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Deutsche Gründlichkeit:

Liberalization and local industrial relations in German hospitals

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Abstract

How does the creation of markets affect the processes and outcomes of industrial relations?[1] This paper examines German hospitals, where national liberalization policies have put immense pressure on wages, especially at the bottom of the labour market. We find that the effect of intensified competition on labour-management relations varies between locales, and there are some cases of mobilization and union revitalization. From an eight-way case comparison, we infer a configuration of three factors – local labour markets, local politics, and sector-specific co-determination rules – that together provide a well fitting explanation for both variation and change.

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1. Introduction

In the 1980s and 1990s, industrial relations writers asked why German labour-management partnership was resilient in the face of changing world markets. The answer was that institutions mattered: nationally specific rules regulating in-firm worker participation (codetermination) and wages (coordinated collective bargaining) produced mutual gains for workers and employers on a mass scale (Turner 1991). In recent years, however, Germany has gone from being one of the most equal societies in Europe to having an incidence of low-wage work only marginally below that of the UK (Bosch and Weinkopf 2008), with much of the low-wage workforce covered by collective agreements (Bispinck and Schäfer 2006). If, as theorists argue, formal institutional change has been gradual and has served to shore up the system's basic logic (Streeck and Thelen 2005), why have these outcomes changed?

We argue that, in order to understand the changes of the past decade in Germany, theory needs to depart from the standard toolkit of comparative institutionalism and turn to issues of market-making and local political economy. This argument is based on publicly available data on change over time in a sector, as well as in-depth qualitative case studies of eight hospitals. In response to the relentless liberalization of the sector, we observe a wide variation in the functioning of worker representation.[2] Using an eight-way comparison, we find that variation is due to differences in local politics and labour markets, as well as sector-specific (but locally chosen) co-determination rules.

We examine hospitals in the east (Berlin, Chemnitz and Erfurt) and west (Stuttgart, Hamburg, Dortmund, and Gießen-Marburg), five of which are public, and three of which now belong to large, expanding private hospital chains. At each site, we interviewed works councillors and staff of the main union in the sector, *vereinte Dienstleistungen* (ver.di), and at most sites we interviewed managers, politicians, and union allies. We triangulated this information using the trade press, union documents, newspapers, publicly available statistical data, and interviews with national union officials. From 2003 to 2008 we conducted 60 interviews with 57 individuals and in January 2009 held a two-day conference including representatives from most of the hospitals in our sample (see appendix).

We begin by reviewing recent developments in institutional theory and German industrial relations. Second, we provide an overview of changes in the terms of competition in the hospital sector and their effects in the workplace. Third, we examine workplace restructuring and worker representation in the eight case studies. Fourth, we re-examine the case studies in terms of the local labour-market, political, and institutional factors that mediate the relationship between liberalization and

2 'Worker representation' in this paper refers to three kinds of actors. *Gewerkschaft*, or trade union, operating above the level of the firm; *Betriebsrat*, a formally separate works council body at the level of the workplace and firm under private and voluntary sector labor law; and *Personalrat*, a works council in a private-law company under public sector rules. In all of our cases, most works councillors are union members and work with union full-time officials.

labour-management relations. We conclude with a discussion of the theoretical and policy implications.

2. Market making and institutional theory

The story of German hospitals is theoretically unlikely, because it is about employers covered by collective bargaining, subject to other forms of non-market regulation, not subject to global competition, who nevertheless compete on the basis of labour costs. Despite widespread acknowledgement of decline in union membership and collective bargaining coverage (Hassel 1999), German industrial relations is still used as a defining instance of rule-based obligatory institutionalized behaviour. Streeck and Thelen (2005), for example, argue that in Germany, '. . . an employer who turns his shop into a "union-free environment" will not just be reproached by the unions he has locked out, but also by the courts that will remind him of the obligations the law of the land imposes on an employer of labor as a matter of legal duty' (15). A second surprise is the union response, which includes localized mobilizations that resemble what US scholars call 'social movement unionism'. Theory predicts that German unions have incentives to use social partnership to pursue their goals due to their institutionalized leverage (Baccaro et al 2003; Frege and Kelly 2004). In order to understand the gap between theory and reality, it is worth examining the two main mechanisms in this literature that cause capitalist diversity and inform standard narratives of German industrial relations: institutional complementarities and societal embedding.

Most institutional theories contain a notion of systems, with elements that co-evolve in a coherent and functional way. For Hall and Soskice (2001), for example, complementarities between institutional systems governing such activities as training, corporate governance, and wage setting create stability and difference in national institutions. The coherence of these interacting systems produces comparative advantages for employers, which employers have an interest in preserving. The result should be 'dual convergence': coordinated market economies such as Germany will become more coordinated and liberal market economies such as the US will become more liberal.

Events in Germany since the late 1990s have not confirmed this prediction, spurring a theoretical concern in institutional change. While the institutions of industrial relations remained stable, those of corporate governance were subject to major revision (Höpner 2007). Over this period, collective bargaining saw a major functional shift, despite this formal institutional stability (Rehder 2003). Drawing on the Polanyian thesis of societal embedding – that societies tend to devise measures to counter the perceived destructive effects of the market – this group of writers argues that change has happened, but that social institutions have made it 'path dependent' (Streeck and Thelen 2005). Liberalization entails neither wholesale convergence on a neoliberal model nor retention of the old system, but rather, 'strategic behavior on the boundaries of institutions [leading] to incremental forms of institutional change' (Sako and Jackson 2006: 563).

For some of these writers, and for us, a defining feature of liberalization is the making of markets. But what do we mean by the market, and how can one be made? We speak of the market in a sociological sense (e.g. Krippner 2005), as a set of exchanges where more or less commodified 'things' are bought and sold. Every market is structured by government regulation, self-regulation, and participants' norms, and is as a result more or less governed by prices as opposed to non-economic concerns. Of interest to us is the kind of market that emerges as a deliberate choice by the state: a choice to use the price mechanism more and to ignore certain other non-economic concerns. In German hospitals, where there is little tradition of free competition and restructuring is politically sensitive, the state has retained its strong roles in planning and pricing and used these as levers to promote marketisation.

While the social effects of marketisation have been peripheral to the sociology of markets (Beckert 2007: 17-18), they have shown up in much empirical industrial relations literature. For example, market mechanisms are important in the 'new public management' internationally (Kirkpatrick and Martínez Lucio 1996) and in Germany are increasingly used by large firms to allocate resources internally (Brinkmann and Dörre 2008). Market making is associated with Reaganite or Thatcherite politics; but it is also central to the EU's methods for securing the free movement of goods, services, capital and labour (Lillie 2010). The creation of markets matters centrally to how outsourcing and other forms of vertical disintegration affects industrial relations in Germany (Doellgast and Greer 2007).

As in most countries, German unions are active in 'embedding' markets, i.e. preventing them from eroding the terms and conditions of employment. Conversely, the complexity and uncertainty caused by marketisation forms the background of most of the academic literature on unions. They face crisis, existing patterns of action seem untenable, and new leaders with different outlooks implement, with more or less success, new strategies (Nissen 2002). This adaptation can take the form of the re-establishment of bargaining at the new scale of the market, as in Commons' (2009) narration of the rise of a national market for shoes and a national union for shoemakers or Lillie's (2006) case of global collective bargaining for seafarers as a response to Flags of Convenience. Unions can also adapt by changing the way they intervene in the complex mechanisms of state, local and national government, in legislation, administrative decision-making, or the judiciary (Katz et al 2003; Benz 2007). While traditions of national industrial relations still sometimes matter for how unions respond to liberalization (Holst 2008; Doellgast 2009), this has not prevented local experimentation by German trade unions (Dörre and Röttger 2006; Turner and Cornfield 2007; Turner 2009). These responses have been shaped by the character of local civil society (Locke 1992), conflicts or communities of interest (Tattersall 2005), or ideology and power relations within firms and sectors (Anner 2003).

The dynamics of liberalization can be seen in Europe, where courts and administrative bodies have promoted more open international competition in markets for services. One result in Germany has been the selloff of public service organizations in sectors such as energy, telecommunication, postal services, and public transport. In the absence of sectoral collective agreements to regulate new competitors, to paraphrase John Commons, the wage bargain between workers and

employer is increasingly determined by the price bargain between producer and customer, leading to downward pressures on wages (1909).

Unlike Commons (and unlike contemporary sectors subject to global market pressures), the salient changes in German health care not a geographic extension of the market, but rather a functional extension of market mechanisms into new areas of activity. In both instances, intensified competition is the result. But here, marketization is a policy of managers and politicians to govern differently, rather than a loss of control by sovereign rule makers due to the actions of distant competitors (MacKenzie and Martínez Lucio 2005; Lillie 2010). Although it poses a threat to workers and unions, there is no obvious scale at which unions could re-establish control analogous the national shoemakers union or the global collective agreement for seafarers. Union responses vary, and the task of this paper is to uncover how and why.

3. The local effects of national market-making

The finding of change and diversity may in itself seem surprising, given German unions' and employers' reputation for hierarchical national coordination. Why is there so much variation and change? The answer can be found in the features of local context that support or undermine different patterns of labour-management interaction.

We examine local industrial relations in terms of the character of worker representation. While all works councils in the sample were led by ver.di members, and could therefore be considered trade unionists, they behaved very in diverse ways. Some were working in close consultation with management, with a minimum of conflict, accepting responsibility for the effects of change, but receiving additional rights and resources; in keeping with other writers, we call this 'co-management' (Rehder 2006). Others had good management access, which they augmented with worker mobilization. This can be called *Konfliktpartnerschaft*, and is a well established pattern in German industrial relations, in both the east and west (Müller-Jentsch 1999). Third, we met trade unionists who were excluded from decision making and had to pressure management and politicians from the outside, through coalition building, member mobilization, and an appeal to broader social issues; this can be labelled social-movement unionism (Greer 2008). Finally, we met trade unionists, mainly in the East, who had a resigned attitude towards exercising power or seeking influence and exercised their co-determination rights primarily in order to gather information and provide better advice to workers. This approach we label quiescence (table 1).

Our explanation (table 2) focuses on three aspects of the local political economy, which on their own are insufficient in explaining this variation, but in combination supply a well fitting explanation for the observed variation and change. First, *co-determination rules*, which vary according to whether the hospitals are governed by non-profit, for-profit, or public sector law, shape worker representatives' access to management. However, they do not assure union power, because they are subject to change in line with the decisions of state and local politicians, and trade unionists

are not always able or willing to mobilize workers in support of demands. Second, the level of *local unemployment* affects unions' abilities to mobilise workers. Four of the hospitals we studied are in the places where unemployment is very high and four are in places where it is relatively low, and mobilization is more common in the latter group than in the former group. Third, *channels of influence in local government* may provide access to decision making despite weak co-determination rights or mobilization capacity. Some cities in our sample are governed by a strongly entrenched union-supported centre-left establishment, while others are governed by conservatives who tend to freeze trade unionists out of decision making. These channels, however, do not ensure that social partnership will work smoothly; weak co-determination rights and a shift in the governing coalition can both undermine social partnership.

Table 1. Types of worker representation

Degree of...	***Konflikt-partnerschaft***	**Social-movement unionism**	**Co-management**	**Quiescence**
access to management	High	Low	High	Low
Worker mobilization	High	High	Low	Low
coalitions with civil society	Medium	High	Low	Low
engagement with justice issues beyond the workplace	Medium	High	Low	Low

Table 2. Comparison of cases

		local politics	
co-determination rules	Unem-ployment	Open to union influence	Closed
Strong	Low	***Konfliktpartnerschaft*:** Gießen-Marburg post-2004* **Co-management:** Hamburg pre-2001	**Social-movement unionism**: Hamburg post-2001
	high	**Co-management**: Dortmund Berlin-Vivantes	**Quiescence**: Erfurt
Weak	Low	***Konfliktpartnerschaft***: Gießen-Marburg pre-2004 *	**Social-movement unionism**: Stuttgart
	high	***Konfliktpartnerschaft***: Berlin-Charité	**Quiescence**: Chemnitz

4. Liberalization and working conditions in German hospitals

Germany is an especially far-reaching case of hospital liberalization. No other European country has privatized a larger percentage of hospitals (Böhlke and Schulten 2008) or seen such fragmentation in hospital wage determination (Grimshaw et al 2007). Sickness and health are not commodities that can be bought and sold, and health care is an existential good that Germany, like every society, provides in some form independently from the patient's ability to pay (Deppe 2002). While there is a strong element of patient choice, the real powers in this so-called 'dual system' are the two funders: the *Länder,* who are also responsible for planning and investment, and the (mostly quasi-public) health insurers, who cover hospitals' operational costs through reimbursement contracts. This organizational landscape is structured by the Social Security Code (*Sozialgesetzbuch V*) and the Hospital Financing Law (*Krankenhausfinanzierungsgesetz*).

In the beginning of the 1990s, lawmakers began to introduce market mechanisms into the statutory framework, in order to encourage the 'economization' of hospitals. Their aim was to cap costs in the face of new medical technology and rising life expectancy. Because the health system depends on employer contributions to insurance funds, the fear was that excessive growth in healthcare costs would have undermined the international competitiveness of the German industry. Thus, although markets in the hospital industry – for patients, reimbursements, and investment capital – remained domestic, reformers justified their actions as a necessary adaptation to globalization.

One crucial area of reform was hospital financing, or more specifically, the de-coupling of payments to hospitals from the cost of provision (Simon 2007a). In the 1993 Health Care Structure Act, lawmakers abolished the old principle of full-cost recovery, introduced a cap on increases in reimbursements to any given hospital (regardless of the service provided), and created new mechanisms for hospitals to operate under budget surpluses or deficits. In 1996, lawmakers added a component of reimbursement to take the specific diagnosis into account, and in 2000, they took this principle further. Using the argument that per-diem payments created incentives for hospitals to unnecessarily extend patient stays, lawmakers adopted a modified version of an Australian system of standardized payments called Diagnostic Related Groups (DRGs).

Although the DRG system was not completely implemented until 2009, its effects on the management of hospitals were clear from the beginning (Brandt and Schulten 2008a, Wendl 2008). By standardizing payments according to average 'production costs' of each diagnosis, the system made it difficult for hospitals to hide their costs from the insurers and easier for insurers to extract cost reductions for lucrative diagnoses that had previously subsidized other parts of hospital operations. This put pressures on hospitals to reduce costs, increase staff-to-patient ratios, and compete for patients with relatively lucrative diagnoses. Under the threat of bankruptcy, hospitals operating under deficits faced increasing pressure to restructure; meanwhile, their competitors with surpluses began to save up investment capital and

expand. For local governments with scarce resources running loss-making hospitals, privatization thus became an attractive solution.

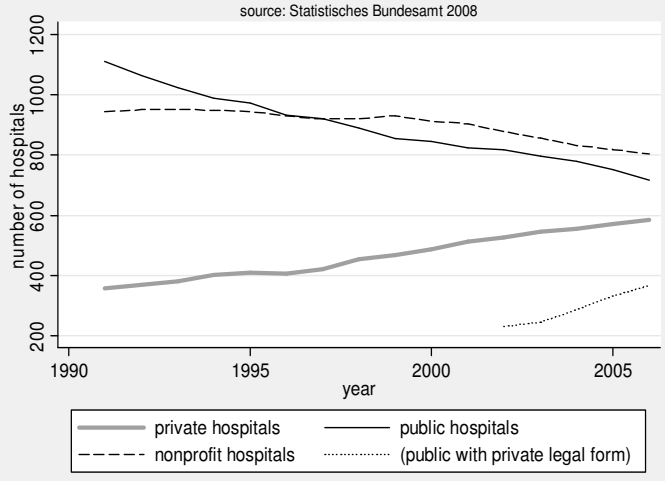
The other side of the dual financing system, investment, reinforced these pressures, especially the trend toward privatization. Between 1991 and 2008, the share of GDP invested in the public sector dropped from 2.6% to 1.5 %, putting Germany in second to last place among EU member states (European Commission 2009). The hospital trade association estimates the resulting backlog of investment at around €50 billion (Blum and Offermanns 2009); some economists estimate it at €100 billion (Simon 2008). Given the government's reluctance to increase taxes, the financial tug-of-war between state and national government built into the federal system, and the limits on government borrowing set by the 'European Stability and Growth Pact', *Länder* turned to privatization as an alternative source of investment capital.

Until the 1990s most German hospitals were run either by local government or not-for-profit organizations (mainly churches), while for-profit hospitals played only a minor role, with smaller, specialized clinics. The first wave of privatization began in 1991 in the eastern *Länder*, where planners created a mixed economy of hospitals with less government ownership than in the west. After 2000, a second wave of restructuring occurred, this time in the west, which included the privatization of some of the largest municipal hospital systems. The share of hospitals in private ownership increased from 15% in 1991 to 30% in 2006. At first, the targets of privatization were smaller hospitals with under 100 beds, but as the private hospital chains expanded, so did the average size of private hospitals. From 2002 to 2006 the share of beds in these hospitals increased from 9% to 16% (Statistisches Bundesamt 2009), and by 2005, of the more than 65,000 beds controlled by private companies, more than half were controlled by three companies, Asklepios, Rhön, and Fresenius (the parent company of Helios), each with just over 10,000 (Brandt and Schulten 2008a).

Meanwhile, hospitals that remained state-owned were merged into independent subsidiaries with a private legal form, giving hospital administrators more autonomy from the administrative rules of state and local government. The share of beds at public hospitals with a private legal form increased from 25% to 57% from 2002 to 2008, while the figure at more closely held public hospitals declined from 26% to 13% (Statistisches Bundesamt 2009) (figure 1).

Figure one: Ownership structure

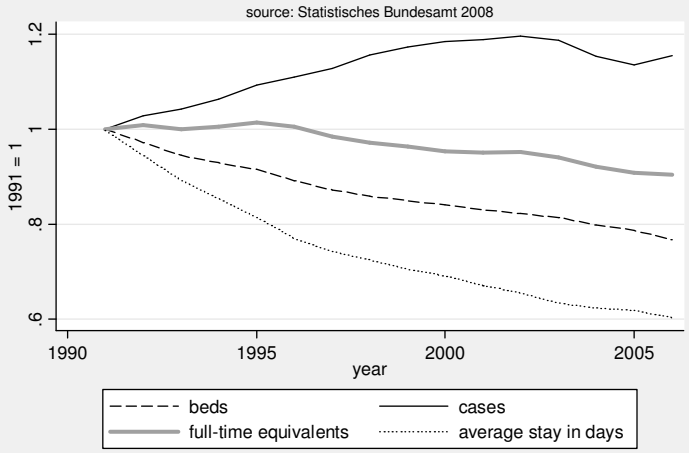
source: Statistisches Bundesamt 2008



Since more than 64% of hospital expenses are spent on personnel (Statistisches Bundesamt 2008), cost pressures have had several implications for industrial relations. One result has been downsizing. Between 1995 and 2005 the number of hospital employees dropped by 85,000 full-time equivalents (FTEs). Doctors were the only group that saw an increase, of about 19,000 FTEs, while all other groups, including nurses and assistants, experienced cuts (Simon 2007b). One method of reducing staff has been the outsourcing of support services such as cleaning, cooking, driving, and information technology systems. These measures have usually accompanied a significant deterioration of pay and working conditions, usually under private-sector collective agreements (Jaehrling 2008), in order to bring wages below the lowest rung of the public-sector collective agreement (in 2008, €7.61 per hour in the west and €6.98 in the east).

As the number of employees has declined, the number of 'cases' has increased (Figure 2), leading to higher patient to staff ratio and work intensification (Marrs 2007). At privately owned hospitals this trend has gone especially far: while an average full-time nurse in the private sector was responsible for 505 occupied bed-days in 2007, the corresponding public-sector figure was 421. A private-sector doctor, on average, treated 23% more patients than a public-sector doctor; the difference is even greater for physiotherapists, psychologists, pharmacists, and social workers (Böhlke and Schulten 2009).

Figure two: More cases and less capacity



This divide also matters for pay: in 2007, labour costs per employee at for-profit hospitals were 4% lower than in the public sector, with even greater savings for nurses (9%) (Böhlke and Schulten 2009: 111). Before liberalization, all public hospitals were covered by the public sector collective agreement, known as the *Bundesangestelltentarifvertrag* (BAT) and now known in a modified form as *Tarifvertrag des öffentlichen Dienstes* (TVöD), and most not-for profit hospitals oriented their working conditions to those in the public sector. As for-profit chains have bought hospitals, they have shifted their staff into company- or hospital-level agreements or unilaterally implemented pay freezes. A survey carried out by the German Hospital Association found out that 24% of employees in private hospitals have no collective bargaining at all, and the wages of only a third of private hospital employees are oriented to TVöD (Deutsches Krankenhausinstitut 2007). Other private hospitals use a collective agreement agreed between an association of

private hospitals and a small 'Christian' trade union with lower rates of pay (Gröschl-Bahr and Stumpfögger 2008).

However, this is not simply a case of disorganization and decline: ver.di membership has increased or been stable in the hospitals we have studied. The physicians union Marburger Bund grew from 70,000 to 110,000 members after a 2005 strike, giving it a membership density of 70%. Because of the implications for pay, work tempo, and service quality, hospital restructuring often leads to conflict at local level; every case of hospital privatization we know of has faced serious opposition. This local movement may be influencing national events: while ver.di had little success in influencing the design of markets in the 2002 reforms, in 2008 it worked in a broad health-care industry coalition to mobilize 130,000 workers and win a €3.5b increase in hospital funding for 2009. Liberalization thus presents an opportunity for union revitalization, nationally and locally. The next section will discuss the local politics of workplace restructuring.

5. Local trade union responses

Compared to IG Metall, the union most commonly studied in the English-language literature on German industrial relations, ver.di is an extremely diverse organization. It was formed in a 2001 merger of five service-sector unions, two of which were present in hospitals (the white-collar DAG and the public-sector ÖTV), making it Germany's largest service-sector union. Ver.di's structure – a 'matrix' intended to preserve sectoral identities, while integrating administrative functions – has two cross-cutting dimensions of relevance here: (1) a sectoral dimension of 13 broad *Fachbereiche*, including FB3: Churches, Social Services, Welfare and Health Care, and a much larger number of narrower *Fachgruppen*, including one within FB3 for hospitals; (2) a geographic dimension of 11 state-level *Landesbezirke,* plus local *Bezirke* and *Ortsvereine*. [Adding to this complexity are two additional dimensions: *Personengruppen* (e.g. gays, youth, unemployed), which are nominally represented at every geographic level, and *Ressorts* (e.g. social and health care policy), and departments covering specific issues across the whole organization]. The advantage of this fragmented structure is its relative openness to innovation within a locality or a sector (Greer, 2008); its disadvantage is the difficulty of top-down coordination in national campaigns (Doellgast and Holtgrewe, 2005).

Local trade unionists have not been completely on their own. In some local cases, such as Hamburg and Stuttgart, battles around hospital restructuring were important early moments in defining the local *Bezirk's* identity and strategy; in these cases material support came from the national union. Hospitals have become increasingly important in national public-sector strikes, as the large blue-collar-dominated enterprises that were the old ÖTV's main source of leverage have been privatized or taken out of the national public-sector bargaining framework. Likewise, establishing collective bargaining and co-determination at for-profit chains has become an important task for the national staff of FB3, as has the hospital financing campaign. Compared to most of the public sector, ver.di has been successful at the hospitals we have visited in avoiding derecognition of collective bargaining. Only in Chemnitz has the employer lowered the wages of core workers substantially below the rate the

TVöD, although the other hospitals have seen lower-paying collective agreements implemented in outsourced support work.

We now turn to the four patterns of worker representation, how they are shaped by the local politics of restructuring, and how they can change. (For more information on our cases and sources, please see appendix.)

5.1. Co-management

In Dortmund, Berlin-Vivantes, and pre-2001 Hamburg, restructuring was negotiated with a minimum of conflict. Some of these cases had a history of mobilization, as in Hamburg, where local trade unionists had occupied a hospital slated for closure in the mid-1990s, or a strong mobilization potential, as in Dortmund, where union density approaches 40% (in Berlin-Vivantes and pre-2001 Hamburg, density ranged between 10 and 15%).

All of these workplaces went through dramatic restructuring starting in the mid to late 1990s. In 1995, for example, Hamburg turned its hospitals into a separate state-owned enterprise, Landesbetrieb Krankenhäuser (LBK) Hamburg, closed a historic hospital, and set about eliminating 3000 out of 15000 jobs. Berlin's state owned hospitals were merged as Vivantes in 2001 and given a private legal form; afterwards, management eliminated nearly 2000 out of 12000 jobs and outsourced most support services. When Dortmund's hospitals received a non-profit legal form in 1999, management moved to reduce costs through changes in procurement, rather than personnel cuts.

In each case, the union's success in influencing the process had to do with personal ties with policymakers. In Hamburg and Dortmund, these channels of influence ran through the Social Democratic Party (SPD), which had dominated municipal politics continuously for most of the post-WWII era in close cooperation with trade unions. Vivantes was created by a 'grand coalition' (SPD and conservatives) in Berlin's local government; here, the union also worked constructively with conservative politicians. Key managers were part of these networks. In Dortmund and Berlin, the worker-nominated *Arbeitsdirektor* was built into the hospitals' enabling legislation. In Hamburg, the arrangements were less formal: like many of his trade-union counterparts, the director of the hospitals was an active SPD member. Furthermore, these cities' unions were represented directly on the city councils by their own officials and activists.

Worker participation in restructuring these hospitals extended well beyond the minima stipulated by law, which in Hamburg and Dortmund were relatively weak. Hamburg, Dortmund and Berlin all went through a change of legal form under co-management, with the aim of cutting costs and reducing staff numbers. The negotiations over this process went far beyond bargaining over the effects of staff. In Hamburg and Dortmund, workers won rights in addition to the legal minima under their legal forms. In Hamburg, management agreed with the union on a committee structure for negotiating the restructuring of departments, complete with an independent consultant to support worker representatives, to augment the relatively

weak public-sector co-determination framework. In Dortmund, the enabling legislation for the restructuring stipulated co-determination practices reflecting those under the private-sector framework, despite the non-profit legal form, and a 2005 collective agreement extended these practices. In all three cases, strong political influence led to a strengthening of co-determination practices in the newly restructured workplaces, reinforcing the pattern of co-management.

These worker representatives thus enjoyed long-lasting close relationships with management and local politicians. However, co-management was not to last in Hamburg and seems to be coming to an end in Dortmund. In Hamburg, the immediate cause of change was a switch in local government to one willing to ignore trade unionists. The more general cause, however, was the squeeze on resources associated with the liberalization process: Hamburg had massive pension liabilities, and Dortmund operates at a loss and faces delays in receiving investment from the state government. In Hamburg, local politicians were not interested in union offers for a compromise, making social partnership impossible. In Dortmund, the local political establishment came under pressure due to funding delays and the categorical refusal of wage concessions for physicians by the Marburger Bund. Autumn 2008 seemed to signal the end of business as usual; ver.di activists and the DGB set up a local coalition dubbed ‘ProKlinikumDo’ which used media work and public demonstrations to defend the hospitals.

5.2. Social movement unionism

In Stuttgart and post-2001 Hamburg, change has been negotiated against a backdrop of worker and community mobilization. While in Hamburg this strategy represented a change for the union, in Stuttgart it reflected a history of exclusion from politics. The link with civil society required unions to engage with issues beyond the defence of jobs and collective bargaining, such as public service quality, democracy, and human worth.

The majority buyout of LBK-Hamburg by Asklepios Kliniken was the largest hospital privatization in German history. After the Conservatives won the elections in 2001, they immediately pushed for privatization. In this situation the newly established union, ver.di, initiated a referendum, together with a wide range of allies from civil society. Although the referendum was successful and spilled over into a second campaign to make ballot initiatives legally binding, a majority stake was sold to Asklepios. After an 18-month dispute, which included a series of demonstrations and work stoppages, an agreement was signed in 2007 that mirrored the national public-sector framework.

In Stuttgart, by contrast, worker representatives had no history as co-managers. They did have a long history of battling the conservative-dominated local government over hospital restructuring. Nor did they have privatization to contend with: *Stuttgarter Kliniken* was created from a merger in 1999 and is a closely held municipal agency. Shortly after the formation of ver.di in 2001, the union and works council ran a campaign against the concentration of cooking in a single location. Called ‘no to the

cooking factory', this campaign was coordinated closely with the Catholic industrial chaplaincy, and highlighted the difficult working conditions of the low-paid, mostly female, staff. Two years later, the city announced its intention to close three hospitals and concentrate activity on one large campus, in hopes of finding efficiencies and reducing staff numbers. After demonstrations involving a wide range of local activists, the city agreed to take ver.di's alternative concept into account. In 2005, the union followed up with a successful protest against turning the hospitals into a private legal form, fearing that such a move could make the hospital susceptible to bankruptcy and privatization. That same year, workers struck for 14 weeks to prevent the city from leaving the employer's association, and as the largest part of the city government, the hospitals played a key role.

While there is relatively little worker participation taking place in these hospitals, ver.di seems to be succeeding in establishing some amount of influence. In Stuttgart, pressure is building on the hospital management to reduce debt, and worker representatives have been in a series of negotiations to minimize the pain to workers in keeping with a goal to eliminate debt by 2010. Meanwhile, at Asklepios, ver.di is involved in setting up national co-determination, not only for Hamburg, but for other locations. In both cases, campaigning has also led to an increase in union membership, in Hamburg, more than doubling since privatization to more than 30%. In Stuttgart and Hamburg, a social-movement approach developed over a long period. Both places were the sites of strikes in response to employer challenges to the framework of public-sector collective bargaining, and union membership grew as a result. If ver.di persists, new insider channels of influence may be created. If so, it will be different from co-management, because it will be more tentative on the union side, and shaped by 7-10 years of conflict.

5.3. Konfliktpartnerschaft

At the two university clinics, Berlin-Charité and Gießen-Marburg, we see a pattern of participation backed up with mobilization, with neither having the intensity seen in co-management or social-movement unionism. At first sight, these seem to be cases of social-movement unionism. However, these mobilizations are much closer to traditional German industrial relations, because coalition work is not central to the mobilizations, and they strengthen insider channels of influence in the short run. Union density here is around 10-20% and tends to increase in times of conflict.

Universitätsklinikum Gießen und Marburg was the first privatized university hospital in Europe; it was created through a merger of two university clinics and sold to the *Rhön Kliniken AG* in 2006. The merger was a necessary step to find an investor who was willing to buy the heavily indebted clinic in Gießen. While trade unionists resisted privatization, especially in Marburg, they accepted an invitation by the conservative government to participate in a planning group. After the clinics were privatized, ver.di took industrial action to achieve a collective bargaining agreement. This mobilization built on a strong local tradition of trade unionism that had developed in a context of good political connections and weak co-determination rights. Under the post-1999 conservative-led and pre-1999 SPD-led governments alike, the union faced

pragmatic politicians willing to listen, but at the level of the hospitals was stymied by the unfavourable governance arrangements of university hospitals.

Like *Vivantes, Charité* is publicly owned and located in Berlin, but since it is a university clinic, co-determination rights are significantly weaker. It is the product of a merger in 2003, under a new left-wing coalition government, which brought together the university clinics in West and East Berlin into a single organization. Works council members have relatively little access to the management and thus cannot negotiate over changes as successfully as their colleagues at *Vivantes*. In 2005 and 2006 there were several brief 'warning strikes' and rallies to use the standards of TVöD, rather than the less generous terms and conditions of the *Land* Berlin, and, without mobilizing much public support, worker representatives achieved most of their goals.

At Berlin-Charité and Gießen-Marburg, worker representatives have not faced the exclusion from management and politics seen in Hamburg and Stuttgart; nor do they have management committed to intensive worker participation and collective bargaining seen in Dortmund or Berlin-Vivantes. True to a traditional industry focus, these worker representatives mobilize workers almost exclusively around workplace issues.

5.4. Quiescence

In Erfurt and Chemnitz, two eastern cities with high unemployment rates and weak traditions of trade unionism, we observe quiescence within the hospitals. Here, works councillors – most of whom are ver.di members – tend to play a social-work role, rather than mobilizing or participating in detailed consultations over the management of change, and neither hospital belongs to the public-sector employers association. Klinikum Chemnitz is owned by the city government and, since 1994, has been run as under a non-profit legal form. Despite the presence of key trade unionists in the three largest party groups on the city council and a long-serving SPD mayor, trade unionists have had little influence in the management of the hospital. According to worker representatives, employees are satisfied with having a job and unwilling to take action for better working conditions or higher wages. Furthermore, the mayor and administration are highly effective in saving costs and winning support for their restructuring plans in city council. Hence, management has been able to outsource support services without union resistance, and in 2005 left the employers association and introduced low pay grades for new employees.

At first sight Erfurt seems very different: not only is the Klinikum Erfurt in the private sector, but it became Germany's first large case of privatization when it was bought by Helios in 1996. Although worker representatives formed an alliance with groups in civil society to oppose privatization, the coalition collapsed when it failed to prevent the sale. Helios began cutting costs by changing its procurement practices, and later moved on to reducing staff. Since there were no mandatory redundancies, works council members found little basis to organize resistance. In January 2007 Helios signed a national company-level collective agreement, negotiated by national ver.di staff. Under this new framework, Erfurt's pay scales introduce East-West parity earlier than the TVöD, with little downward deviation from the national agreement.

Why is quiescence specific to the East? Our interviewees pointed to unemployment rates between 15 and 20% and weak union influence in local government.

Surprisingly, low union membership is not always the issue: in Chemnitz, density is around a quarter, higher than some of the western hospitals. It may be that, in the event of an economic upturn or the retirement of workers, managers, and union staff educated under communism, worker representatives in Erfurt and Chemnitz could become more assertive.

6. Accounting for diversity

Why do local industrial relations vary when market mechanisms are rolled out on a national scale? We find that in local polities closed to union influence, we saw either quiescence or social-movement unionism, depending on labour-market pressures. In more open local polities we saw *Konfliktpartnerschaft* under conditions of weak co-determination rights and (with one exception) co-management under conditions of strong co-determination rights. In this sense, these three variables are inseparable characteristics of the local context that shape industrial relations in a context of liberalization.

6.1. Co-determination rights

Co-determination rights matter, because they determine how much access workers have to management decisionmaking. However, different statutory frameworks apply, and public, private and non-profit legal forms all have different mandatory subjects of consultation and stipulate different worker roles in governance. Public-sector co-determination rights are set by *Länder*, but additional rights are often built into restructured hospitals through collective agreements or enabling legislation, sometimes associated with a switch to a private legal form. State and local governments thus have much flexibility in setting co-determination rules in hospitals.

Public-sector co-determination is limited to immediate workplace issues by the legal theory that elected parliamentarians, rather than the public-sector workforce, should be ultimately responsible for public-service provision. Under public legal forms *Anstalt* or *Körperschaft des öffentlichen Rechts* (AöR or KöR, used for municipal and university clinics, respectively), co-determination does not extend to ‘strategic’ decisions around investment and technology and there are fewer worker representation on supervisory boards than in the private sector. Hospitals with the private legal form *Gesellschaft mit beschränkter Haftung* (GmbH), whether publicly or privately owned, fall under national private-sector co-determination rules, with more mandatory issues of consultation than under the public-sector framework. Large GmbHs have parity representation on the supervisory board – i.e. half of the seats, but no veto power – and an *Arbeitsdirektor* responsible for personnel issues and nominated by worker representatives. But the non-profit variant (gGmbH) is weaker and has no requirement for parity or an *Arbeitsdirektor.*

The three large for-profit chains have distinct enough industrial relations strategies that the roles of worker representatives vary significantly between them. These hospitals are all covered by the co-determination rules associated with the GmbH form, although smaller subsidiaries doing service work usually fall under the size threshold for parity co-determination. Over the period of our study, ver.di was in the process of organizing collective bargaining and establishing collective bargaining within the private hospital companies. With Helios they signed a national collective agreement in 2007 which stipulated almost the same conditions as determined by the public-sector agreement. Asklepios, after taking a much harder line in Hamburg and nationally, is now negotiating over a nationwide collective agreement. Rhön-Kliniken remains only willing to bargain at the hospital level (Gröschl-Bahr and Stumpfögger 2008).

Surprisingly, two of the hospitals in our sample with the most labour-management conflict are state-owned with a public legal form. Weak public-sector co-determination rights have led to the exclusion of worker representatives from management decision making. Stuttgart's municipal clinics (which were spun off into *AöR* in 1999) and at the Charité in Berlin (which was a merger of three university hospitals and became in 2005 a *KöR*), workers have struck to defend the link to national bargaining. In Stuttgart, this mobilization involved a strong element of support from local 'social networks', as trade unionists called them – citizens initiatives with overlapping interests, as well as worker-priests – supporting campaigns against speedups in service areas, or for more funding for hospitals. This problem is especially severe at university clinics, where workers are represented as one of many interest groups on governing bodies, and where professors tend to dominate.

At state-owned hospitals with a private legal form, we observe two different patterns of trade unionism. The first we observe at the municipal clinics of Dortmund (a gGmbH) and Vivantes in Berlin (a GmbH), namely a strong pattern of social partnership. In Dortmund, trade unionists won a stronger form of co-determination than that required for the non-profit gGmbH form. They accomplished this by threatening a campaign that would have disrupted restructuring and by negotiating an alternative with the social democratic local government. Before privatization, Hamburg had a functional equivalent. Because of its public legal form, it lacked an *Arbeitsdirektor* or supervisory board, but the complex deal that established the new organization also introduced a wide range of consultative mechanisms. These mechanisms were also established after a conflict, this time the occupation of a hospital that was to be closed. The second option, which we observe in Chemnitz, which is also a wholly-owned municipal gGmbH, is that co-determination takes place at the absolute minimum level allowed under a non-profit legal form.

The notion that German co-determination rules limit within-country diversity does not apply to hospitals, where these rules vary depending on organizational form. Those hospitals subject to strong statutory co-determination frameworks do not all have smoothly operating labour-management partnership, and in hospitals operating under weaker non-profit and public-sector rules, ver.di sometimes negotiates improvements in participation rights. The way these rights are used depends on other factors.

6.2. Local labour markets

Unemployment rates matter for the mobilization potential of employees. As many East German trade unionists argue in interviews, if workers are merely happy to have jobs, they are unlikely to mobilize against restructuring. If they have good chances of employment on the outside labour market, the level of fear should be lower and mobilization easier. This labour market effect is consistent with the impressions of national ver.di officials we interviewed and confirmed by the variation in our sample. Our sample, like Germany, can be divided into two kinds of local economies. Dortmund, Erfurt, Chemnitz and Berlin – four locales hit very hard by deindustrialization – have had unemployment levels fluctuating between 13% and 20% from 1993 to 2008, with 15-year averages ranging between 16% and 18%. Marburg, Hamburg, and Stuttgart, by contrast, which had either stable manufacturing sectors (Stuttgart), or enough new service employment to compensate (Hamburg and Marburg), had unemployment levels of between 5% and 13% over the same period, with 15-year averages between 8% and 11% (Bundesagentur für Arbeit 2008).

In cities with higher unemployment, mobilization is more difficult, and most cases fall into the co-management or quiescence category. In the one exception, Berlin-Charité, mobilization was not as sustained as in Hamburg or Stuttgart and the political structure more open than in Erfurt and Chemnitz. Although works councillors won a collective agreement linked to the national public-sector settlement – which is not self-evident in Berlin, since the *Land* itself has left the employers association and negotiated pay concessions with ver.di – they did not win the strong co-determination rights seen at Dortmund, Vivantes, or pre-privatization Hamburg.

The pressure put on workers by high unemployment explains much of the east-west divide in German trade unionism. However, eastern trade unionists are not all quiescent (at least not in Berlin), and western trade unionists are not all militant. Nor are all of the high-unemployment zones in the east; Dortmund is in the west. Finally, labour-market pressures do not necessarily translate into low union membership density: membership is high in Chemnitz (probably due to the aggressiveness of management) and Dortmund (reportedly due to the city's tradition of coal and steel).

6.3. Local politics

The receptiveness of local politics to unions matters in their decisions about mobilizing workers and allies against restructuring plans. This is a rarely explored field in academic studies of German industrial relations, partly due to the widespread perception that the industrial relations system is centralized and the usual focus on large private-sector firms. However, hospital privatization and restructuring is a matter for city- and county-level politics, and public-sector co-determination rules, hospital planning, and universities (and their clinics) are matters for *Länder*. Usually, SPD-led governments are more open to union influence, and conservative-led governments are more closed, although conservative politicians in Hessen and Berlin have chosen a more pragmatic approach towards trade unions and left-of-centre politicians in Chemnitz unreceptive.

In some cities, unions have a long history of influence due to their tight connection to the SPD. This is most clearly the case in Dortmund, where – typically for the Ruhr area – politics are shaped by a history of coal and steel, high union density, and decades of uninterrupted SPD electoral dominance. Hamburg is also a traditional union stronghold, with strong, politicized trade unionists in the manufacturing and transportation industries by the harbour. Prior to their respective electoral defeats in 1999 and 2001, Social Democrats had led Hessen's and Hamburg's governments almost continuously since the end of World War II. In Berlin, unions have also had good connections in politics partly due to the moderation of local Conservatives. This influence improved after 2001 with the advent of a coalition of Social Democrats and former communists. In these places, while public-sector industrial conflict is not unheard-of, union embeddedness in elite networks makes it easier to settle disputes, and in some cases, like Hessen, union influence has persisted despite the coming of a conservative government. Under these conditions, trade unionists either take advantage of the chance to be co-managers or (in more difficult times) seek to reinforce their influence through the complex dance of *Konfliktpartnerschaft*.

Other cities have little tradition of union influence. In the former GDR, for example, the networks of trade unionists, politicians and public administrators are quite thin. In Chemnitz, despite an SPD mayor and trade unionists in the three largest party groups on the city council, unions have very little influence in public-sector restructuring. In Erfurt from 1990 to 2006 the mayor was from the conservative party and never established working relations with trade unionists. Similarly, in parts of the West, such as Stuttgart, local politics are dominated by conservatives, and the left is on the outside. In these places, politicians have little fear of taking on trade unions, and unions either fight back creatively, as in the social movement unionism seen in Stuttgart or post-2001 Hamburg, or counsel workers at an individual level on how to cope with the effects, as in Erfurt and Chemnitz.

In the hospitals in our sample, state and local politics have shaped what trade unionists can accomplish. Some important decisions, such as whether to privatize, outsource, or leave the employers association, are not subject to co-determination. As a result, there are important moments in which the institutions of co-determination or sectoral bargaining provide little assistance to trade unionists. Sometimes unions have retained strong traditional channels of influence, as in Dortmund or Berlin-Vivantes, where labour-management partnership has been possible, at times with an element of conflict. Other times, these channels break down, as in Hamburg, or have never existed, as in most of the east and conservative-dominated parts of the west. In the latter cases, unions have built alternative forms of pressure or simply retreated.

7. Implications for policy and theory

In German hospitals, the effects of market making are far reaching. The state has attempted to raise capital investment by privatizing hospitals and slow cost increases by altering the reimbursement formulae used by insurers. These policies have encouraged the rise of for-profit hospital chains and led to greater transparency in pricing, leading to intensified cost-based competition between hospitals. As

competition has intensified, managers have come under ever more pressure reduce costs and increase revenues. In this labour-intensive industry, this means treating more 'cases' with fewer employees, in some cases on lower pay. Although this is not exactly a zero-sum game, it is also not a fertile ground for mutual gains between insurers, hospitals, and workers. In general, the market's effectiveness as a way to cap costs undermines ver.di's bargaining power: we see concessions both in cases of partnership and conflict. Concessions have been especially deep in easy-to-outsource support services such as cooking and cleaning, which has lead to greater pay inequality. While the causal chain between market construction and workplace change is complex, it is also robust: most actors refer back to it in explaining their actions.

Setbacks in bargaining notwithstanding, we do find some evidence of union revitalization. In some of the cities we visited, hospitals were the largest employers and sites of creative campaigns and massive membership gains. At the national level, ver.di built on this success by establishing national collective bargaining at the for-profit chains and mobilizing members and allies to win a massive infusion of cash into the sector.

Our central argument is that the locale is an important place to look for understanding how market-making translates into change in labour-management relations. This point is highly generalizable. In any country where domestic liberalization is taking place, there is good reason to believe that it is affecting industrial relations and that local labour market pressures and institutional frameworks matter for workers' capacities to resist concessions. If these vary across the cities in our German sample, they probably vary within other countries as well. There is also good reason to believe that trade-union influence in state and local government matters, not only in the public sector, but also in highly regulated private-sector industries like telecommunications (Doellgast 2009), industries with a high degree of dependence on public contracts such as construction (Lillie and Greer 2007), and manufacturing industries dependent on industrial policy (Dörre and Röttger 2006).

In German hospitals, as in many industries and countries, intensified competition is not an uncontrollable outside force, but rather a steering mechanism used to contain costs. Under these conditions, the state and employers cannot be relied upon as agents of market correction. The problem is not only a gap between national institutions and local implementation. In our cases, the formal rules could even be read off of a national model, because employers and local policymakers were able to choose between statutory co-determination frameworks, and in low wage services, between sectoral collective agreements. More fundamentally, some of the agents that constitute the German model were politically committed to a form of marketisation that led to socially undesirable consequences (low-wage work) and generated political struggle. In these conflicts, worker representatives took part in shifting and fragile coalitions at several levels, including that of the locale.

Market making and resistance deserve a more central place in policy-relevant social science. In many areas where markets do not exist, public policy is creating them, which may be leading to a shift of costs and risks from the rich and powerful to the poor and powerless. As we have documented above, this process has led to union revitalization in some large private service-sector workplaces. A general theory of

how different kinds of markets affect workers and workplaces would be a theoretical advance relevant beyond the field of industrial relations and could lead to alternative proposals for institutional design.

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Appendix: Sample and sources

Name	Employees in 2007	Owner	How and when formed	Data gathered
Vivantes Netzwerk für Gesundheit GmbH	13,500	*Land* Berlin	Municipal clinics merged into an autonomous subsidiary in 2001	11 interviews
Charité Universitätsmedizin Berlin	12,800	*Land* Berlin	University clinics merged into a closely held agency in 2003	3 interviews
Asklepios Kliniken Hamburg GmbH	8900 (FTEs)	Asklepios Kliniken GmbH (74.9%)	Municipal clinics merged in 1995 and privatized in 2005	20 interviews; participant observation; workshop presentation
Klinikum Stuttgart	6400	City of Stuttgart	Municipal clinics merged into a closely held agency in 1999	6 interviews; workshop presentation
Klinikum Dortmund gGmbH	4200	City of Dortmund	Municipal clinics merged into an autonomous subsidiary in 1999	4 interviews
Universitätsklinikum Gießen und Marburg GmbH	4000	Rhön AG (95%)	University clinics merged in 2005 and privatized in 2006	10 interviews; workshop presentation
Klinikum Chemnitz gGmbH	3710	City of Chemnitz	Municipal clinics merged into autonomous subsidiary in 1994	6 interviews
Helios Klinikum Erfurt GmbH	2000	Helios AG	Municipal clinics privatized in 1997	2 interviews

We also spoke to 5 national-level experts, and one national-level and one NRW-level expert presented at the workshop. Where possible, we also collected annual reports, consultant reports, collective agreements, and newspaper articles.