the cognitive structure would remain traditional, safeguarding of interests based on formal rules (collective agreements and labor law) as well as the assertion of the interests of the employees should occur. Both, even if this is clearly directed against economic interests or has negative consequences for the hospital.

*Table 1:* Staff councils' co-managerial versus traditional mindset differentiated by normative and cognitive institution

Archetype Institution	Co-managerialism	Conflict between capital and labor
1. Normative institution	Ensuring organization's economic success	Protecting and enforcing employees' interests based on formal rules
Source of legitimacy	Corporate economic success also ensures employees' interests	Decommodification and elimination of labor exploitation
2. Cognitive institution	Joint decision-making with management under economically framed factual constraints	Irreconcilability of interest of capital and labor
Reduction of complexity	Mimetic isomorphic functional differentiation and corresponding division of labor	Negotiation on work's value and significance based on collective agreements and labor law

Source: own compilation

Since the orientation towards either co-managerial or traditional mindset is a purely analytical distinction, empirically variation of expressions of the respective paradigms should occur. Therefore, to test the co-management hypothesis via qualitative methods means to estimate where between the above-mentioned extremes the collectively shared normative and cognitive structures of staff council member's mindsets have to be placed. This gives an insight in how co-determined governance of hospitals is shaped against the background of institutional change on the regulative level.

## 5 Methods and Design

To test this co-management hypothesis, it is necessary to proceed step-by-step. Because the diversity of ownership structure (public, non-profit and private entities in Germany), legal forms and different co-determination frameworks as well as their high rate of change in the hospital landscape is an obstacle to simple comparability (cf. Greer et al., 2013). For this reason, the study concentrates on the federal state of Baden-Württemberg and staff councils at its four university hospitals located in Heidelberg, Freiburg, Tübingen and Ulm.<sup>2</sup> Here a uniform collective agreement and an exchange of strategies on uniform problems in co-determination arose in the course of the legal independence and change of legal form (AÖR, i. e. public agency) at the end of the 1990 s through networking of the four staff councils in a joint working group (o. A., 2016), which emerged from the main staff council institution. In a methodological sense, this design generates constancy in terms of entities, legal framework, and collective agreements.

<sup>2</sup> To guarantee anonymity, in the further text we use the randomly assigned letters A, B, C, D instead of the city names.

In total, 29 problem-centered interviews (Witzel, 2000) with the corresponding staff council members were carried out in 2017 and 2018. To map the heterogeneity of the group, the method of selective sampling with a qualitative sampling plan (Merkens, 1996) was applied. The selection criteria that were considered were position in the staff council, duration of membership, degree of exemption, occupational group, trade union membership and gender.

Table 2: Sample

	Case				Total
	A	B	C	D	
Number of interviews	5	11	4	9	29
Female	3	6	1	5	15
Male	2	5	3	4	14
With exemption	5	8	4	8	25

Source: own compilation

The sample of 15 women and 14 men (Table 2), of whom all except four were partially or completely exempted, represents the professional groups of physicians, medical technicians, nurses and administrative staff as well as several positions like chairperson, committee member and observer or ordinary member.

The semi-structured interviews with narrative generating questions as well as ex- and immanent follow-up questions focused on five topics (1) career as staff council, (2) main tasks performed, (3) relationship to the hospital management and (4) the workforce, (5) cooperation with trade unions. The underlying research focus was on changes that respondents perceived during their term of office. The interviews, each lasting on average 45–60 minutes, resulted in a text corpus totaling around 400 pages. The text was initially analyzed with the method of content analysis and examined for key passages. The key passages were paraphrased, generalized, and reduced to gain a deeper level of abstraction (Kuckartz, 2016). To reconstruct the cognitive and normative structures, a collective mindset analysis according to Pohlmann, Bär and Valarini (2014) was conducted. The concept of mindsets is not restricted to individual attitudes and action orientations. The analysis of mindsets aims to reconstruct the collectively shared forms of sense-making, the corresponding knowledge inventory and the normative rules behind the individual attitudes, opinions, and social practice (Stachura, 2005, p. 167 ff.; Ulrich, 1999, p. 430). Although the social practice of staff councils cannot be directly observed via this method, it enables us to reconstruct the normative and cognitive patterns which are involved in the day-to-day business. To answer the research question, the results were systematically related to the theoretically developed indicators regarding a co-management mindset (Table 3).

Table 3: Indicator set differentiated by normative and cognitive structure

Level of analysis	Indicator of a co-managerial mindset
Normative structure	<ul style="list-style-type: none"> <li>• Naturalization of:               <ul style="list-style-type: none"> <li>- Hospitals as a market player of competing service providers for medical treatment</li> <li>- The survival of the organization as shared interest of management and employees</li> </ul> </li> </ul>
Cognitive structure	<ul style="list-style-type: none"> <li>• Increased cooperative contact with the management including shared decision making</li> <li>• High decision autonomy in management affairs beyond the possibilities provided by law</li> <li>• Formalized division of labor and responsibilities with a high degree of specialization</li> </ul>

Source: own compilation

## 6 Findings

The findings based on a case-by-case analysis are portrayed in Table 4. The separate case results are presented in an abstract and generalized fashion along the distinction between normative and cognitive structure. For illustration purposes interview-quotations<sup>3</sup> are presented.

Table 4: Findings on dimensions of a co-management mindset

Dimension	Case			
	A	B	C	D
Naturalization of hospitals as a market player of competing service providers for medical treatment	<p>Not present.</p> <p>Political conflict. Fighting for the ideal that the hospital is part of welfare-production which must kept free from market interests. Marketization processes are negatively evaluated. They</p>	<p>Implicitly present.</p> <p>The commodification of the healthcare system is normatively accepted as a factual constraint.</p>	<p>Not present.</p> <p>Marketization of health care is an external force (overwhelming diffuse pressure), but this is morally wrong.</p>	<p>Not present.</p> <p>Political conflict. Fighting for the ideal that the hospital is part of welfare-production which must kept free from market interests. Marketization processes are negatively evaluated. They</p>

3 Sequences were translated by the authors. Linguistically, they were corrected in a few passages without changing the original meaning.

Dimension	Case			
	A	B	C	D
	produce factual constraints (diffuse pressure).			produce factual constraints (diffuse pressure) and as a consequence hardened fronts.
Naturalization of the survival of the organization as shared interest of management and employees	General rejection.  Partly acceptance due to factual constraints in the context of political decisions the survival of the hospital creeps into the normative evaluation of the situation.	Present.  The hospital is considered a community of fate. Survival of the organization first, except in the case of bargaining disputes. Retreat to a legalist view on the responsibilities of the staff council.	Present.  Due to factual constraints, the survival of the hospital creeps into the normative evaluation of the situation: Formation of the staff council as a problem-related and reactive intermediary position between employee's interest and management in the context of market forces.	Strong rejection.  The irreconcilability of the profit-oriented exploitation interests of the management and the interests of the employees for fair remuneration and working conditions free from alienation is explicitly stated.
Increased cooperative contact with the management including shared decision-making	Not present.  Corporate success oriented on external expectations is opposed to the representation of employee interests.	Present.  Focused on achieving compromise in cooperative contact with the management.	Present.  Close cooperation with the management; mainly to prevent spin-offs.	Not present.  Negotiating partner to the management on the basis of the State Staff Representation Act.
High decision autonomy in management affairs beyond the possibilities provided by law	Not present, but there is a desire to be involved in entrepreneurial decisions.	Not present.	Not present, but there is a desire for it.	Partly present in anticipating the regular path of co-determination.
Formalized division of labor	Generally, not present, but	Not present.	Not present.	Present, especially for staff

Dimension	Case			
	A	B	C	D
and re-responsibilities with a high degree of specialization	partly existing (medical vs. nursing concerns). Unclear “informal” division of labor, partly arbitrary preferences (“hobbyhorses”).	Model of committee work.	Model of committee work, partly specialization in consulting services.	council members with exemption.

Source: own compilation

## 6.1 The Normative Structure

The staff councils are predominantly opposed to the concept of hospitals as market participants. Inpatient health care is normatively framed in terms of public welfare, which can only be provided, if and only if sufficient monetary and human resources are allocated and the employees are given appropriate working conditions. If not, hospital's character fundamentally changes to the negative from providing health care to earning profits

“Personally, I’m of the firm believe that hospitals should not be run like factories. And that the way in which we manage them should not be the same as in a factory, which has to earn money. So that a doctor doesn’t make decisions based on economic reasoning, but from his expertise and heart and soul [...]” (AI3, 597–616)

Nevertheless, all interviewees acknowledge that (neo-liberal) political course-setting led to ongoing marketization and a corresponding increase of factual constraints within the hospital. In this context, the staff council is part of a political allegiance against neo-liberal politics and the associated processes. Conflicts and negotiations with the management in hospitals are therefore directly connected to the ongoing political process in the health care system.

The general perception is, that conflicts of interest become more intense and the corresponding normative – or for that matter – ideological fronts are hardened. The perceived political conflict leads to a reinforcement of traditional normative structures in which inpatient health care must be kept free of profit interests. Here, two main variances in staff councils’ mindsets must be emphasized, as they display first evidence for a fundamental change in the normative structure directing to co-management:

The first variance consists in the perception that the political battle is more or less lost and marketization processes are comparable to a natural force, which one cannot withstand for a prolonged period of time but has to deal with in a constructive or proactive manner. Marketization and privatization efforts are still normatively rejected but became a surreal reality. Negative consequences for the employees must be mitigated in this context.

The second variance consists in the perception that factual constraints are increasingly dominating the hospital but are not connected to a surrounding political conflict. Therefore, factual constraints are naturalized. The staff council members do not formulate an alternative

socio-political model and therefore implicitly acknowledge the reign of economic principles over the hospital sector.

This leads us to the hypothesis, that the intra-organizational social construction of factual constraints can undermine the traditional normative structure of staff councils. When factual constraints become normality, the formulation of a social-political alternative becomes unlikely. A mechanism for this could be, that a strong reification of economic thinking in form of factual constraints shatters the material foundation of a traditional mindset: If there is no money, if there are no more human resources and the only way to receive at least some is to be competitive in health care market, then the fight for a traditional mindset becomes futile.

This argument gains even more traction, examining the normative structure further, whether staff councils naturalize the concept that the survival of the organization is shared interest of management and employees.

Despite the result that staff council bodies reject the notion of the hospital as a market participant, they do however increasingly accept normatively that economic survival of the hospital is of shared interest. In this perspective, external pressure puts management and employees in one boat, in which factual constraints lead to the de-politicization of intra-organizational conflicts.

By neutralizing the political dimension, marketization as external force normalizes the concept, that management and employees share – at least partly – the interest for the survival of the organization, although in principle the interests between management and employees are perceived as irreconcilable. The factual constraints force the staff council more and more to compromise as they reshape the balance of power. Consequently, we find a strange side by side of the concept of the survival of the organization as shared interest and at the same time, the notion that the interests are irreconcilable. We interpret this as a transitional phenomenon. This can be made plausible with the help of two main variances in the mindset on a case basis:

In one staff council body there is a strong notion of the conception of the “organization first”, combined with a dominant co-management mindset on the cognitive level in this regard. This staff council body prefers to work on tangible intra-organizational problems and mediates between the interests of employees and management. More generally, we find at the level of individual staff council members regardless of membership of a concrete staff council body, that the stronger the concept “organization first” is normatively accepted, the stronger we find normative and performative acceptance of co-management combined with a (de-politicized) legalist view on what responsibilities of a staff council are.

“I think that’s also a little bit due to our staff council, I’ve been influenced by the fact that we always look a little bit, that’s often a tightrope walk, we of course feel like a countervailing force in the company. That is what the staff council [...] always means that they simply have to look, we are the countervailing power, that we look there, that rights are protected, but on the other hand we also always say that everything has to go well with the company. Because otherwise it has effects on employees, and that is why we are often in a co-management role.” (C11, 447–463)

In contrast, in another case we find a strong rejection of this concept of “organization first”. This staff council emphasizes the irreconcilability of the profit-oriented exploitation interests of the management and the interests of the employees for fair remuneration and working conditions free from alienation. Improving the working conditions and to ensure fair remuneration is seen as the main responsibility of the staff council, as part of the institutional structure, and political struggle. The major implication from these results is, that factual

constraints introduced via marketization may lead to a paradigm shift, in which the interests of employees and management seem not irreconcilable anymore.

Therefore, we can refine our hypothesis. The reification of economic principles in form of factual constraints puts the hospital in danger of not being competitive enough. The concept of “organization first” is a way of rationalizing this context. Compromising and working together with management becomes a rational choice, since the management must work within the same factual constraints. When the concept of “organization first” and its rationalizing force is missing, a traditional mindset including its political dimension is readily apparent. “Organization first” can be identified as a main normative gateway to colonize staff councils’ mindset. It decouples staff councils’ intra-organizational day to day business from the political dimension.

## 6.2 Cognitive Structure

Concerning the cognitive structure of staff councils’ mindsets, we find two main ways of conducting day-to-day operations under the changed framework conditions within the hospital.

### Cognitive Mindset A – Compromise

Two out of the four staff council bodies focus on cooperative contact and achieving compromises with the management. Given the necessary reciprocal trust on the individual level, the aim is that the staff council and the management work harmoniously together to guarantee that a reconciliation of corporate’ and employees’ interests take place.

“I would say, [...] we have an extremely good relationship with our management. We work together very well on many points and that we also – and this may sound a bit silly – have a very good reputation as a staff council. In other words, that we don’t just make a fuss, but that we also work together constructively. We have concluded a large number of service agreements, for example, which I believe is not the case in other hospitals. We have regulated a great deal for the good of the employees, over and above the collective agreements, and I believe that this is an indicator that there is a very good cooperation.” (B14, 147–155)

This corresponds, without being semantically and normatively present, with a co-management identity. This connects to the above-mentioned normative structure that staff council and management are sitting in the same boat. Political conflicts become concrete organizational problems of reconciling interests which can be solved by regulating issues via agreements and not collective bargaining and corresponding conflict methods based on solidarity like strikes. Interestingly, this increased cooperative contact with the management does not involve shared-decision-making.

“The management always tries to get us, of course, or the other superiors, into a cooperative attitude. So that we support the things that they do. [...] The [C] Staff Council is perhaps different from many others, more in its cooperative attitude and less in its negative, counter-orientated attitude, but we always try to turn everything into the positive. So even if something happens that we don’t really want to happen, we do say that a change is good, but not the way it is planned. Instead, we imagine it one way or another. And with that we actually have relatively much success, also in the company.” (C12, 160–174)

Despite this fundamental design of a constructive cooperation, the relationship between management and staff council has latently changed for the worse. This is primarily attributed to change of management toward professional personnel. This can be interpreted as the arrival



of institutional entrepreneurs, which have a rational approach in bargaining situations. Staff councils are reviewing the situation with disappointment, as they are increasingly seeking to reach compromises against a background of increasing factual constraints.

For example, in one case-study, a close cooperation with the management takes place mainly to prevent the spin-off of subsidiaries. Here, staff council members work together with the employees to develop concepts that allow them to compete with private suppliers.

“We said that we would work constructively to ensure that our own cleaning staff would continue to be covered by the university hospital’s collective wage agreement. And then they said: Okay, but it has to be about as cheap as if it were a private provider. And it was truly a painful process: we got together with the employees and contemplated on how to clean as effectively as private companies do.” (C11, 519–527)

In other words, within parameters set by the management the staff council tries to preserve as many jobs as possible. Generally, this kind of staff council can be described as having little to no autonomy in management affairs, but at the same time having a focus of compromises based on factual constraints. These types of staff councils are under threat becoming a management appendix, rather than co-managers.

#### Cognitive Mindset B – Conflict

Contrary to this, we find in the two remaining cases, a completely different approach towards the arrival of professional management personnel and methods. Since new management techniques have changed the way interests are negotiated, these staff councils aim to professionalize themselves in order keep up in the arms race with the management.

“It used to be like a football game [...]. So, you played football together, you were in different teams but after the game you could go for a drink. Today it is more professional, and you meet on a different, a professional level. [S]o we are also approaching large industrial companies’ structures and corresponding relationships. I think as a rule, if you are lucky and it works reasonably well, you will understand each other reasonably on a normal, human level, but you simply have different tasks and functions.” (D14, 361–378)

Staff council member’s aim here is not to represent management’s decisions, but on the contrary to be taken seriously by the management as an institutionalized negotiating partner based on the SSRA. Consequently, the contact to the management becomes formalized and traditional mindsets are reinforced. The staff council refers to health care as part of the welfare production. Following this logic, the staff council is also responsible for ensuring that the staff can meet patients’ needs.

In this perspective, corporate success oriented on external expectations is conveyed via the board of directors in a concrete management practice, which is opposed to the representation of employee interests oriented on internal institutional expectations. This in and of itself generates potential for conflict and the corresponding need for negotiation. The cognitive structure is docked to the traditional conflict-oriented mindset.

“We primarily have to represent the interests of the employees, right? In counterpart to the management. And of course, the board of directors has the task of managing the hospital, right? And to ensure that it runs on a financially secure track, right? And of course, these are completely different interests. [...] And so, it’s inevitable there’s a conflict, when you have different tasks.” (A15, 631–641)

In these cases, the staff council members do not acknowledge but rather reject an over-emphasis on economic aspects with consequences for the employees and the rigid application of economic principles. When conflicts inevitably arise and the fronts harden, the manage-

ment interprets justified concerns of the staff council as a declaration of war. Negotiations are brought to a hold, a formalized way of conflict like legal proceeding is pursued. Generally, this kind of staff council can be described as having no autonomy in management affairs and rejecting compromises based solely on factual constraints.

### Division of Labor

Predominantly there is no indication for a formalized division of labor and responsibilities with a high degree of specialization. In all four cases the work of the staff councils is dominated by the classic committee work. Work organization of the staff council as a collective body (explicitly in two cases) is presented as being characterized by routine discussions and meetings, and the division of labor is presented in a rather ad hoc manner.

“Monday morning at half past seven is the board meeting of the staff council. [...] Then there is an early meeting every day at 08:15 a.m. in our office, in which all staff council members who work in the office, including the secretariat, [...] take part. So [...] these are the staff council members who are exempt from work. And, and then at 11 o'clock on Mondays, for example, there is always another strategy group, a meeting, which discusses certain topics that are on the agenda this week or in the near future in particular detail. There are just then only two topics. While in the early morning meeting it is actually only discussed what has come by mail, what appointments are pending, so that somehow you know to some extent who is doing what in the office.” (CI2, 125–137)

Work is organized in line with the requirements of the SSRA, such as the composition of bodies and committees. In addition, individual hobbyhorses are reported in both cases, but in one case the possibility to divide work along competences is cognitively represented. In two cases the work seems to be rather unorganized and this corresponds with the conviction that it is non-formalized communication work which allows achievements for the employees.

The partially existing division of labor corresponds closely with the applicable law: The division of labor is organized along the different professional groups (e. g. medical or nursing related concerns), along the difference whether the staff council has an exemption or not and along the question if the member belongs to the staff council board. Against this background one relevant variance as an adaption towards the changed framework conditions must be emphasized:

In one of the cases, due to hardened fronts following the fallout of a type B mindset, the staff councils felt compelled to become more professional themselves and work is along the competences.

“We’ve also become much more professional over the years. So, it used to be like that: We got into the discussions, were well prepared, our fighting heart was beating. And today it’s like qualification is really the be-all and end-all. I can’t talk about a business plan if I don’t know the numbers.” (DI9, 67–71)

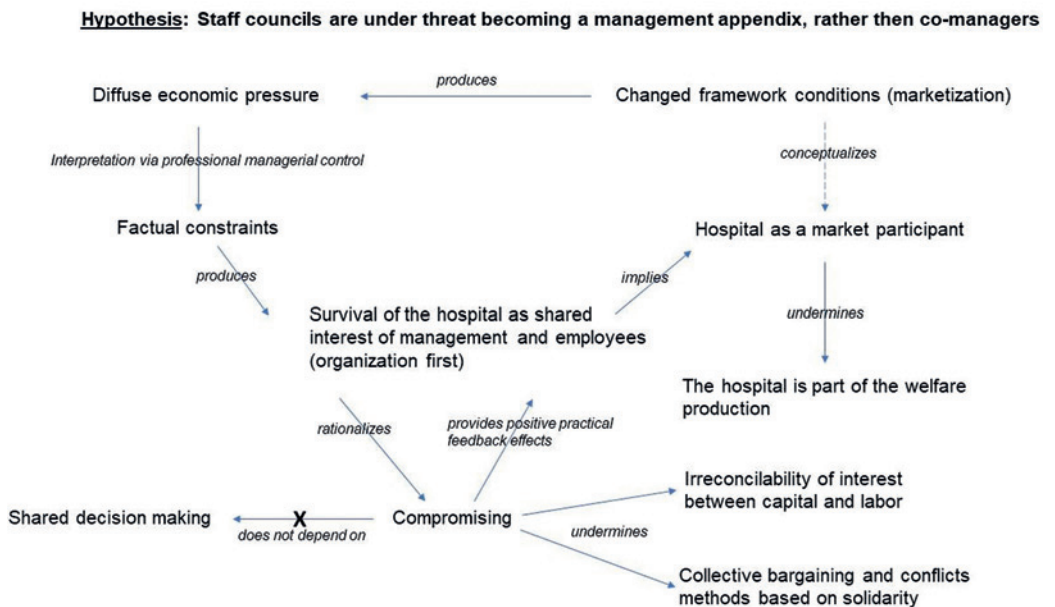
Overall, we find the mindset of specialization and division of labor along competencies in the case where the shared interest of management and employees on the normative level is strongly rejected. It is justified with the fact that one must be able to keep up with the management to achieve something for the employees. In the other cases a kind of fatalism seems to reign.

## 7 Main results and discussion

The results show that the structural change in the German hospital sector affects employee representation in university clinics extensively. However, there is not a clear-cut development towards a co-management orientation within the mind-sets of the staff council members. On the contrary, co-management is rejected in varying degrees. The reason for that being is that staff councils in German university hospitals – in addition to their institutional co-determination function – see themselves closely linked to the institutional mission of providing a public good. This is firmly embedded in the cognitive and normative structures of the mindsets.

Against the background of the findings, the changes due to NPM may lead depending on the organizational settings to 1) hardened fronts and a corresponding arms race between management and staff councils (cognitive mindset B) or 2) staff councils becoming no real co-managers, but rather a management appendix (cognitive mindset A) (Figure 1).

Figure 1: Elaborated hypothesis and the corresponding mechanisms



Source: own compilation

*Cognitive Mindset Type A* is connected with the deterioration of the traditional normative mindset and *Cognitive Mindset B* with its reproduction. But the reification of factual constraints and the trend towards the acceptance of the concept of “organization first” may lead to more and more staff councils adapting a *Cognitive Mindset Type A* further reinforcing this trend in form of a vicious circle, which is characterized by a mutual reinforcement of the normative and cognitive structure.

The reification of economic thinking in form of factual constraints can lead in this context to the perception or framing that the current change in the reimbursement economy and the corresponding change in corporate governance is inevitable. This changes the political dimension of co-determination profoundly: Since the political fight is lost, staff councils have to make the best of a bad situation. Therefore, factual constraints introduced via marketization may lead to a paradigm shift, in which the interests of employees and management seem not irreconcilable anymore.

Staff councils sharing a *Cognitive Mindset Type A* run the risk of becoming a management appendix, because the regulatory institutions are shaped in a way that capital and labor are not equally represented in the decision-making process. Real co-management is not possible in the purview of the SSRA.

## 8 Conclusion, limitations and open questions

The way of becoming a real co-managerial body seems to be blocked. The adaption pattern on the normative and cognitive level point in the direction of (1) keeping up the traditional mindset against all odds of success or (2) compromising more and more to guarantee the survival of the organization but without gaining decision-making autonomy, that is running the risk of becoming a management appendix. It is remarkable that some of the staff council members reproduce the classic pattern of “capital and labor”, even though it has no empirical basis in the German co-determination context in its pure form, and that another part of the staff councils, in trying to adapt co-management for the hospital sector, threatens to be instrumentalized by management (appendix hypothesis).

Due to limitations of the research design the study cannot show whether co-management is widespread among staff councils in hospitals and to which extent they are in danger of becoming a management appendix. Nor can it show that the boundaries of interest representation are becoming blurred and that employee representatives are internalizing company interests and strategies. However, that was not the aim of the study. This would have required a large comparative study covering all legal forms of hospital organizations and different co-determination rules.

However, the results show that staff council members in publicly funded university hospitals in one German federal state, activate cognitive and normative patterns in very different ways against the background of identical co-determination regulations, which indicates that co-determination in this field has come under considerable strain. Triggered by the changes in the hospital sector, this is a snapshot of a clearly unfinished process of reaction and adaptation to changed framework conditions for the institutionalized representation of employees' interests. Both, the changes in hospitals and the changed conditions of co-determination in hospitals are the subject of the challenge faced by members of staff councils. Normatively, the majority of them refer back to what is already institutionalized, namely the position of hospitals as organization for the provision of a public good, which is not primarily oriented towards economic principles, and on the other hand the positioning as the primary representation of employees' and not of corporate interests.

Although the study focusses on a very specific area of co-determination, the study exemplifies how the political agenda of NPM can irritate and break institutionalized patterns in the industrial relations. A little light has been shed on this blind spot in co-determination research, but further research is needed, especially on hospitals with different forms of ownership and applicable co-determination laws, as well as across generations of staff council members.

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