ARCHETYPE TRANSITION IN THE GERMAN HEALTH SERVICE? THE ATTEMPTED MODERNIZATION OF HOSPITALS IN A NORTH GERMAN STATE

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In this paper, we argue that, rather than aiming at universal contingency relationships, archetype theory needs to go down a path where 'local variants' can be discovered and understood by relating them to their organizational and institutional context(s). The case study of a public sector hospital group in a North German state (Hamburg) is drawn on here to elaborate the argument. We found evidence for a change from a Public Sector hospital archetype to a Public Hospital Corporation archetype. Drawing on this model permits us to explore the impact of the introduction of new forms of public management organization and the implications the managerial ideology underpinning this may have for the professional organization. The study explores the consequences of the innovations for professional/managerial relations. We also suggest that the 'archetype' approach may be particularly useful for the comparative study of organizations. This is particularly pertinent given the different – corporatist – organization of the German health care system and its different approach to public sector reform to that of the Anglo-American and Scandinavian systems where the 'archetypal' approach has so far been applied.

INTRODUCTION

This paper is concerned with an analysis of an attempt to introduce 'New Public Management' (NPM) or something like it into a German hospital network. For this purpose, we will be drawing on archetype theory and the literature on New Public Management. During the last two decades, the restructuring of the public sector in industrialized countries has been heavily influenced by ideas from the private sector. Much of this agenda has been associated with the notion of the 'hollowing out of the state' whose purpose, it has been famously argued, is one of 'steering not rowing' (Osborne and Gaebler 1992). Initially taken up under the Reagan and Thatcher administrations in the US and UK, with an emphasis on enterprise, it has subsequently become transmuted into a 'third way'. Advocates see this as providing the best means of defending the public sector by providing more efficient and better quality services (Kickert and Koppenjan 1997,

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p. 36). In Germany there has not been any serious or extended consideration of applying private sector management to the public sector. As Kickert (1993, pp. 192–3) has pointed out:

> [in] North-West-European countries, with their more legalistic tradition and their much stronger public and political legitimacy of the state. General questions about (the limitations of) governance has attracted more attention. . . .

The equivalent German debate on the role of private management within the public sector and/or public/private partnerships that has challenged 'third way' thinking in the UK has been 'the general debate on the limitations of government steering' (ibid.). This distinction is not always apparent in discussions around NPM, embedded as it is, within its Anglo-Saxon historical starting point and assumptions.

It was Hood who in 1995 asked whether a 'new global paradigm' had emerged in contemporary public management (Hood 1995). Even though there are obvious national variations, 'modernization' of public services or, more specifically, 'New Public Management' (NPM), has been reported from a number of different countries. These include Sweden (Harrison and Caltorp 2000), Norway (Christensen and Lægreid 1999), Denmark (Borum 1999, 2000; Jespersen 2000), The Netherlands (Groot 1999), the US (Osborne and Gaebler 1992; Terry 1998), and the UK (Ferlie *et al*. 1996; Kitchener 1998, 1999), amongst others. Kaboolian (1998, p. 190) argues that '[w]hile the reform movements vary in depth, scope, and success by country, they are remarkably similar in the goals they pursue and the technologies they utilize'. The available evidence seems to suggest that the diffusion process has been most advanced in the English-speaking world, and in particular the UK and New Zealand (Ferlie *et al*. 1996; Pollitt and Bouckaert 2000). With an, arguably, more embedded social democracy model, many of the European nations are seen as coming to this reform process later and in a perhaps less 'complete manner' (Ferlie *et al*. 1996). In summary then:

> NPM is seen as a general structural prescription, spreading from OECD or Anglo–American countries as an instrumental 'super standard' or collection of structural standards for coping with problems common to public organizations. (Christensen and Lægreid 1999, p. 171)

Indeed, there may be cycles in the diffusion of organizational innovations and doctrines, with the dominant role of the English-speaking world becoming established during the 1990s, but not necessarily lasting much into the New Millennium (Olsen and Peters 1996). The answer one gives here would be partly dependent upon whether one views NPM as a fashion – or useful myth (Pollitt 2001) – that has already turned the corner and is undergoing de-institutionalization or, at the very least, re-assessment (Harrison and Caltorp 2000). In addressing this question, it would be naïve to underplay the shaping role played by national institutions and policies. Christensen

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and Lægreid (1999, p. 186) summarized their study of administrative reform in the Norwegian Civil Service by describing reform processes in the following terms:

> [a] complex interplay between international trends, particular national structures, historical-institutional contexts, and specific institutional traditions.

The research reported here addresses the 'complex interplay' in the setting of a German hospital network. The justification for our focus is (1) that the German case is under-researched; and that (2) Germany is a relative latecomer in terms of NPM (Hood 1995). This is perhaps the result of a more embedded social welfare system as well as the shared power loci enshrined within the structure of welfare provision in the German system (see page 000, below, for a discussion on the German archetype). The German case reported provides a 'testbed' for our understanding of the limits of NPM and archetype theory. It is possible – we would hypothesize – that the adoption of NPM practices within Germany marks not its inevitability but something else. As Wollman (2001, p. 160–1) has pointed out, NPM was first introduced into German local administration under the rubric 'New Steering Model' (*Neues Steuerungsmodell*) (NSM), which is not quite the same as NPM (see also Pollitt and Bouckaert (2000, p. 239–40). Whether the differences are of significance is a particular concern of this article. In analysing these changes we are also proposing that this archetype theory needs to avoid assuming universal contingency relationships but, instead should explore the rationale for local and national variants.

The rest of our paper is structured as follows: in section two we will discuss and assess NPM and archetype theory and their potential relevance for our case. Following the section on data collection and methodology there is a brief section describing the institutional context of the German hospital system; this leads into the case study, which is drawn upon to evaluate and develop the theoretical framework. We start, however, by summarizing existing literature in order to outline our analytical framework.

THEORY AND LITERATURE

In his influential 'A Public Management For All Seasons?', Hood (1991) lists seven doctrinal components of NPM: (1) hands-on professional management; (2) explicit standards and measures of performance; (3) greater emphasis on output controls; (4) shift to disaggregation of units; (5) shift to greater competition; (6) stress on private-sector styles of management practice; and (7) stress on greater discipline and parsimony in resource use: notions such as customer (patient/client) focus, best value services, financial responsibility and corporate accountability are all to be copied from the private sector (Flynn 1999). Hood – with others – (1999, p. 191–3) has subsequently argued that NPM has become more concerned with the issue of accountability (increased 'oversight') and regulation through mechanisms

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such as audit and the whole question of governance (see also Jones 1999; Lapsley 1999). Aspects of NPM pose an often little disguised challenge to the traditional legitimating role of professionals (Abernethy and Stoelwinder 1995; Kitchener *et al*. 2000; Exworthy and Halford 1999, p. 9). The parallel debate on the restructuring of professions, which partially overlaps the debate on 'New Public Management', is therefore also relevant for our purposes as we are dealing with public sector health professions. Indeed, professional organizations all over the world have faced intense pressure to change, something which has been observed for a number of professions, including law, medicine and accounting (Brock *et al*. 1999).

While the US might be in the forefront of this change process in terms of organizational analysis, the work has been primarily done elsewhere. It has been New Zealand health care providers (Powell *et al*. 1999), Australian law firms (Gray 1999), Canadian accounting (Greenwood *et al*. 1990), health (Denis *et al*. 1996) and law firms (Cooper *et al*. 1996) and UK hospitals (Kitchener 1999) that have been analysed. These studies have applied the 'archetype' concept that incorporates dimensions of structure, systems and processes, and interpretive schemes. The model suggests that, over time, organizations will evolve towards archetypal coherence (Miller and Friesen 1982; Greenwood and Hinings 1993, 1996) – still, discordance always exists to some extent:

> [as] there are likely to be a variety of value commitments in any given organization unless it has a very strong set of values. (Hinings *et al*. 1996, p. 894)

This will be the case, for example, where management, intent to press ahead with implementing elements of NPM, intrude on the territory monopolized by the medical profession (Harrison and Pollitt 1994; Harrison 1999; Reed and Anthony 1993; Pollitt 1993; Dent 2003). Different parts of the public sector have been investigated in NPM project work and found to contain tensions, contradictions and discordance (Exworthy and Halford 1999, p. 12). The co-existence of partly contradictory values, ideologies or interpretative schemes, has been analysed in the UK for railways (Laughlin 1991), hospitals (Dent 1993; Montgomery and Oliver 1996) and academia (Dent and Barry 2000), in the US for hospitals (Alexander and D'Aunno 1990; Arndt and Bigelow 1995) as well as in Canada (Denis *et al*. 1996). While the aforementioned changes in the public sector have been widely analysed, as far as an organizational perspective is concerned, there has been comparatively little mention of developments within Continental European countries with a strong *Rechsstraat* tradition – such as Germany – within which the state has the central integrative role underpinned by a strong legal framework (Pollitt and Bouckaert 2000; Wollman 2001; Dent 2003). In this paper, our intention is to contribute to filling this gap with the analysis of our German case study. This links a specific (network) organizational setting with an analysis of broader institutional developments in Germany. We believe that a case

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study of a scenario of potential archetypal change in a German public sector hospital group (see Tables 1 and 2 below) can serve an important indicative purpose and contribute to the present research endeavour. We now proceed to a discussion of methodology.

THE CASE STUDY: METHODS AND METHODOLOGY

The research reported here focuses solely on the public sector hospitals of Hamburg, which are run by the LBK group (*Landesbetrieb Krankenhauser* [State Enterprise Hospitals]). The selection of this case study is to be justified in terms of 'theoretical sampling' (Glaser and Strauss 1967) for as Hammersley and Atkinson (1995, p. 43) have pointed in their classic qualitative research methods text:

> [s]trategic selection of cases can be . . . employed in testing theoretical ideas. Here the aim is to select cases for investigation which subject theories to relatively severe test.

In other words, we were not concerned about issues of representativeness or statistical validity but rather its pertinence. This case study offers a microcosm of the German public sector hospital service, not in terms of its typicality, but rather that when you have seen one you can see the *différence*.

The research methodology was qualitative and based on documentation (legislation, publicity material, annual reports and media articles as well as grey literature, i.e. internal documents and reports) and primary interviews. The pre-existing public sector archetype is probed through the interrogation of this case study which is one where the public sector hospitals are engaged in a radical change process. The case study is well documented but in order to illustrate the responses of managers and physicians in the changes we draw upon interviews with some of the key actors (Kumar *et al*. 1993). We interviewed a senior manager from the public sector hospital headquarters (Hamburg LBK), the president and a senior member of the physicians' chamber (*Ärztekammer*), a medical director from one of the LBK hospitals, a senior figure from the hospital association (*Krankenhausgessellschaft*) and a counsellor from city hall who has a special interest in the health system. These interviews provided a good oversight of the policy and strategies and their implementation. We also conducted interviews with 12 physicians working at various hospitals in Hamburg; these are not directly reported on here. Interviews typically lasted 1.25 hours although some were longer – in one case, 2.5 hours. All were tape-recorded, transcribed and then analysed. About half the interviews were conducted in German and half in English. Two of the authors are native German speakers and a third approaches fluency. Research access was arranged on the understanding that no individual would be identified in the research publications. The fieldwork for this project took place in May 2000.

The LBK represents a strategic case and the research reported here provides a well-informed viewpoint into current developments within a

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Public Hospital Corporation committed to reform and it provides a valuable basis for testing out the value of 'archetype transition' analysis. We recognize, however, given the limited scope of this project, that there is a need for further research.

THE DYNAMICS OF THE PUBLIC SECTOR HOSPITAL ARCHETYPE IN GERMANY

The three main actors with which the patient has direct contact (sickness fund, office-based physician and hospital) are sharply separated, and office-based physicians provide many of the services, which in other systems are provided by hospital outpatient departments. Sickness funds, as elsewhere in Europe, are bodies separate from the service providers, resulting in an automatic separation of 'purchaser' from 'provider' within the system. These features have an impact both on the methods of cost containment and the areas of expenditure strain. For example, the division between providers and sickness funds embodies the principle of negotiation between purchaser and provider. It thus enables these discussions (although not without some pain) to encompass decisions concerning the 'benefits catalogue', and pricing of items contained in it, more easily than may be the case in a unitary system where the funding of the service is provided centrally from direct taxation. While the opportunity might exist, the overall evidence is that the German sickness funds have not been effective at controlling medical costs. Expenditure, for instance, on hospital care, including public sector hospitals, has risen inexorably over the last 35 years and has lead to federal attempts at cost containment. These concentrated, firstly, on legally fixed budgets as in the case of the Hospital Expenditure Stabilizing Act (1996) followed, in 1997, by the introduction of a quasi-prospective payment system. This latter has some passing similarities to DRGs (i.e. Diagnosis Related Groups) and was to be the precursor to the introduction of DRGs nationally by 2003 or thereabouts. While it is too early to pass judgement on the DRG implementation, the earlier attempts at cost containment have been judged a relative failure (Busse and Howorth 1999, p. 320). At the same time, some commentators see in these developments evidence of a centralization of power with a shift away from state (*Länder*) autonomy to federal (*Bund*) control (Schwartz and Busse 1997, p. 114). This may, however, be overstated for while the introduction of DRGs is going ahead, another aspect of hospital financial arrangements remains unfinished business. Currently, the *Länder* are responsible for the capital costs while cost of treatment is paid by the sickness funds. It has been the intention of the federal government for a number of years to make the sickness funds responsible for both treatment and capital costs, a system known as monist funding. This would increase the influence of the sickness funds *vis à vis* the states (*Land*) and the medical profession. This proposal was recently overturned in the *Bundestag*, a consequence of the political strength of the *Land* at the national level.

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Hospitals, therefore, continue to lie outside the corporatist institutions of the health system, with each hospital negotiating individually with sickness funds. This too undermines attempts at cost containment (Schwartz and Busse 1997, p. 107) although the cost explosion within health care is also the consequence of other factors, not least the implications of German unification (European Observatory on Health Care System (Germany) 2000, p. 51; Wollman 2001, p. 160).

It is against this background of pressure for greater efficiency and cost controls that has led to a growing interest in moving health care administration more towards a management-driven regime that might result in a shift from 'professional dominance to managed care' as observed in the USA (Scott *et al*. 2000) and the UK (Ham 1997, p. 132; Moran 1999, p. 18). In principle, this represents a potential shift in archetype from the 'Public Sector Hospital' embedded within the traditions of German public administration to a 'Public Hospital Corporation' archetype reflecting a different form of public management (see Tables 1 and 2).

Whether such an archetypal shift is happening or will happen depends in part on whether and to what degree the peculiarities of the German corporate system are so deeply embedded (see, for example, Moran 1999, p. 10–2) that any management reforms will be so path-dependent (Wilsford 1994) that they will always transmogrify into something else more consistent to the institutional culture, practice and traditions of the country. In order to explore these issues in greater detail we now turn our attention to the specific and strategic case of the Hamburg Public Hospitals.

TABLE 1 *The public sector hospital archetype*

INTERPRETIVE SCHEME
1. Politically moderated solidarity
2. Increase standards/ quality, without a loss in efficiency
3. Professional autonomy unquestioned
SYSTEMS, PROCESSES AND PRACTICES
4. Patient care generates expenses
5. Doctor-driven system. Doctors act as part-time managers
6. *Per diem* compensation
7. Medical career progression: from hospital to private practice
8. Patient- not cost – focused. Cost containment a relative failure
9. Poor management information systems
10. Dualist financing
STRUCTURE
11. Loose federation
12. Doctor-driven system (organisation chart; resource allocation; budget responsibility)
13. System is legally enshrined

Source: Adapted from Kitchener 1998 (*Public Administration*, 76, 73–95, with permission), Kitchener 1999 (in D. Brock, M. Powell and C.R. Hinings (eds) *Restructuring the Professional Organization: Accounting, Health Care and Law*, Routledge, with permission), Kitchener and Whipp 1997 (*International Journal of Public Sector Management*, with permission) and the Authors.

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TABLE 2 *The public hospital corporation archetype*

INTERPRETIVE SCHEME
1. Managerial moderated solidarity
2. Increase efficiency, no loss in standards / quality
3. Attempts to reduce professional autonomy
SYSTEMS
4. Patient care generates revenue
5. Management becomes a separate role
6. DRG: average cost per illness
7. Blocked medical career progression: move to office practice becomes rare
8 Cost- not patient focused
9. Information-driven system
10. Monist financing
STRUCTURE
11. Corporate entity
12. Management-driven system
13. System is still legally enshrined

Source: Adapted from Kitchener 1998 (*Public Administration*, 76, 73–95, with permission), Kitchener 1999 (in D. Brock, M. Powell and C.R. Hinings (eds) *Restructuring the Professional Organization: Accounting, Health Care and Law*, Routledge, with permission), Kitchener and Whipp 1997 (*International Journal of Public Sector Management*, with permission) and the Authors.

THE HAMBURG PUBLIC HOSPITAL SYSTEM: A CASE OF ARCHETYPE SHIFT?

Within Hamburg there are eight public sector hospitals as well as one university hospital and 21 independent acute hospitals, 14 of which have religious affiliations (information derived from *Hamburgische Krankenhaus-gessellschaft* 2000). The research reported here focuses solely on the Hamburg public sector hospitals, which are run by the LBK group, and consist of eight acute hospitals (*Allgemeines Krankenhaus*) supported by about 20 service centres. These hospitals provide just over 6800 beds (LBK 1998, p. 12) and 'treat . . . about 108,000 in-patients a year and about the same amount of out-patients per year' (LBK manager). The smallest hospital has 235 beds and the largest 1700. The average size is 850 beds. For comparison, the 'not-for-profit' hospitals within Hamburg all have fewer than 600 beds and a typical size is 200–250 beds (*Hamburgische Krankenhausgessellschaft* 2000). This is consistent with the national figures (Perleth and Busse 1998).

The LBK has been the largest 'experiment' of its kind within the public hospital sector in Germany and has been judged sufficiently successful for the model to have been adopted in some degree by the public sector hospital corporation, *Vivantes*, of Berlin and also in Hanover (Butler 2002). The challenge that the new corporation was charged with was to cut costs by between 25–30 per cent by 2003. Hospital expenditure within Hamburg had historically been higher than in other *Länder* and this coupled with the cost containment policies of the 1990s were the drivers to the establishment of the LBK in 1995 as an autonomous organization promising radical changes.

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TABLE 3 *Modernity through FIT*

Progress (*Fortschritt*)→ **Innovation** (*Innovation*)→**Teamwork** (*Teamarbeit*)
The programme is in three parts: **FIT 1**[P]roductivity. This means about 2000 reduction in work places . . . **FIT 2**is the 'slimming down' of the range of services. [All] the services that are not patient oriented . . . are to be taken out of the hospitals . . . **FIT 3**[H]ospital enterprises that are able to optimize medical processes have the chance to survive. . . . Each . . . provides the basic services. . . . Special[ist] services [will be] restricted [to particular hospitals]. . . . [T]he aim [is] to standardize the process of treatment . . . (Translation: C. Preuschoft)

The official management version of the LBK strategy has been summarized by the chief executive in the form of a 'Management Letter' (LBK – *Vorstandssprecher* 2000, pp. 4–7) as shown in Table 3.

This is clearly a managerialist manifesto expressing an ideology that closely matches the interpretative scheme of the Public Hospital Corporation archetype (Table 2). It is one that clearly challenges the traditional doctors' medical dominance within hospitals for the manifesto clearly states that it will be the corporate management who will ultimately decide the medical services provided within the hospitals.

Traditionally, at the head of all German hospitals there is a triumvirate of directors: nursing, financial and medical director. Formally, they constitute a 'colleagium . . . speaking with one voice' although in practice the medical director has been viewed as '*primus inter pares* [first among equals]' – to quote one hospital medical director's accurate assessment. Within the LBK, however, the role of the medical director has crucially changed. The pressures on the collegiate model have increased since the new systems, reflecting more the Public Hospital Corporation archetype, mean that their relations with their colleagues have consequently changed. No longer is the medical director's role one of *primus inter pares* – it is emerging as a distinct and separate specialist managerial role. To quote a leading member of the *Ärztekammer*:

> in the past the medical director was a personality appointed by the chief doctors, . . . who represented the hospital and its doctors externally. The medical director today is the willing assistant (*Erfüllungsgehilfe*) of the executive board. (Translated by C. Preuschoft)

More generally, the organizational reforms within these LBK hospitals appears to fundamentally question the authority and legitimacy of the role of the medical profession within the hospitals even though according to German federal law hospitals are defined as organizations under permanent medical direction (Hajen *et al*. 2000, para 7.1). In the past, this law has justified the professional and organizational dominance of doctors, conjointly with the medical director, now, within the LBK, the medical director is a

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primarily a manager *qua* manager within the hospital. This represents a significant alteration to the pre-existing interpretative scheme. Medical autonomy may not be directly undermined but it is questioned in terms of 'cost' and 'benefit'. Moreover, the organizational solidarity (see Tables 1 and 2) is in the process of being shifted from a 'politically moderated' one that favours the doctors to a 'managerially moderated' solidarity. This new version attempts to incorporate elements of the medical staff establishment (always the medical directors and sometimes the departmental chiefs) into the LBK managerial discourse and away from their professional/ collegiate concerns. These senior doctors are in the ambivalent position of being employed within a strongly managerialist organization co-ordinating the activities of medically run departments that are formally autonomous. Lest such changes should be viewed as a proletarianization of the German hospital physician it is worth pointing out that the professional autonomy of hospital doctors remains strongly and effectively protected, and that senior hospital doctors continue to constitute a powerful elite. These are the Departmental Chiefs (*Chefärzt*) who are well paid and influential figures (Knox 1993, p. 103). They also have the right within the hospitals to treat private patients alongside their other work – although this has been modified within the LBK so that 'private patients' are 'paying patients' (*Wahlleistungspatient*) of the hospital and not the doctor – who is rewarded not by private fees but with a performance bonus (LBK press release 2000). It is hardly surprising, therefore, that the *Chefärzt*, who were previously the organizational as well as medical elite within the system, represent the main source of conflict within the process of change. The LBK legally has the right to merge hospitals and departments; even so, individual 'chiefs' occasionally refuse to co-operate. Non-co-operation, however, is not a common occurrence and most doctors have come – reluctantly – to accept the changes as unavoidable, reflecting the advice of the local *Ärztekammer* the doctors' professional organization and which represents all the doctors in the locality (including independent practitioners). As one member of the local *Ärztekammer* board (and representative on the LBK board and *Marburgerbund* activist) expressed it: 'We . . . tell our colleague that there's no other way – it's legal[ly prescribed] – it's, it's "*gesetzlich*"'. The tone was a regretful one, based on the recognition of the legal position and not on any attraction of managerialism.

There is another factor influencing the doctors' responses too; most hospital doctors view their hospital careers as an anteroom to independent office-based practice (Moran and Wood 1993, p. 69; Knox 1993, p. 85). The opportunity to move into independent practice across Germany, however, has fallen significantly (Knox 1993, p. 117, Moran 1999, p. 115). The problem is that the overall number of doctors has 'almost tripled over the last 25 years' (Perleth and Busse 1998, p. 11–12). Whereas in 1970 there were more independent practitioners (49 827) than hospital doctors (40 172), by 1996 the relationship had more than reversed: 115 538 hospital doctors to 95 271 independent practitioners (Perleth and Busse 1998, p. 12). During this same

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period, the sickness funds have been given increased powers (as a result of 1993 legislation) and will now refuse new applicants if sufficient office physicians are already in practice. Hospital doctors, therefore, have had to substantially reassess their career expectations and in the LBK hospitals they are having to come to terms with the new managerial ideology.

ANALYSIS AND DISCUSSION

Rather than assuming a convergence around a commonly agreed model of (Anglo-Saxon) NPM, this case study confirms Pollitt and Bouckaert's (2000, p. 93–4) assertion that there are multiple 'visions' and trajectories. The LBK case is an example of the application of *Neus Steurungsmodell* (NSM) (Pollitt and Bouckaert 2000, p. 239–40; Wollman 2001), one that is more compatible with *Rechsstaat* principles and reflecting a more path-dependent approach to modernization than any importation of NPM would be. This distinction between NSM and NPM has implications for our understanding of the archetype transition and, as this study demonstrates, it is important to clearly discriminate between the variants of public management reforms and modes of governance. In the literature on archetypes the underlying premiss has been the existence of a 'high degree of commonality of structures, systems and, most of all, in their fundamental interpretive scheme' (Powell *et al*. 1999, p. 4). This assumption is beginning to be questioned: and the isomorphic imperative (see DiMaggio and Powell 1991) implicit in the above quote does not always apply, even within Anglo-Saxon countries (see, for example, Kirkpatrick and Ackroyd 2003) and even less so across other welfare regimes.

Pollitt and Bouckaert (2000, pp. 93–4) also suggest that we can distinguish between: (a) change to maintain the *status quo*; (b) modernizers; and (c) marketizers. This is helpful, but in suggesting Germany falls into the first category – (a) maintaining the *status quo* – may be too simple. It may be more appropriate to distinguish between 'modernizers' and 'marketizers' with the recognition that German 'modernizers' may be minimalist in their approach and conservative in their intent. Nevertheless, the changes in the wake of NSM on the systems and structures of the Public Sector archetype (Table 1) and transforming them more in line with the Public Hospital Corporation archetype (Table 2) – as in the LBK case – does imply a radical modernization programme even if it is seen as necessary in order to maintain the broader corporatist framework of public sector governance. To quote a particularly apposite sentence from Powell *et al*. (1999, p. 4):

> While archetypes are difficult to change as key aspects of the interpretive scheme may well be deeply institutionalized, they are not chiselled in stone.

Not even in Germany.

In the LBK case it is important to recognize that in interpreting the transition to the Public Hospital Corporation archetype (Table 2) that this process

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reflects far more the 'New Steering Model' (*Neues Steuerungsmodell*), designed to reconfigure the hospitals within the institutional framework of German corporatism, rather than New Public Management. While there are clear parallels between the two in terms of reducing costs, improving quality and increasing accountability (Pollitt and Bouckaert 2000, p. 95), the tensions between these components will be different, as will the managerial trajectories and the implications for doctors.

The managerial strategy of the LBK has not been one aimed at undermining the corporatist institutions with the introduction of Anglo-American 'New Public Management' (NPM). Rather, it has been the adoption of a 'corporate' strategy designed to enable LBK managers to effectively control costs while strengthening the integration of these public sector hospitals within the legal framework of German corporatism. It is an example of what Pollitt and Bouckaert (2000, p. 236) describe more as a process of 'administrative tightening up and modernization . . . than marketization and minimization', although in the case of the public sector hospitals within Hamburg, the consequence of 'tightening up' has been experienced as a major challenge to the traditional autonomy of the physicians. In the process of moving from the 'Public Sector Hospital' to the 'Public Hospital Corporation archetype (Tables 1 and 2), the balance of organizational interests and power has been directly challenged and it would appear from our study that medical dominance might be replaced by managerial control. Certainly the combination of DRG pricing and interventionist sickness funds has engendered a sharp managerial thrust to the corporate strategy of the LBK. In Cooper *et al.*'s (1996) view, and one with which we concur, transitions between archetypes are often disruptive and complex, 'causing several archetypes to be simultaneously present on the surface' (sedimentation); moreover, 'different archetypes can dominate in different parts of the organisation'. Within the LBK there is clear movement from one towards the other, but it is still too early to judge this 'experiment' a success (or a failure).

CONCLUSIONS, THEORETICAL IMPLICATIONS AND SUGGESTIONS FOR FURTHER RESEARCH

In this paper, we have argued that an 'archetype transition' model provides a particularly useful framework for the analysis of the public management reforms being introduced within the Hamburg public sector hospitals network. We argued that, rather than aiming at universal contingency relationships, archetype theory should go down a path where 'local variants' of an archetype (Kitchener 1998, p. 94) can be discovered and understood by relating them to their organizational and institutional context(s). It is in this context that our case study of a German network of hospitals has to be seen. We have attempted to explain the tensions in this particular organization with reference to the challenges facing the broader institutional environment.

Building on archetype theory, it was our intention to show how, in the institutional environment of the German health service and more

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specifically a public sector hospital group, there are clear signs of an intended and fundamental programme of change. The programme is designed to take this hospital group from the German Public Sector archetype to a Public Hospital Corporation archetype (see Tables 1 and 2). In Germany, by the 1990s, it was possible to diagnose an institutional field where some question marks had appeared, some expectations were different from before, some elements of the archetype had begun to be questioned. But this would have been discernible in some German states more than in others, and in some hospital (groups) more than in others. By looking at a 'model' hospital network, with a particular focus on the year 2000, it is clearly no surprise to detect signs of most of the elements of the 'new archetype'. The caveat must be that this seems to indicate an institutional field in movement, that is, as part of an ongoing process, rather than a completed change episode. The train has left the station, but has not arrived at its destination, and it is not known whether it ever will. Overall, our 'model' case study brings out features long seen as typical for the German 'National Business System' (see, for example, Whitley 1992). Change is slow, by necessity, since it needs to be negotiated and mediated with all stakeholders affected by it. The law plays a more substantial role than it does, for example, in the UK, as it imposes real limitations on change episodes. Our case illustrates some of these features and tensions, and gives examples of how actors give expression to them in interview settings. We believe that similar case studies could make a valuable contribution in extending this analysis.

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