

Understanding how groups of managers and professionals within two elderly health care organizations experience and respond to market-based change initiatives and how these experiences and responses differ from each other within the organization.

A dual case study focused on experiences and responses of groups of managers and professionals within an elderly health care organization to market-based change initiatives.



Radboud Universiteit Nijmegen

Radboud University Nijmegen

Master Thesis Business Administration

Specialization: Strategic Management

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2016

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1. Introduction

1.1 Introduction

In the last twenty years the Dutch government has implemented several initiatives, in the spirit of the so-called New Public management movement, to increase the competition within the public sector (Groot & Budding, 2008; Speklé & Verbeeten, 2008). These market based initiatives should lead to making those organizations within the public sector more efficient, effective and to make their achievements more visible and transparent (Moxham, 2009; Helderma et al., 2005).

One of the most significant parts of the public sector in the Netherlands that was affected by this movement, is the health care sector (Groot & Budding, 2008). In order to gain more control on health care expenditure, the government introduced a market logic in the health care sector to stimulate the competition between organizations in the health care sector. This should in the end lead to a health care sector that reduces its expenditure for the future (SER, 2001). The introduction of a market logic is expressed by market based initiatives which have goals such as increasing productivity and efficiency, improving the quality of health care and to increase the accountability of employees within the health care sector (Chassin et al., 2010; Hendriks et al., 2009; Meyer & Hammerschmid, 2006).

Due to this development, which prescribes how health care organizations should be managed and structured, an important challenge arose for different actors within the health care sector concerning how to effectively respond to these market-based change initiatives (Ter Bogt, 2008). First of all, the difficulty of this challenge is based on the nature of the health care sector since it is not a private sector industry but a high quality service sector where professionals aim at providing the best care for people. As a result a second difficulty arises due to the existence of different groups of actors within a health care organization that are guided by their own dominant logics which might interfere with the introduction of a market logic from the government (Greenwood & Hinings, 1996).

Institutional logics are socially shared assumptions derived from cultural beliefs and rules that drive the behavior of organizational actors and shape their cognitions (Thornton & Ocasio, 2008). Since an actor can be influenced by multiple different logics simultaneously (Dunn & Jones, 2010), logics may also pose conflicting demands. Literature has shown that at least three distinct logics can be identified within the health care sector, a professional logic, a market logic and a state logic (Scott et al., 2000; Reay & Hinings, 2005; Goodrick & Reay, 2011). Actors who are mainly guided by a market logic within a health care organization are

the Chairman of the Executive Board and other line managers. Their behavior is focused on customer service, performance, managerial control, deciding which goals are legitimate to pursue and translating them into the functional level (Townley, 2002; Pache & Santos, 2010; Thornton, Ocasio & Lounsbury, 2012; Chen & Mahony, 2006). Proponents of the state logic are governmental officials and decision makers (Freidson, 2001). Those actors use formal procedures and rules in order to control the offer of services and products, to determine standards for quality and set the price offered to the client (Scott et al., 2000). Professionals however, are mainly guided by their professional logic which results in strong occupational values and identities (Brock et al., 2014; Freidson, 2001). These professionals, such as nurses, are facing conflicting logics when a market logic interferes with the professional logic (Pache & Santos, 2010). Such situation, when actors face conflicting logics, is called a situation of institutional complexity (Greenwood, et al., 2010).

The influence that institutional complexity exerts on organizational strategies, structures and practices has been widely examined by researchers (Reay & Hinings, 2005; Pache & Santos, 2010; McPherson & Sauder, 2013; Kraatz & Block, 2008). For instance, McPherson and Sauder (2013) showed how actors from different institutional and professional backgrounds employ multiple logical frameworks in their response to institutional complexity. This research states that actors may exercise a great deal of agency in their use of different logics depending on the situation they are faced with. Goodrick and Reay (2011) showed in their historical case study in U.S. pharmacy from 1852 until 2011 that both competitive (segmenting) and cooperative (facilitative or additive) relationships among coexisting logics allow for an influence that is exerted simultaneously on professionals and their work. However, it is still unclear how actors within an organization may experience and respond to multiple institutional logics (Kraatz & Block, 2008; Pache & Santos, 2010; Smets et al., 2015).

1.2 Problem statement

It's important to note that research on institutional complexity focuses on different levels of analysis. Most research has been conducted on the organizational- or societal-level (Bhappu, 2000; Greenwood, Díaz, Li, & Lorente, 2010; Miller, Breton-Miller & Lester, 2010). These studies for instance show how one logic gains dominance over another in a particular field or that logics might peacefully co-exists (Thornton, 2002; Dunn & Jones, 2010). Studies on these levels have provided significant insights, however they also lack insight in how processes of institutional complexity actually work within the organization.

Here the intra-organizational dynamics are neglected and an organization is seen as a 'black box' or a single unity that is either a passive receiver of institutional complexity (DiMaggio & Powell, 1983) or develops a single strategic response to institutional complexity (Kraatz & Block, 2008; Meyer & Rowan, 1977; Oliver, 1991). This thesis tries to open this 'black box' by examining institutional complexity on an intra-organizational level and examines how different groups of actors within a health care organization, namely managers and professionals, experience and respond to institutional complexity that arises from the introduction of a market logic from the government.

Research on intra-organizational processes suggest that it should not be ignored how organizations experience and respond to institutional complexity within the organizations. The reasoning behind this statement is that a more profound knowledge about intra-organizational processes helps explaining why organizations might respond differently to institutional complexity (Thornton & Ocasio, 2008; Greenwood et al., 2011; Detert & Pollock, 2008; Pache & Santos, 2010).

Institutional complexity is not experienced and addressed homogeneously throughout the whole organization (Greenwood & Hinings, 1996; Greenwood et al., 2011; Powell & Colyvas, 2008; Zilber, 2002). When a market logic enters a health care organization, it is likely that managers and professionals perceive and assess this market logic in different manners. These groups may have different interpretations and responses as a result of the existing and dominant logics that structure the behavior and thinking of actors within their group (Detert & Pollock, 2008). Other reasons for different interpretations and responses are the relative degree of influence of a group within the organization, the nature of the institutional complexity, and the nature of the appropriate goals as well as the appropriate means to achieve these goals (Besharov & Smith, 2014; Greenwood & Hinings, 1996; Greenwood et al., 2011; Greenwood & Suddaby, 2002; Powell & Colyvas, 2008; Zilber, 2002). In other words, the way that groups of individual actors within the organization experience and respond to conflicting institutional demands is influenced by the nature of demands and the internal representation of the conflict (Pache & Santos, 2010).

When assessing different possible responses to institutional complexity, literature has distinguished different levels on which these responses may be exerted. Recent research showed how individuals can dynamically balance coexisting logics to make them conflicting yet complementary (Smets et al., 2015; Pache & Santos, 2013). Furthermore, recent work from Smets et al. (2015) focuses on responses of individual actors to conflicting logics where

former research (Oliver, 1991; Greenwood et al., 2011; Pache & Santos, 2010) focused on responses at an organizational level.

This paper aims at gaining a more profound understanding of how two different groups - namely professionals and managers - experience and respond to the introduction of a market logic in an elderly health care organization. The research question therefore becomes:

“How do managers and professionals within two elderly health care organizations experience and respond to situations of institutional complexity that have arisen from the introduction of market based change initiatives by the government?”

In order to develop an answer to the research question the following sub-questions will be have to be answered:

- *“Which institutional logics within health care organizations, distinguished by literature, structure the behavior of professionals and managers?”*
- *“What are possible ways that professionals and managers, derived from literature, experience and respond to conflicting logics?”*
- *“How do managers and professionals internally represent the introduction of market based change initiatives by the government in the elderly health care organization?”*
- *“How do does the nature of demands influence how managers and professionals experience the introduction of market based change initiatives by the government in the elderly health care organization?”*
- *How do managers and professionals, as a combination of the nature of internal representation and the nature of demands, respond to the introduction of market based change initiatives by the government in the elderly health care organization?”*
- *“How do the responses and experiences to the introduction of market based change initiatives differ for the managers and professionals within the elderly health care organization?”*

The reasoning behind these sub questions will be elaborated in the next section which also covers to what extent the sub questions are relevant in order to provide a profound answer to the main question.

The first sub question is a general one that provides understanding about which institutional logics can be distinguished within the health care organizations. This is relevant since it is necessary to have knowledge about the different logics within health care organizations before it is studied how different groups of actors within the health care organization experience and respond to these logics. Furthermore it is relevant to examine what makes logics different from each other and which actors are usually associated to be the proponents of these logics. This helps the research in finding differences between the market logic and professional logic in terms of how they influence professionals and managers within the health care organization.

The second sub question provides knowledge about how research in the field of institutional logics has developed an understanding regarding the way that groups within organizations may experience and respond to conflicting logics until now. It provides insight in how literature describes the different possibilities of how conflicting logics are experienced and responded to by professionals and managers. This is relevant for this thesis since it helps recognizing the different responses and experiences of the managers and professionals when it will be studied at the two health care centres. Furthermore it is relevant to get an understanding about the relationship between how institutional complexity is experienced and responded to by different groups of actors within an organization. This helps to understand why certain responses are enacted in certain situations. Answering the first 2 sub questions provide a theoretical bases which is used as a framework when applying it into the empirical situation. This will be the focus of the last sub questions.

Sub questions three and four are about studying how managers and professionals within the two health care organizations experience and respond to the introduction of a market based change initiatives by the government. These questions provide empirical knowledge about how groups, consisting of individual actors within the two health care organizations, actually experience and respond to institutional complexity that arises from the introduction of market based change initiatives by the government.

Sub question five is about distinguishing possible differences between professionals and managers with regard to how they experience and respond to market based change initiatives by the government.

In the end, an answer to these five sub questions should lead to a profound understanding and knowledge which is required to provide an answer to the main question.

1.3 Relevance of study

This paper aims at gaining a more profound understanding on how different groups of professionals and managers within a health care organization experience and respond to institutional complexity as a result of the introduction of market based change initiatives by the Dutch government. Pache and Santos (2013) pointed out that there is still a lack of understanding about how institutional logics are experienced within the organization by different groups of actors and how these groups of individual actors respond to conflicting logics (Kraatz & Block, 2008). Most research has been conducted on the organizational field-level (Lounsbury 2002; Scott et al., 2000; Greenwood & Suddaby, 2005) or on the organizational level (Oliver, 1991; Kraatz & Block, 2008). Research on this level acknowledges that organizations develop strategic responses in situations of institutional complexity (Oliver, 1991; Kraatz & Block, 2008).

However, those studies do not provide insight in the process how organizations develop these responses to the institutional complexity they are confronted with. Knowledge about this process might better explain what drives the variety of responses that organizations express in order to deal with institutional complexity. A better understanding of the variety of responses organizations have towards institutional complexity may improve predictions of how those organizations respond, under certain conditions, towards institutional complexity.

In order to provide a more profound knowledge about the process how organizations develop their responses, the intra-organizational processes should be taken into account for a closer examination. From this perspective the organization is not seen as an unitary actor that strategically responds to institutional complexity but as an organization which consists of different groups of actors that, compared to each other, experience and respond to institutional complexity in different ways since their behavior and way of thinking is driven by different dominant logics (Pache & Santos, 2010). Since those intra-organizational processes have an influence on the development of organizational responses to institutional complexity, a more profound understanding about those intra-organizational processes might help with explaining the variety of organizational responses to institutional complexity (Thornton & Ocasio, 2008; Greenwood et al., 2011). This might create a more profound understanding which parameters and conditions lead to situations in which institutional complexity is experienced and responded to in a certain way. This, for instance, could be an outcome for policy makers and change agents since they can adjust the change initiatives to the intra-organizational characteristics of an organization or a branch of similar organizations.

Within the organization the logics are not experienced and addressed homogeneously throughout the whole organization (Greenwood & Hinings, 1996; Greenwood et al., 2011; Powel & Colyvas, 2008; Zilber, 2002). Therefore it is essential to examine how institutional logics are experienced within the organization by different groups of actors and how they respond to conflicting logics. Furthermore, recent research stresses out the relevance of examining individual responses in the context of groups that individual actors are a member of (Smets et al., 2015; Thornton et al., 2012; Lounsbury, 2007; Pache & Santos, 2010). According to these studies, individual behavior is partly structured by a normative basis which is mainly provided by group-membership rather than self-interest. Therefore it is relevant to take groups of individual actors into account in order to gain a more profound knowledge about how different groups respond to institutional complexity within an organization.

Conducting two cases studies at two elderly health care centre's also provides a practical, managerial relevance for decision makers such as managers and executives within the health care sector. Understanding how groups, such as nurses and managers, deal with institutional complexity might provide a deeper understanding for those decision makers concerning how to interpret institutional logics that shape the behavior of groups of individual actors. This might help the decision makers in developing and implementing more suitable conditions in order to implement change, as a result of the introduction of market based initiatives by the government, more effectively in a highly institutionalized environment (Greenwood et al., 2011).

1.4 Outline of the study

In order to provide an answer to the research question, a case study is conducted at two elderly health care centre's since this sector contains an environment where plural institutional logics co-exist or compete with each other (Reay & Hinings, 2009; Freidson, 2001; Boyd, 2004). Within the health care sector a distinction can be made between organizations that are focused on 'care' and organizations that are focused on 'cure'. 'Cure' organizations aim at healing a patient, and is applied to interventions in the course of a disease. 'Care' organizations are focusing on treating patients in such a manner to make daily life more bearable for them. They do this for example by washing, feeding and dressing wounds (Mol, 2008). This paper will focus on two elderly health care centre's which is typically part of the 'care' sector within the health care sector.

This paper will contain the following structure. In the next section the focus will be on previous research regarding institutional logics and how plural logics are conceptualized. This also contains the different theories about how managers and professionals within the health care sector may experience and respond to institutional complexity. Subsequently, the research methods will be described, the analysis explained and the findings presented. Finally, the paper will provide a discussion section, develops conclusions and implications for future research.

2. Theoretical framework

2.1 Institutional complexity

Institutional theory contributes to an understanding of how organizations behave within today's complex and highly competitive environment. This environment that influences organizations and individuals within organizations is called the institutional context (Greenwood et al., 2008). From this institutional environment, Meyer and Rowan (1977) showed in their paper that institutional processes influence and also drive the behavior of organizations. The paper of Meyer and Rowan (1977) turned out to be a start of extensive research on institutional processes which have been widely examined over the years. A contribution for this matter has been made by DiMaggio and Powell (1983). Their research showed processes of isomorphic change which causes organizations to look similar to each other although they are changing as well. This paper helped gaining understanding about how conflicting demands may arise in an organizational field and how it affects organizations. This knowledge provided the base for further research to understand how organizations actively may respond to institutional demands (Oliver, 1991; Pache & Santos, 2010; Delmas & Toffel, 2008). In order to understand how socio cultural demands influence organizational and individual actors, institutional logics are used (Thornton, et al., 2005).

Institutional logics provide actors a common frame with cultural beliefs and rules that provide guidance and gives meaning to the cognitions and behavior of actors (Thornton, 2004; Smets et al., 2015). Actors comply with logics in order to gain legitimacy from important referent audiences and it provides understanding about how to act in a certain social world. It is important for actors to gain legitimacy from important referent audiences since it increases the chances of survival in the institutional environment (Greenwood & Suddaby, 2005). Multiple institutional logics exist and may interact and compete with each other for influence in all societal domains (Nigam & Ocasio, 2010). Logics are often in conflict with each other due to respective systems of meaning and normative understandings which is expressed in rituals and practices (Greenwood et al., 2011, p. 321). Typically, when actors face multiple logics that may be mutually incompatible it generates challenges and tensions for actors. This situation, where actors face incompatible prescriptions from multiple institutional logics, is called a situation of institutional complexity (Greenwood et al., 2011, p. 318). The nature of the institutional complexity not only depends on the number of logics but also on the degree of relative incompatibility between them (Greenwood et al., 2011). An

example of logics that might show signs of incompatibility with each other are the professional logic and the market logic.

A variety of research has been conducted on institutional complexity since the pattern of how institutional complexity is experienced by different actors shows a great variety (Scott, 2008). The next section will elaborate on the different levels of analysis that can be conducted on institutional logics.

2.2 Institutional logics & levels of analysis

Research on institutional logics has variously focused on different levels of analysis within social domains. Logics can be examined on the level of an organizational field, an organization, different groups within the organization and the individual actors within the organization (Greenwood et al., 2010). The literature and implications for assessing institutional logics at these various levels will be further explained in the next section.

2.2.1 Organizational field

An organizational field is a community of actors held together by their joint values and beliefs (Scott, 2008). These actors consists of consumers, suppliers, regulatory agencies, and organizations that compete or cooperate with each other (DiMaggio & Powell, 1983). An organizational field represent the intermediate level between organization and society (Smets et al., 2012). When defining the field, it helps to describe the institutional logics that guide the behavior of actors of the particular field. Therefore institutional change is usually associated with a new logic for the field (Lounsbury 2002; Scott et al., 2000; Greenwood & Suddaby, 2005).

Most theorists have argued that organizational fields are organized by a dominant institutional logic, although it may be possible to have multiple logics in an field at the same time (e.g. Scott 2008; Thornton, 2002). A new dominant logic provides new guidance for field members, meaning that the previous dominant logic is no longer the driver for behavior in an organizational field (Kitchener, 2002; Scott et al., 2000).

In contrast, a few studies showed that, due to the fragmentation of institutional contexts, situations exists where competing logics continued to co-exist within organizational fields for a lengthy of time (Lounsbury 2007; Reay and Hinings 2005). However, these studies do not provide insight into how the co-existing logics are sustained within a field and how stability is sustained in such an environment. Dunn and Jones (2010) showed in their paper that both science- and care logics may coexist in a medical education field and are balanced over time since it is unlikely that one logic dominates over the other logic for a

significant amount of time. Furthermore showed Marquis and Lounsbury (2007) how competing logics could cooperate to facilitate resistance to the introduction of a new logic in the sector banking. The introduction of a new banking logic resulted in a cooperation of an entrepreneurial- and community logic although those logics conflicted with each other before. Their research showed that conflicting logics may co-exist and cooperate for a certain amount of time under various conditions (Marquis & Lounsbury, 2007). This cooperation between logics is maintained for a longer time when the logics are supported by powerful actors (Thornton & Ocasio, 1999). When a new logic enters an established field, rivalry among those powerful actors is likely to arise since the challenger actors support the new logic while incumbent actors are supporting the old logic (Reay & Hinings, 2009, p. 631). From this perspective, co-existing logics only co-exist on a temporarily basis until one logic becomes the dominant logic in the organizational field (Di Maggio & Powell, 1983) or becomes a new hybrid logic derived from the two previous logics (Glynn & Lounsbury, 2005). Although the concept of institutional logics translates field-level values and beliefs into actions at all organizational levels, most literature in institutional theory focus on actors on field level. As an example, authors such as Greenwood and Suddaby, (2006) examined in their research about the big five accounting firms in the U.S.A. how field-level actors facilitated the shift of one dominant logic to another. However they do not focus on how organizations strategically respond to institutional complexity. Authors such as Pache and Santos (2010) and Dunn and Jones (2010) provided more in depth knowledge about how organizations experience and respond to institutional complexity. This will be discussed in the next section.

2.2.2 Organizational level

As seen in the previous section, organizational fields often times contain multiple logics or conflicting demands. This means that organizations are increasingly subject to multiple logics by their institutional environment. These multiple logics may be conflicting which makes compliance impossible to achieve for an organization since satisfying one demand means that other demands are neglected (Pache & Santos, 2010, p. 456). This may in the end jeopardize the organizational legitimacy. In this situation an organization is facing institutional complexity since the organization experiences incompatible demands from actors containing different institutional logics (Dunn & Jones, 2010; Pache & Santos, 2010). As a result, organizations are multiple logic-entities by nature who possess multiple identities derived from different segments of its pluralistic environment (Kraatz & Block, 2008; Smets & Jarzabkowski, 2013). Put into other words, it is the broader, heterogeneous institutional

environment that imposes these multiple identities, which leads to conflicting demands, and thus generates institutional complexity within the pluralistic organization itself. Previous research suggests that organizations may have some level of strategic choice when it comes to responding to conflicting demands from influential stakeholders (Pache & Santos, 2010; Oliver, 1991; Kraatz & Block, 2008). According to these studies the organizations develop strategic responses to these conflicting demands. However, the way they respond and how these responses depend on particular conditions have been examined by several researchers. For example, Oliver (1991) formulated a useful typology of responses to institutional demands in general. According to this model an organization won't find it easy to acquiesce the conflicting demands and, thus, are highly likely to resort to more resistant strategies, such as compromising, avoidance, defiance, or manipulation. Pache and Santos (2010) used Oliver's (1991) typology for describing organizational responses, however they extended their research by identifying how conflicting institutional demands penetrate organizations. The authors explored the combined interaction of nature of demands and their internal representation which showed that different types of conflicting demands are perceived differently by organizations which eventually lead to different responses of organizations. Pache and Santos (2010) extended Oliver's (1991) paper by taking into account the intra-organizational processes instead of viewing organizations as unitary actors that develop optimal response strategies to exogenous institutional demands. This will be further elaborated in the next section.

2.2.3 Intra-organizational processes

The relevance for not ignoring the process of how organizations experience and respond to institutional complexity within the organization is emphasized by several authors (Thornton & Ocasio, 2008; Greenwood et al., 2011; Detert & Pollock, 2008; Pache & Santos, 2010). They recognize that institutional complexity is not experienced and addressed homogeneously throughout the whole organization but may vary over various subgroups within the organization. Detert and Pollock (2008) focused in their paper on how teachers, as part of a group of professionals, experience and respond to changes that were initiated at higher levels in two U.S. high Schools which is regarded as an highly complex, multileveled institutionalized environment. The researchers found how these change initiatives showed consistencies and inconsistencies with the values, interests and capacities of the professionals. The degree to which those demands were compatible, determined the responses of the teachers to the initiated change. Here the 'micro politics' of change come into play which is

about “ those strategies and tactics that organizational actors use in negotiating the alignment of logics of action” (Bacharach et al., 1996, p. 479). Another research of Pache and Santos (2010), as mentioned in the previous paragraph, emphasized on the importance on seeing members within the organization as heterogeneous groups. Pache and Santos (2010) identified situations in which conflicting institutional demands resulted in different responses from different groups of actors within the organization. In this perspective, different groups of actors within the organization have a huge impact on how demands, that an organization faces, are interpreted and responded to. Powel and Colyvas (2008) emphasized also on the influence of status of individual actors within groups that may determine their responses to institutional complexity. They describe how power and prestige are often based on social stereotypes regarding gender, race, age, education and occupation.

When focusing on how conflicting demands are experienced within the organization, Pache and Santos (2010) argued that the nature of these experiences of groups within the organization is a function of two factors. These two factors are the nature of demands and the degree to which the demands are represented within the organization. Differences in these two factors among groups might explain the differences in responses of these groups to institutional complexity.

The nature of demands is about the degree of negotiability of the conflicting demands. When the characteristics of conflicting demands show rather fixed incompatibilities which cannot be changed easily, then the degree of negotiability is not considered as high (Pache & Santos, 2010, p. 459). This influences the responses of groups within the organization towards those conflicting demands. Conflicting demands may exert influence at the ideological level or functional level of groups within the organization. Demands on an ideological level prescribe which goals are legitimate to pursue whereas demands on a functional level prescribe which appropriate means or courses of actions it should implement (DiMaggio & Powell, 1983; Oliver, 1991; Townley, 2002; Pache & Santos, 2010). In terms of negotiability, functional demands are material and peripheral which means they are potentially flexible and negotiable (Pache & Santos, 2010, p. 460). However, demands at an ideological level are more fixed since they are expressions of the core system of values. This means that the negotiability of these demands is less flexible (Pache & Santos, 2010). As a result it is likely that the way that groups experience institutional complexity is influenced by the nature of demands. In line with Pache and Santos (2010), Besharov and Smith (2014) describe the nature of demands as the degree of compatibility between logics within the organization. In their paper they theorize that when logics are more incompatible to each other

it usually generates more conflict compared to multiple logics within the organization that are compatible to each other.

The second factor that influences the response of groups within the organization is the internal representation. The nature of internal representation refers to the stakes involved in the conflict of the different groups within the organization (Pache & Santos, 2010). These stakes are a result of the different logics that the groups adhere to and determines if actors are committed to defending this logic when it is challenged. Another factor of influence on the internal representation are the different power dependencies of groups (Besharov & Smith, 2014; Powel & Colyvas, 2008). Pache and Santos (2010) state that it is important to consider to what extent the different sides of the conflict are represented within the organization. Once only a single side of a conflict is internally represented within the organization, organizational members adhere to the same logic and the responses are most probably aiming at promoting and defending it against external conflicting pressures. In this situation it is less likely a conflict between groups will occur. However, when multiple (at least two) sides are internally represented within the organization it is more likely that conflict will arise between groups since those groups try to defend their logics that they adhere to.

Besharov and Smith (2014) call this situation, whether multiple logics or a single logic is the core to organizational functioning, the degree of centrality of logics. In their paper they describe how the degree of centrality of logics in combination with the degree of compatibility influences the responses to institutional complexity within the organization. According to the model of Pache and Santos (2010), organizational responses to institutional complexity are the outcome of intra-organizational processes. These processes consists of different groups adhering to specific logics which results in responses to ensure that their own logic prevails.

This characterization of groups within the organization drive the way that group members experience and respond to conflicting demands. Since groups consists of individual actors, recent research has paid more attention on how individual actors within organizations respond to institutional logics to deal with the institutional complexity (Thornton et al., 2012). This level of analysis will be discussed in the next part.

2.2.4 Institutional complexity on individual levels.

Examining institutional complexity on the individual level have recently gained more attention. Those researchers have focused on how institutional complexity might create space for individual agency when responding to logics (McPherson & Sauder, 2013, Smets et al.,

2015; Pache & Santos, 2013). On this level of analysis the researchers mainly discuss how individual actors employ a framework of logics in their micro-level interactions. From this point of view it can be stated that logics affect the behavior of these actors' day-to-day activities (Powell & Colyvas, 2008; Smets et al., 2015).

The study of McPherson and Sauder (2013) of a drug court showed how individual actors use institutional logics in their daily interactions with each other. This contributes to the legitimization of individual actors within the organization. Their study also points out that individual actors not only use logics in their daily interactions, but that they use institutional logics to have a tangible influence on decision making within the organization.

Another factor that influences how individual actors experience and respond to institutional complexity is the difference of members' adherence to logics (Besharov & Smith, 2014). When individual actors adhere strongly to a particular logic, they are more likely to comply to that logic and incorporate it in their daily activities. However, when individual actors adhere weakly to a particular logic, they are more likely to resist demands from field-level actors which results in less incorporation of the logic in their daily activities (Besharov & Smith, 2014; Pache & Santos, 2010). A factor that influences the degree of adherence to dominant logics is described by Thornton and Ocasio (1999). They described that a rise of perceived loss of legitimacy to their referent groups enlarges the strength of the members' adherence to their dominant logic. Furthermore, the adherence of individual actors to certain logics is depended on an individual's social network and organizational position. When actors have thicker ties to field-level referents associated with a particular logic, it is likely that they will adhere more strongly to that logic than those with weaker ties (Besharov & Smith, 2014; Greenwood et al., 2011). Furthermore, certain positions within the organization provide a buffer from the influence of logics present within a field, whereas other positions (e.g., boundary spanning, senior management) entail greater exposure to external influence (Besharov & Smith, 2014; Townley, 2002). This means that factors such as network ties and organizational position may determine the influence that a logic has over individual actors within the organization (Pache & Santos, 2013).

2.3 Responses to institutional complexity

The way that organizations may respond to conflicting institutional demands is first described by Oliver (1991). Oliver (1991) formulated a typology of strategies that actors may use in order to deal with institutional complexity. These strategies are: acquiescence, compromise, avoidance, defiance, and manipulation (listed here in increasing order of

resistance to the demands). Pache and Santos (2010) extended this research by using the typology of responses that Oliver (1991) developed to see how intra-organizational processes influences the strategic responses of organizations. Acquiescence is the most passive response strategy and is about adopting requirements derived from external institutional pressures. This strategy may be expressed in three alternative tactics which are habit (unconsciously following invisible, taken for granted norms), imitate (mimicking institutional models) and comply (obeying rules and accepting norms). Compromising is the second strategy formulated by Oliver (1991) which refers to the aim of an organization to satisfy all the institutional expectations of different constituents through mild alteration. Possible tactics to achieve this are balancing the demands of multiple constituents, pacifying and bargaining. Avoidance as a third strategy of Oliver (1991) aims at restraining the necessity to conform to institutional pressures. In order to achieve this an organization might try to escape from the demands by changing goals, activities or domains. Furthermore a buffer may be created to loosen the attachment with the institutional demands and the last tactic is to conceal the nonconformity. Defiance is a more aggressive strategy organizations may opt to use since at least one of the institutional demands explicitly gets rejected with the aim of removing the source of contradiction (Oliver, 1991). Tactics to defy institutional demands are dismissing certain norms and values, challenging the rules and requirements and attacking the sources of institutional pressures. The last strategic response formulated by Oliver (1991) is about manipulation. This strategy focuses on actively altering the content of institutional demands and to influence the carriers of these demands. Here the three options of tactics are co-opting the sources of sources of the institutional pressures to neutralize institutional divergences. The second is influencing the values and criteria and the third tactic, controlling, refers to dominating institutional constituents and processes (Oliver, 1991).

Furthermore showed Kraatz and Block (2008) four strategies that organizations might execute in order to adapt to pluralistic legitimacy criteria. These strategies partially overlap with the strategies of Oliver (1991) but also are partially distinct at certain aspects. The first strategy of Kraatz and Block (2008) in order to adapt to pluralism refers to trying to eliminate pluralism. Actors may deny the validity of various external demands that are posed on them, attack the legitimacy of the entities making the claims, or try to escape the demands or all together. The second strategy is to “compartmentalize” identities and relate independently to various institutional constituencies. The organization might implement this strategy by sequentially attending the different institutional demands or creating separate units and initiatives that express its commitment to the values and beliefs of certain constituencies. This

strategy is also called 'decoupling' (Meyer & Rowan, 1977; Lounsbury, 2001) which refers to the decoupling of the institutional demands from the core of the organization which often results in a rather symbolic adaption to institutional demands (Kraatz & Block, 2008). The third strategy refers to balancing multiple demands, manipulate constituencies and finding cooperative solutions with the actors that pose different demands. The aim of this strategy is to develop an internal balance among various objectives, constituencies, and role identities in order to deal with institutional complexity. The last strategy, formulated by Kraatz and Block (2008), refers to the possibility of organizations to create sustainable identities of their own and to emerge as institutions in their own right. This means that an organization may become a self-directing entity which is not just a result of demands but also the producer of those particular demands. Especially the last strategy is distinct from the strategic responses formulated by Oliver (1991) who is focused on mitigating, transforming, attacking and avoiding multiple demands. So far the discussed strategies refer to tactics that organizations might use to deal with institutional complexity. Literature of how actors may respond to institutional complexity also contains different levels on which these responses are expressed.

Recent literature provided increasingly more attention on how individuals respond to institutional complexity within the organization (Thornton, Ocasio & Lounsbury, 2012; Voronov et al., 2013; Smets et al., 2015). In order to assess how individuals respond to conflicting demands the researchers focused on how logics become tangible for individuals in their day-to-day activities. A recent paper of Smets et al. (2015) provides a more profound understanding for this field of research. In their paper they formulated three balancing mechanisms that individuals may use to cope with conflicting demands in their day-to-day activities: segmenting, bridging, demarcating. Segmenting refers to separating practices governed by different logics from their personal work. Bridging is about importing outputs from one logic into their enactment of the other. Demarcating refers to the practices of countering the tendency to over privileging one logic over another (Smets et al., 2015).

2.4 Logics within the health care sector

Organizations within the health care sector are pluralistic domains where participants (e.g. physicians, managers, nurses, administrators and academics) are guided by multiple institutional logics (Kitchener, 2002; Detert & Pollock, 2008). This makes such an organization a highly institutional environment which is confronted with divergent demands from multiple constituents since this is a field where mission and resource dependence patterns require the interaction of a wide variety of stakeholders and where the field is

dependent on a few key resource providers (Pache & Santos, 2010). A fundamental question that arises in such an environment, especially those dominated by professionals, is how to effectively implement change (Kitchener, 2002; Scott et al., 2000; Thornton & Ocasio, 2008). This topic has been subject of an increasing amount of research over the past two decades since the development of the new public management movement in for example Europe and the U.S.A. (Chassin et al., 2010; Hendriks et al., 2009; Meyer & Hammerschmid, 2006). This movement tries to initiate change in the health care sector that improves the efficiency, responsiveness to customer needs, quality of services and the accountability of employees. This movement has also taken place in the Netherlands in the last 20 years (Groot & Budding, 2008; Speklé & Verbeeten, 2008).

These change initiatives, that may be grounded in a market or state logic, often face strong resistance by professionals which are dominantly guided by a professional logic (Goodrick & Reay, 2011; Thornton, et al., 2005). This resistance of professionals within the health care sector, towards the introduction of a market logic depends on multiple items. Researchers emphasize that the tension is a result of a struggle for control which is especially relevant when the professionals, as the core “technical” workers, have strong occupational or professional identities which is expressed in autonomy over the process and outcomes of work (Freidson, 2001; Detert & Pollock, 2008). However, a preference of autonomy over work is not the only characteristic of this professional logic within the health care sector. Reay and Hinings (2005) points out that the relationship with the patient can be regarded as the most important component which results in the goal of providing the best possible care, without regarding the financial expenses.

The market logic, in most pure form, is expressed in free and unregulated competition with consumer preferences and choice determining success (Freidson, 2001). In a situation of only a pure market logic, professional knowledge is widely available and easy to be obtained and there no specific credentials or educational requirements from any association for professional work (Goodrick & Reay, 2011). An essential form of market logic reflects an absence of controls by professions, corporations or the government. In the case of the health care sector this would mean that health care would be open to everyone. The patients determine, together with the professionals within the health care sector, the price of services and medicine within the context of a broader market which consists of a big pool of patients and professionals within the health care sector. Furthermore patients are completely free in the choice for a medical professional or medical organization (Goodrick & Reay, 2011). However, the market logic is not likely to exist in its pure nature in the health care sector. The

next section will discuss what market based initiatives, derived from a market logic, are usually applied to the health care sector.

The main goal of a market logic within the health care sector is to achieve a more efficient and effective way of providing services. In order to achieve this, a market logic within an health care organization focuses on customer service, performance, setting goals to pursue for professionals and managerial control (Thornton, Ocasio & Lounsbury, 2012; Hopwood, 1974).

When it comes to managerial control there are two types of control that market based initiatives may focus on. The first type is about control over process which contains facilitating adoption and assimilation of organizationally mediated norms, values, expectations and goals. Initiatives to achieve such control are training where the professionals are trained to perform the demanded behavior for their work. Other initiative are protocols which refers to the development of written rules specifying correct and desirable behavior (Parker & Lawton, 2000). The second type of control refers to the outcome of the professionals' work. Usually this is expressed by compensation plans that are connected with the outcome or performance of the employee or department (Arnold, 2010). How performance is measured in a service sector such as the health care might be rather arbitrary. The market logic tries to commodify the clients to a certain extent which makes it easier to evaluate the performance of the professionals (Garrow, 2013). An example of this commodification is stressed out in the study of Garrow (2013). This paper showed how clients, within a public human service centre, are commodified which conflicted with the core of human service organization which believes clients should be decommodified. So far this paper discussed what the market logic and professional logic contain. The proponents of these logics, the actors within the health care organization which behavior is structured by those logics will be discussed in the next paragraph.

Actors within health care organizations who are dominantly guided by a market logic are usually the chairman of the executive board and other line managers. Their task is to translate the demands from a market logic into the functional level consisting of professionals (Freidson, 2001;Townley, 2002; Pache & Santos, 2010; Thornton, Ocasio & Lounsbury, 2012; Chen & Mahony, 2006). Therefore it is likely that both managers and professionals are likely to experience and respond to the introduction of market based initiatives by the government in different ways. An important distinction that should be made is between the market logic and state logic. The state logic will be described in the next section.

The third logic that is likely to exist in a health care organization is the state logic (Goodrick & Reay, 2011). The state logic is, in its most pure form, about the government taking direct responsibility for the work professionals conduct (Thornton et al., 2005). Here the professionals are employees of the state which means that the state controls how professional work should be done, determines if professional work meets the required quality, how professional knowledge is obtained and distributed across professionals, and credentials for the practices of professionals are also determined by the state (Thornton et al., 2005; Goodrick & Reay, 2011). The usual proponents of the state logic are decision makers from the government who determine standards for quality and the price customers should pay for the offered products and services. Formal procedures and rules are the main methods through which decision makers of the government exert the state logic on the health care sector (Scott et al., 2000).

How groups may experience and respond to institutional complexity has been assessed by several authors including Pache and Santos (2010) and Detert and Pollock (2008) and will be further analyzed in this paper. Table 2.1 provides an overview of the state logic, market logic and professional logic regarding their core characteristics. This helps the understanding concerning the key characteristics that distinguishes the three logics from each other.

Table 2.1: Comparison of ideal types of Institutional Logics and Associated Characteristics within the health care sector.
 (Derived and adapted from Goodrick & Reay, 2011; Thornton et al., 2005)

Characteristic	Market logic	State logic	Professional logic in health care sector
Belief systems	Services and products offered by the best provider in terms of costs and quality	The state controls the offer of services and products by legislation.	Services and products are offered under supervision of a professional
Control over knowledge	Knowledge about health care is widely available	Knowledge about health care is only available to the state	Professionals rely on specific knowledge obtained through education.
Scope of practice	The activities of professionals are a result of the preferences of the consumers	State determines activities of professionals by using parameters	The activities of professionals are reflecting the demands and standards of professional associations
Entry to practice	No credentials needed	Credentials determined by the state	Credentials determined by professional associations
Education/training	No specific educational programs determined	State determines the educational programs	Professional associations control the educational programs
Control of work processes	Market pressures determine the activities of work of professionals	State determines the activities of work of professional through formal procedures and rules.	Professionals control their own activities according to standards determined by professions

Performance standards	Consumers evaluate the performance of the professionals	The state evaluates the performance of professionals	Professionals evaluate their own performance.
Determination of price	The ratio buyers/sellers determine the price	State determines the price	The profession determines the price
Primary proponents	Directors, managers	State officials, representatives of the state	Professionals such as nurses

2.5 Conceptual framework

The methodology of this research will be explained in the next chapter. First, a conceptual framework, which can be seen in figure 2.1, will be provided to show which aspects will be examined in this thesis. This conceptual framework provides an overview of the key variables of this research. How these variables and their interrelationships will be analyzed will be explained in the next chapter.

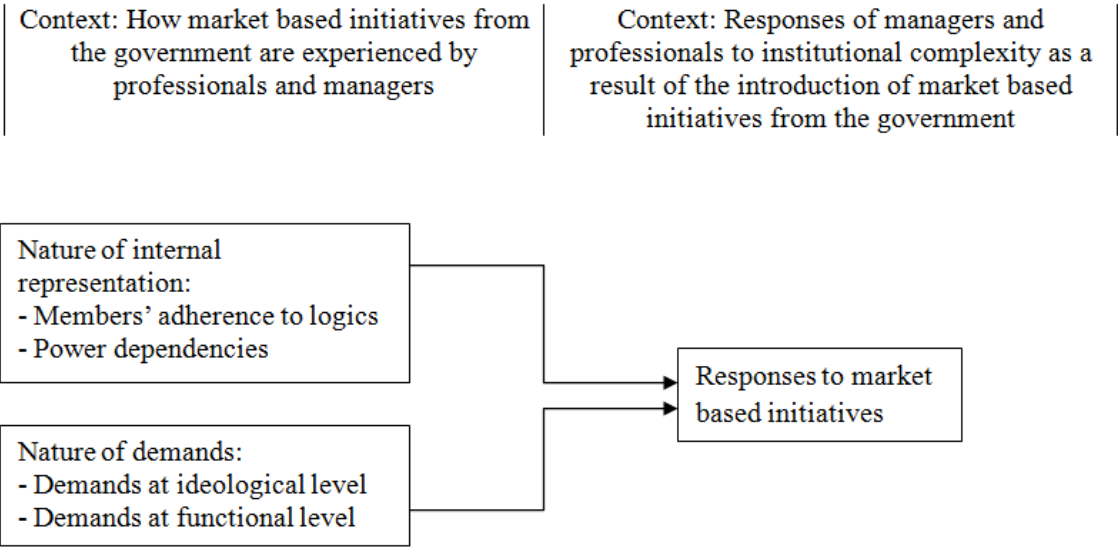
As can be seen in figure 1, the model shows how managers experience and respond to market based initiatives from the government. In order to analyze how this process is perceived by those groups, the internal representation and nature of demands will be the subject of focus (Pache & Santos, 2010). In order to study the nature of demands that groups of managers and professionals face, the following variables will be taken into account: demands on an ideological level and demands at a functional level. As stated before, the demands at an ideological level are about which goals should be pursued whereas demands at a functional level describe by which means or courses of actions these goals should be reached (DiMaggio & Powell, 1983; Oliver, 1991; Townley, 2002; Pache & Santos, 2010). With the introduction of market based initiatives, which is grounded in a market logic from the government, it is important to assess the degree of compatibility between the logics perceived by the groups of managers and professionals. The degree of compatibility may explain possible tensions that arise due to conflicting logics (Pache & Santos, 2010; Kraatz & Block, 2008). It is important in this thesis to distinct if these tensions are a result of conflict over means or a conflict over goals between groups of managers and professionals.

The second factor to get an understanding of how managers and professionals within the health care organization perceive institutional complexity is the nature internal representation. The nature of internal representation represents the stakes involved in the possible tensions between logics of the different groups of managers and professionals (Pache & Santos, 2010). The nature of internal representation can be explained by the different power dependencies of groups and the members' adherence to the logics that are dominating and structuring their behavior compared to other logics.

This thesis will examine how managers and professionals experience possible institutional complexity, as a function of the nature of internal representation and the nature of demands, caused by the introduction of market based initiatives by the government. The final step will be to focus on how professionals and managers respond to possible institutional complexity based on how they experience possible institutional complexity as a result of the

introduction of market based initiatives by the government. In both steps will be examined how the role of groups of both professions influence the responses to market based initiatives. Also the interaction within and between the groups will be the subject of research. For example, how do group members interact with each other or with group members of other groups? How does this influence the way that market based initiatives are experienced and responded to by the groups of professions? These topics will be included in the topic lists which can be found in the appendices.

Figure 2.1: Model for understanding how managers and professionals respond to institutional complexity as a result of the introduction of market based initiatives from the government.



3. Methodology

In this section the methodology of this research will be explained. First of all will be elaborated on the research context and setting. Then the two case studies will be introduced which will be followed up with a section about how the data is collected. After that part the analysis of those required data will be the focus which precedes a section about how the validity and reliability of the research is taken into account in order to make those quality indicators as high as possible. Finally the methodology section will end with a paragraph about the research ethics.

3.1 Research Context and Research Setting

This research is performed at two different elderly health care centre's in the Netherlands. Both centre's are typically part of the so called 'care' organizations as it is formulated for example by Mol (2008). As mentioned in the introduction, 'care' organizations are distinct from 'cure' organizations by the nature of treatment they provide. 'Care' organizations aim at treating the patient in such a way that daily life becomes more bearable whereas 'cure' organizations focus on healing the patients. The two health care organizations in this research are part of the 'care' organizations since they provide care to elderly people who cannot care for themselves anymore in a sufficient way or do not have people in their environment who are able to provide the necessary care. Furthermore they provide specific intramural care for mostly elderly patients who need extra attention and care compared to the elderly people who are located at a senior centre. This means that the actual process of the care takes place at the locations of the organizations itself. They do not provide care at the homes of the patients.

In order to focus on how groups of individual actors within an organization respond to institutional complexity, the health care sector in the Netherlands is an interesting and appropriate subject of analysis since it contains a pluralistic environment with multiple logics (Groot & Budding, 2008). The last twenty years the institutional environment of the Dutch health care sector has significantly changed (Groot & Budding, 2008). This is especially accounted for by the market based initiatives of the government in order to gain more control on health care expenditure, to improve a stricter performance assessment and to improve the quality of health care. As stated before in this paper, introducing a market logic in the health care sector in the most pure form would focus on deregulating the sector in order to create free market processes (Freidson, 2011; Goodrick & Reay, 2011). However, in the case of a market logic in the health care sector, especially in the 'care' sector, market based initiatives

aim at providing services in a more efficient and effective manner. To achieve this desired situation the market based initiatives are usually expressed by focusing on customer service, quantification of performance, managerial control and clear goals that can be easily evaluated (Thornton, Ocasio & Lounsbury, 2012). These initiatives will also be the subject of research in this thesis since they proved to be of a significant influence on the health care sector within the Netherlands. Furthermore they have a direct impact on groups of individuals within the elderly health care sector since they face the pressures and institutional complexity as a result of the introduction of the market logic (Volkskrant, 1997; NOS, 2015). As an example the perceived working pressure by employees within the health care sector seems to have been increasing which may jeopardize the quality of the care that they provide for the patients (Volkskrant, 2015). Besides, the market based initiatives do not seem to achieve the desired result (Volkskrant, 2015). The total costs of health care has increased from €52,5 billion in 2001 up to €94,2 billion in 2013 (CBS, 2014). This means an increase of 79,43% which is not the desired result of the market based initiatives. Taking a closer look at the costs of the elderly health care, it shows that there is an increase of 83,8% for the period 2001-2013 (CBS, 2014). This also means that the elderly health care relatively is becoming a larger part of the total costs of the health care sector in the Netherlands. This makes it an interesting environment to take a closer look at how market based initiatives are perceived by different groups within the elderly health care organizations and how they respond to those initiatives. Especially how the introduction of a market logic influences the managers and professionals such as nurses who are, as described in literature, strongly guided by a professional logic (Reay & Hinings, 2005; Reay & Hinings, 2009).

3.2 Research design: Two case studies

This research aims at gaining a more profound understanding of how managers and professionals within two elderly health care centres experience and respond to the introduction of market based initiatives by the government. In order to achieve this goal the data are collected using a qualitative research at two cases.

A qualitative research has been chosen as the most suitable approach since assessing experiences and responses of managers and professionals includes personal perspectives and more profound reasoning behind the respondents' experiences and responses. In order to gain data from the respondents about those feelings, qualitative research is the more appropriate method of research in this thesis (Boeije, 2008; Bleijenbergh, 2013).

A case study has been chosen as the desired research method since it provides a lot of detailed information which is not easily obtained by other research methods. The collected data provide more in depth knowledge than can be found through other research methods (George & Bennett, 2005). Furthermore it offers the possibility to study a phenomenon within its real-life context taking into account more contextual factors than that can be achieved in for example a quantitative research (Yin, 1999). Moreover, when conducting a research in the health care sector, the use of case studies is usually desired since the developments within the health care sector cause more complex information which usually only can be assessed in a qualitative research (Yin, 1999). In this research two cases will be studied. In such situation of two cases, usually the evidence provided is more powerful as long as the two cases can be compared with each other (George & Bennett, 2005). In this research the elderly health care centre's can be compared with each other since they both provide the same care to the patients in the same way. That means that both organizations provide the care at the location of the organization itself since the patients may stay permanently at the facility or the patients are part time present for day care. Also the type of patients that they provide care for are similar to each other. Both group of patients are elderly who need specific care that cannot be offered at a senior centre or at home. Both organizations do not differ too much in the structure regarding the presence and balance between line managers and professionals. Important to mention is that although two cases are subject of this research, it is not a comparative case study looking for differences between the two cases. It is not a comparative study since there are no differences expected between how managers and professionals respond to market based initiatives since, as mentioned before, the organizations are similar as well as the environmental context they operate in. In this thesis, the two cases are used in order to make the study of the behavior of groups of individuals to market based initiatives less specific for the particular organization. Furthermore, since you are dealing with the availability of respondents, two organizations who are willing to deliver respondents increase the chances of providing a sufficient amount of respondents. Conducting this research is based on a logic of replication (Eisenhardt, 1989). This means that the process of how managers and professionals respond to market based initiatives within a specific health care organization is verified with another similar case. This method of research 'confirms, extends, and sharpens theory' (Eisenhardt, 1989, p. 533). Furthermore a practical issue was involved since both organizations couldn't deliver a sufficient amount of total respondents by themselves. Therefore, two cases are used in order to get enough respondents.

3.2.1 Case selection criteria and cases

The two cases selected in this research are the ‘Valkenhof’ located in Valkenswaard and ‘de Zorggroep’ in Venlo. The reasoning behind the choice for these two cases will be explained below. The two cases are selected purposefully since both cases are positioned in a pluralistic environment that influences groups of individuals within the organizations. Furthermore are both organizations focused on elderly care and part of an environment that face market based initiatives posed from the government. From a practical perspective both cases are selected since they are both willing to cooperate with this research in terms of delivering respondents for interviews. Furthermore, groups of individuals within the Valkenhof and the Zorggroep most likely face institutional complexity as a result of market based initiatives that interfere with the existence of a professional, market logic and state logic that might be conflicting to each other. This makes both organizations interesting and relevant objects to conduct a research on. When specifying which actors face this institutional complexity it has been mentioned before that managers and professionals are the usual proponents of respectively the professional- and market logic. Important to note here is that, regarding the level of research, data will be collected at an individual level from individuals representing their groups. The level of analysis will be on group level. Since both groups consist in both organizations, it makes a further research possible on how groups of managers and professionals within a health care organization respond to market based initiatives. Also a comparison can be made between the groups of both organizations since they are similar in both the responsibilities they have as well as the process of work that they execute. This also makes the organizations relevant since the main proponents of the market- and professional logics are represented within the organizations. This is necessary when examining how managers and professionals experience and respond to market based initiatives.

The Valkenhof is located in Valkenswaard which is in the south of the Netherlands in the province ‘Brabant’. The other location, the Zorggroep, is located in Venlo which is in the southeast of the Netherlands close to the German Border. The Valkenhof consists of 750 employees who mainly work part-time. They are divided over seven different locations, each with their own specialization. The interviews conducted will take place at three locations: ‘Taxandria’, ‘Kempenhof’ and ‘de Vlasgaard’. Although all locations focus on elderly care, Taxandria is specialized in treating patients who are diagnosed with a more severe form of dementia. The Zorggroep is larger than the Valkenhof which is expressed in a total of 6.757 employees where about half of them work part-time. The Zorggroep provides the intramural care at 38 different locations. The interviews will take place at ‘Crescendo’, ‘Jasmijn’, ‘De

Nieuwe Munt', 'd'n Horstgraaf' 'Meeuwbeemd' and 'De Beerendonck'. All the locations are focused on elderly health care where patients are diagnosed with dementia.

3.3 Data Collection

In order to gain a more profound understanding about the way that professionals and managers experience and respond to the market based initiatives within a health care sector, empirical data is collected. These data are derived from information from semi-structured interviews. Furthermore, documents were used to provide background information about the organizations and its context.

3.3.1 Interviews

When conducting a qualitative research the respondents are able to provide a more comprehensive answer in their own words which provides a more profound and complete information for the researcher to analyze the situation compared to quantitative research (Yin, 1999; Bleijenbergh, 2013; Swanborn, 2013). Within qualitative research, interviews are an important source of data collection (Boeije, 2008; Bleijenbergh, 2013). The specific design of the interviews for this research is half structured. This means that the way that questions are formulated may vary depending the specific situation of the interview. The researcher makes sure that the pre-developed topics are all covered during the interview. However, the order of these topics is depended on the process of the interview. The questions are open to make sure that the respondents are able to respond to the questions in their own words. This also enables the researcher to continue to ask questions about a certain topic in order to gain a profound understanding of the situation that the respondent describes. Since the interviews are divided into certain topics, it makes the comparison among individuals easier and enlarges the reliability of the research (Bleijenbergh, 2013).

3.3.2 Respondent selection criteria

The relevance of the respondents of the interviews are depended on the main question that this research focuses on. Since this research examines how professionals and managers experience and respond to market based initiatives, both managers and professionals are selected for the interviews. The professionals are all nurses who are all categorized in at least level four according to a national standard of quality in the health care sector. This guarantees that they have reached a certain level of quality, through education and experience, compared to other nursing personnel who are categorized at a level less than four. This is important since theory assumes that a professional logic is stronger present with employees who are

more skilled and have a higher education (Brock et al., 2014). The managers are all intramural managers who are responsible for a location or several departments within the location.

All the respondents are selected by the two organizations after the researcher communicated the selection criteria of the respondents to the contact persons of the organizations. This led in the end, after assessing the availability of the potential respondents, to a selection of four nurses who are the professionals in this research and 9 managers. At the Zorggroep, five managers and two professionals are selected for interviews and at the Valkenhof four managers and two professionals will be interviewed. An overview of the respondents is given in the table 3.1 below.

Table 3.1: Overview of the selected respondents

Respondent	Organization	Department	Date of interview	Age	Working in current function
Manager 1	Valkenhof	Taxandria	13-7-16	26	2 years
Manager 2	De Zorggroep	Beerendonck	19-7-16	47	3 years
Manager 3	Valkenhof	Kempenhof	13-7-16	31	2 years
Manager 4	De Zorggroep	Meeuwbeemd	20-7-16	52	8 years
Manager 5	De Zorggroep	D'n Horstgraaf	20-7-16	56	9 years
Manager 6	De Zorggroep	De Nieuwe Munt	11-7-16	43	6 months
Manager 7	Valkenhof	Taxandria	15-7-16	63	17 years
Manager 8	Valkenhof	Taxandria	15-7-16	61	4 years
Manager 9	De Zorggroep	Crescendo	19-7-16	57	5 years
Nurse 1	De Zorggroep	Jasmijn	11-7-16	48	5 years
Nurse 2	Valkenhof	Taxandria	13-7-16	54	5 years
Nurse 3	De Zorggroep	Crescendo	19-7-16	25	3 years
Nurse 4	Valkenhof	Vlasgaard	15-7-16	35	4 months

3.3.3 Operationalization

Two separate topic lists will be used for the two separate groups of nurses and managers which are included as Appendices. The interviews are different from each other

since managers and nurses are asked different questions with regard to their positions in the organizations.

However, the first questions in the introduction are the same for both groups. Those questions are asked in order to gain information about the background of the respondent such as age, educational background and position within the organization. From that point, both managers and professionals are asked what market based initiatives mean for them and how they experience market based initiatives within their organization. This provides information about how market based initiatives are perceived by professionals and managers and how they define market based initiatives within their organization. After the introduction, questions are categorized according to the different research topics and themes that are derived from the literature as described in the former chapter. The aim of these questions is to find out how managers and professionals experience and respond to market based initiatives. In order to get an understanding about how they experience and respond the market based initiatives, questions are included about how they perceive the nature of demands and the degree to which the demands are internally represented within the organization by managers and professionals (Pache & Santos, 2010).

3.3.4 Data analysis

After the interviews were conducted they had to be prepared for the analysis. In order to make the interpretation possible the interviews were recorded and transcribed after conduction. The analysis was conducted according to a more deductive approach. This approach, as the opposite of inductive, prescribes that the collected data will be analyzed with pre-assumptions derived from literature (Miles & Huberman, 1994,). However, this thesis doesn't test hypotheses derived from literature but describes the situation in order to gain a profound understanding of the phenomenon being studied.

Fragments of interview transcripts were labeled in order to assign a meaning to different sections of the interview. These labels, also called 'codes', vary from abstract up to specific. 'Coding' helps transforming collected data into results and findings by making a connection between concepts that are observed empirically and the abstract theories which may explain this empiric observation (Bleijenbergh, 2013). Furthermore, coding helps with selecting the relevant fragments from the large amount of transcripts that are available after conducting the interviews (Swanborn, 2013). This process is called data-reduction (Bleijenbergh, 2013). Data-structuring helps to give meaning to the large set of data since it

helps providing patterns that are both consistent with the theory, as described in chapter two, and are consistent with the research question.

In order to make sure not to miss or to have excluded any relevant data concerning subjects that were not captured in the topic lists, the first step of coding starts as close to the empirical data as possible. This approach where every fragment of the transcript is labeled is called 'open coding' (Bleijenbergh, 2013). Open codes are specific and help to unravel the transcript into different fragments by labeling every fragment with a keyword that represents the fragment the most suitable (Boeije, 2008).

In order to conduct the process of coding in a systematic way the computer program 'Atlas.ti' was used which helps the researcher to systematically categorize the different fragments (Bleijenbergh, 2013). The first open coding process resulted in 301 codes. However, some codes overlapped or weren't judged as relevant towards the research question which means they had to be deleted or merged into a single code. After this process of constantly revising the codes, the number of codes has been decreased to 21 different codes.

The second step is axial coding. This phase is characterized by searching for connections between the open codes and trying to derive themes from there. They form categories of open codes and contain a higher level of abstraction (Bleijenbergh, 2013). From this moment a more deductive approach is used in this research since the categories are derived from the literature as described in chapter two. After this process of assigning and linking the codes to an appropriate category the last phase consisted to compare the fragments with the same axial codes in order to recognize patterns in the social phenomenon (Bleijenbergh, 2013). These codes help making a connection between the empiric situation and theory. Besides it also contributes in research with formulating an answer to the main research question. These three stages of coding resulted in a first- and second order categories. Derived from the categories, aggregated themes were developed which in the end resulted in the final dimension. Table 3.2 shows the codebook presenting the data structure. The next section will discuss indicators of quality concerning the methodology of this thesis.

3.4 Validity and reliability

In order to determine the quality of the methodology of this thesis, a number of criteria will be discussed. The criteria that are most often used within deductive qualitative research are: internal validity, external validity and reliability (Boeije, 2008; Bleijenbergh, 2013; Johnson, 1997).

The criterion ‘internal validity’ refers to the degree that systematic errors exists in the way that data is collected or analyzed (Bleijenbergh, 2013). In other words, internal validity refers to what extent the researcher measures what it intends to measure (Boeije, 2008).

Table 3.2: Data structure

	Aggregate themes	Category	Codes
Responses to market based initiatives	Nature of internal representation	Members’ adherence to market logic	Degree of external competition
			Degree of internal competition
			Importance to work efficient
			Importance of financial consideration
			Setting measurable targets/goals
			Degree of administration for increasing accountability
			Need for adjusting to demands client
			Need for efficient organizational structure
			Degree of entrepreneurship
			Adjusting supply and demand
		Members’ adherence to professional logic	Degree of autonomy about their own work
			Degree of pride about profession
		Members’ adherence to state logic	Patient is main goal
			Degree of freedom of use of medical protocols
Influence of inspection by i.g.z.			
Power dependencies	Allocation of z.z.p.		
	Degree of family participating in providing health care		
Nature of demands	Demands at ideological level	Degree of influence of demands from other groups within organization	
		Degree of tension between groups concerning demands	
	Demands at functional level	Demands prescribing goals	
		Demands at prescribing organizational work processes	

Internal validity should be taken into account by examining the ability of the research methods to provide an answer to the main question and sub-questions. In order to improve internal validity, thus lowering the systematic errors, the researcher should have sufficient knowledge about the literature regarding the phenomenon studied as well as sufficient knowledge about the contextual knowledge which is the elderly health care sector in this thesis.

The second criterion 'external validity' refers to what extent the results are generalizable to a population that is bigger than the case that is studied (Bleijenbergh, 2013; Boeije, 2008). In a case study are the specific outcomes not generalizable, however patterns may be generalizable. This is called analytical generalization (Bleijenbergh, 2013). Although this research only consists of 13 interviews, divided over two cases, the results may be generalizable to other similar elderly health care organizations who are facing institutional complexity as a result of the introduction of market based initiatives. However, results of this thesis might be transferable as well to other sectors besides the elderly health care sector. Market based initiatives from the Dutch government also reach other organizations within the public sector. If those organizations or fields of organizations also include professionals who adhere to a professional logic, then the results of this thesis might be relevant for that particular field as well. An example could be the education sector where teachers form the group of professionals and where the government also might force the sector to work more according to a market logic.

The third criterion that indicates the quality of the methodology is 'reliability'. Reliability is about making sure that the findings of a research are not distorted by random deviations (Bleijenbergh, 2013). This is a difficult criterion to meet in this thesis regarding the small amount of respondents since a small set of respondents provide possibly distorted information since the output of one respondent is more weighted than in a research with a larger response set (Bleijenbergh, 2013). Another drawback for 'reliability' in qualitative research and in this thesis is the unstandardized method of data collection. Therefore the role of the researcher is not standardized which means that in interviews the researcher has to improvise a significant part of the interview. For example the researcher has to determine for every situation if it should continue to ask another question about a certain topic and what that particular should be. In other words, conducting semi structured interviews are not contributing to reliability in terms of 'lowering the random errors' (Boeije, 2008). However, in order to improve the reliability in qualitative research it is important for the researcher to be

transparent in every step that is taken in the research process (Boeije, 2008). Therefore it is important in this thesis to clearly state how the process of data collection and data analysis are performed in order to enable the reader of this thesis to assess the validity of this research.

3.5 Research ethics

Guillemin and Gillam (2004) formulated two major dimensions of ethics in qualitative research. One dimension is about procedural ethics which is mostly about agreements between the researcher and respondents. The second dimension refers to ethics in practice which refers to ‘everyday ethical issues that arise in the doing of research’ (Guillemin & Gillam, 2004, p. 263). This thesis will take the research ethics into account by reflecting according to the two dimensions as formulated by Guillemin and Gillam (2004).

Procedural ethics are about agreements that the researcher makes with the respondents concerning the interviews. One of the agreements is that the respondents will stay anonymous in this research and that permission is asked to record the interview. In case the interview is recorded and transcribed, the transcript will be sent to the respondent in order to provide an opportunity for the respondent to check their transcripts for possible mistakes or phrases that are meant or interpreted differently than it is stated in the transcripts. Furthermore the respondents will be informed on beforehand about the aim and context of the interview.

Ethics in practice refer to day-to-day ethical issues that become relevant during the research. Little knowledge can be derived from literature concerning this dimension. Guillemin and Gillam (2004) describe it as “ethically important moments’ which may occur during or around an interview. For example when the respondent confesses something embarrassing or gets emotional it is important for the researcher to respond in such ethical way that the respondents doesn’t feel harmed or embarrassed. The attitude of the researcher should be neutral without being judgmental to the respondent (Swanborn, 2013). These aspects are important for the researcher to take into account when preparing, conducting and analyzing the interviews.

4. Results

This chapter shows the results of the analysis of the collected data. The first paragraph will describe the nature of internal representation. This will be done by examining both the adherence to different institutional logics by managers and professionals and by explaining the nature of power dependencies existing between the actors within the two organizations. The second paragraph will present how the nature of demands influence the actors at an ideological level and a functional level. How the actors, as a combination of the internal representation and nature of demands, experience and respond to institutional complexity as a result of market based initiatives will be explained in the third paragraph. Finally a summary of the main findings will be given which contains an overview of the most important findings of the study.

4.1 Internal representation

As stated before, the nature of internal representation depends on the institutional logics that different groups of actors adhere to and the power dependencies that exists between the groups. Those two factors will be further examined. Derived from literature and described in chapter two, the three logics that professionals and managers commonly adhere to within the health care sector are the professional logic, state logic and market logic. The next paragraphs will describe the results to what extent professionals and managers adhere to these logics. This will be followed up by an explanation of the nature of the power dependencies between the groups.

4.1.1 Adherence to Market logic

After analyzing the interviews of the nurses and managers, it can be stated that both groups adhere to a market logic in different gradations. As described in chapter two by Moxham (2009) and Helderma et al. (2005), an indicator showing the market logic guides the behavior both of managers and professionals is the 'pressure to work more efficient and cost effective;'. The analysis shows that the managers both develop financial and time frames, which set the boundaries within which the professionals have to deliver their work for the clients. This leads to the situation where both managers and professionals look for opportunities to reduce overhead costs, reduce stocks and to organize the work processes itself in the most efficient manner to deliver the same quality of care with less costs and time:

“You have to think about organizing your work in a clever way. We started for example with working in a ‘lean’ way in order to reduce our overhead costs and to reduce stocks of our procurement material.” (Manager 1)

Although managers do not experience tensions directly themselves concerning organizing the work more efficient and cost effective, the professionals struggle with these demands. The pressures to work more efficient leads to higher working pressure and therefore to less job satisfaction. The professionals experience they cannot longer provide the care as they would like to but are constraint by the time in which they should organize their work:

“It leads to a higher working pressure and in a way also to a lower job satisfaction [...]. Some departments are hectic. Everything has to be tightly organized in order to finish everything on time. But if something happens within that time... ,we work with people, if a client gets sick or does something you do not expect, that means you are taken out of your working rhythm. So then you have to keep, in some creative way, an overview. You have to deal with that.” (Nurse 3)

This situation where professionals experience less job satisfaction and work related stress also affects the managers by a possibly higher absenteeism of the professionals. This means that indirectly, the pressures for working more efficient and to reduce costs in then end also may have a counter effect where the managers have to deal with. This is also expressed by the next fragment where a managers is asked what the consequences are for organizing the work in such a way that the professionals continue to do the same work in less time:

“High absenteeism, we have now an average of 8,7% where the national level is 4,5% [...]. You also see the balance challenged of the employees. They have to return often to work, that is challenging for the situation at home, especially with young children. They only work 24 hours but are working 6 days a week [...]. That in the end results in stress.” (Manager 6)

Another indicator of adherence to a market logic are the ‘objectives that managers and professionals pursue’. The question here is to what extent managers and professionals set and pursue financial objectives. After conducting the analysis of the interviews it became clear that most managers state that their main objective is to create an environment where the best possible care may be provided for the patients. However, they also state that they are

responsible to provide such care within the financial limits that are set. This means that they regard the financial objective as almost important as the objective of taking the best possible care which remains the most important goal:

“Of course I am here to provide care for the client. However, also high on my list of priorities is to organize the work in such a way that the work is done within the financial boundaries. It would be a socially desirable answer to say the client is number one for me but it is my task to make sure everything is organized within the boundaries.” (Manager 3)

The professionals are affected by the financial pressures that have been arising over the last years. However, they do not see it as an important goal of their work. That may create tensions between managers and professionals since they do not always prioritize the same financial goals. The financial pressures just set the boundaries within the professionals work on their primary goal which is about providing the best care for the clients:

“To put it bland, the managing board regards the clients as products. And we, the workforce, regard them as humans and that creates tensions. I am not saying the managing board should be concerned about a specific client, but they have an influence on how we do our work and they have to contribute to the passion of nurses.” (Nurse 1)

Assessing a market logic is also about determining the extent to which the workspace is a ‘competitive environment’. Within the organization, little competition exists between different departments. Therefore the professionals experience little competition within their work. However, benchmarking is common between the departments to compare certain key figures as: absenteeism, financial results, waiting lists and the number and nature of clients. Managers however, experience more competition as that most of the times exist between other health care organizations. Here the organizations might compete with the variety of locations they offer, services and type of patients they can treat. This low degree of competition is also more common in the intramural setting of the two health care centre’s. In the extramural health care sector, competition between organizations is more likely to exist. After conducting the analysis it can be stated that the nurses hardly experience any competition in their work, managers tend to experience more competition when they try to fulfill the variety of demands of the clients by offering the right locations to them:

“Competition is a big word but we can zoom in on situations and compare them with other departments. For example the degree of absenteeism can be compared which may create a little bit of competition.” (Manager 5)

Dealing with ‘supply and demand’ is another characteristic of an environment where actors adhere to a market logic. In the case of the elderly health care sector, managers do try to adjust their supply to the demands of the patients by offering locations that are suitable to the demands of the patients. The interviews didn’t show any signs that nurses are dealing with managing the supplies and demands for the (potential) clients:

“What I consider as a market in the elderly health care sector is the existence of a market where the supply we offer has to match the demand in the market. I think that currently there are many different kinds of demands from elderly in Valkenswaard and we have to respond to that.” (Manager 1)

‘Setting measurable, quantitative goals’ is another characteristic of an approach according to the market logic. Managers set measurable goals in terms of the rate of absenteeism, the amount of ‘mic’ situations and client satisfaction. The outcomes of these results are not always communicated to the professionals and the professionals do not experience any tension that arises from setting certain targets by the manager:

“I have a measurable goal that the medical incidents are below a certain percentage. This is hard to achieve due to working pressure of the nurses. We want a 50% reduction compared to last year. Besides that, I have another measurable goal which is to lower absenteeism. This is used to be 5% and which is higher at the moment.” (Manager 1)

The last indicator of a market logic analyzed in the interviews is the ‘degree of entrepreneurship’ that managers and professionals possess in their work. Since this indicator shows overlap with the ‘degree of autonomy’ which will be discussed in the paragraph of the ‘adherence to professional logic’ only that part of entrepreneurship will be discussed to what extent managers and professionals may try out new things on a strategic or functional level. The nurses experience little space for entrepreneurship. Their scope of work is restricted by protocols and a lack of time to invest time and effort into new ideas. This will be further

discussed at the section of ‘adherence to professional logic’. The managers do experience more entrepreneurship, although it is limited. The managers have to conform to outsiders’ demands and money in such a way that they cannot afford to undertake a risky activity. Besides, when managers have a new idea or plan, it takes a lot of effort and time to lobby their idea to various stakeholders in order to get their plan validated which generates the desired investment which is required for the plan. This difficult process may create frustration and demotivates the managers to think and act as in an entrepreneurial way. This results in a situation where managers become more operational managers rather than manager who are thinking about the right strategy for the future:

“Well, how should I put this? We have little place to play in life. I mean, I just have a budget what you construct and follow. I have little space to take a risk or anything. It’s more about taking care of a shop, to operate within strict regulations. I cannot just conduct a little experiment where I can afford to lose €3.500. I do not have that money so it won’t happen.”
(Manager 8)

The next institutional logic that is likely to appear in the health care sector is the state logic. The adherence to this logic by the managers and professionals will be further examined in the next paragraph.

4.1.2 Adherence to State logic

Behavior of actors who are guided by a state logic are usually driven by formal procedures and rules from the government. The interviews showed that managers and nurses in the two health care organizations face those procedures and rules on a daily basis in such a way it can be stated their behavior is for a large part structured by the state logic. Protocols can either be about medical treatments, processes of calamity or safety and hygiene. Most of the specialized protocols about medical treatments do not come from the government but are developed by a group of medical professionals that represent the whole group of professionals in the health care sector. This will be further elaborated on in the next paragraph about professional logic. In order to check to what extent the other protocols are implemented, the government conducts inspections which can be announced before the inspection or is conducted unexpectedly. These inspections create tensions for both managers and professionals since they have to conform to strict regulations. These tensions are also intensified since possible negative results not only affect the specific department but also the rest of the organization:

“When I think about government, I think about the inspection of public health. We had a lot to do with them the last years. We had a lot of unexpected controls and you constantly had the feeling that you had to focused since you do not want to screw it up for the rest of the organization since everyone will be handled if one department doesn’t function. That gave pressure for nurses and management. The government had a huge part in rising this pressure.” (Manager 5)

“We also experience the pressure and the stress that we have to conform to a certain quality indicator or when an audit is coming up. We have to spend attention to that.” (Nurse 2)

Professionals seem to experience more tensions than the managers since the need to comply to the protocols become a goal at itself instead of providing tools to reach other goals. Since the main goal of the professionals is to provide the best care possible for the clients, they are reluctant to pursue other goals than they desire. This development where these demands from the government become goals at itself will be further examined in the paragraph about the nature of demands.

Furthermore, the interviews showed that, besides formal regulation, the government also pressures clients to stay longer at home before they get taken by an elderly health care organization. This means that a more complex health care is required already for the clients at the start of their arrival at a health care centre since they are already further in their decline. Followed up from this development, the government motivates family and volunteers to take care in their own hands by providing care at home and at the health care centre. This influences the professionals and managers in such a way that they have to deal and cooperate, not only with the clients, but also to large extent with the family or volunteers. Families and volunteers may contribute by providing care that professionals are usually not able to do due to time pressure. This care, done by volunteers and families, only contains activities for the client focused on their well-being rather than on medical actions. In order to provide any attention for well-being, professionals experience an increasing dependency on those volunteers and family members. Professional tend to experience more tension from this development of clients staying longer at home since directly affects their work:

“The work pressure is rising, that is what I notice. But that is mainly due to the fact that clients stay longer at home and enter the more severe. That means you have to do more things and arrange more thing from the start.” (Nurse 3)

Managers also face challenges due to a more active involvement of the volunteers and families in the health care process since the managers have to deal with more active stakeholders. They have to create boundaries for these people within which they can do their work:

“We have to organize more information evenings in order to involve the people with the process of health care. To show them the possibilities and what we can expect from them.” (Manager 2)

However, it can be stated that managers experience little tensions from this development compared to the professionals who actively have to adjust their work to the involvement of the volunteers and families. This also contains they have to coach them and guide them along the process .

The next paragraph will show the results of the analysis of the adherence to the professional logic by managers and professionals in the two health care centre’s.

4.1.3 Adherence to Professional logic

Professionals, as described in chapter two, possess strong occupational values and identities. This results in pride that they have about the profession they have. These strong values and pride were also found among the nurses at the two health care centre’s. The managers however show less strong feelings of pride about their job. However, a difference is identified between the managers with a background in the health care sector and managers who come originally from an external environment. Managers who have been nurses themselves in the past are more likely to express feelings of pride concerning the work they do. These feelings are mostly a result of the work that is done in the end for the client but not specifically for the job they execute:

“The work we do cannot be done without passion and devotion. You have the responsibility to guide another person in his or her last phase of life which results in so much job satisfaction.” (Nurse 1)

Another indicator for adherence to a professional logic is the autonomy the professionals perceive about the process and outcome of their work. The interviews showed that the nurses have some autonomy but not as much as you would expect with doctors in a hospital for example. However, the current degree of autonomy that nurses possess is not always the desired level of autonomy by both the professionals and managers. Both groups desire a higher level of autonomy but they are bounded by certain protocols and procedures that determine the professionals how to execute their work. The nurses however, may in certain situations deviate from the protocol since they prefer another option based on their experience and education. This is a clear indication for perceiving autonomy about their work:

“I am working now for 20 years in the health care sector. I have the ability to judge which things are appropriate and which are not.” (Nurse 4)

So the interviews showed that the autonomy of professionals may be challenged by standard protocols and procedures, however the professionals may deviate from these demands whenever the risks are moderate and the nurse judges that the deviation is more suitable than the protocol. However, when a professional is not able to deviate from the protocol and it also doesn't regard the protocol or procedure as contributing to the quality of health care it may challenge the feelings of pride as discussed above:

“All those rules and predicates..., it's all work too far away from providing care. I think it's an undermining of your own profession. Your professionalism is attacked because everything has to be in line with the rules and protocols with the aim to make everything visible for inspection. We are professionals right to take care of the clients? But bureaucracy is taking over which prevents us from spending sufficient energy at the clients”. (Nurse 2)

Perhaps the main characteristic of adherence to a professional logic found in the interviews is the main objective of the nurses to provide the best possible care for the patients regardless the financial costs that comes with it. The nurses state that they put the patient on the top of their priorities:

“The most important thing for us is to deliver the best care for the patient. The satisfaction of our clients is an important indicator.” (Nurse 2)

Compared to the objectives of the managers this may result in tensions for the professionals. Managers not always put the patients on their top of priorities. Professionals therefore feel not always supported in their aim to provide the best care for the patients. Here a clear tension arises since professionals adhere stronger to the professional logic compared to the managers:

“When you talk about goals, they can be different from what the nurses want. They do not always like what I ask them to do but they also realize they cannot get away from that.”
(Manager 3)

An overview of the adherence to the institutional logics is given at table 4.1. When professionals and managers are dealing with pressures from each other or external actors, it becomes interesting to analyze to what extent the position and status of the two groups determine the way that they experience and respond to those pressures. This part about the power dependencies of both the professionals and the managers will be discussed in the next paragraph.

Table 4.1: Overview of the adherence to the institutional logics in two elderly health care centre's.

Characteristic	Market logic	State logic	Professional logic
Core values	<p><i>“I think it is important to make contractual agreements with the clients about what care will be provided for the clients [...]. With the contractual agreements you determine the exact amount of care that the nurses have to provide for the clients. We have to think in a more business-way about this situation.” (Manager 8)</i></p> <p><i>“I notice that we have to be careful with spending our time and money [...]. Furthermore I experienced we have to work in a more efficient manner in order to reduce costs. That is what I have noticed in the last 10 to 15 years.”(Nurse 4)</i></p>	<p><i>“Protocols are made according to guidelines from the government. These protocols have to be implemented by the professionals which requires time. Besides the protocols should also be checked and controlled.” (Manager 5)</i></p>	<p><i>“I am worried about the fact that the health care sector intensifies the bureaucracy. I would rather prefer taking a step back and make more time for actually providing health care. We are all professionals” (Nurse 2)</i></p>
Scope of practice	<p><i>“We experience competition based on how the potential client perceives the location. ‘Can they have a nice room, how do they perceive the hospitality?’ So yes, the quality of the health care is less important, they cannot judge that on beforehand. In a hospital you can see how many knee-operations were successful, in this sector you cannot. However, there is a website where clients and family members can rate your organization on</i></p>	<p><i>“You also see that clients stay longer at home. That is also policy from the government and it’s not a bad development. However, you see that clients enter the elderly health care centre in a different state compared to before. What has not changed is the amount of hours available for the client, that remains the same. This means the health care gets more severe but the bag with money remains the same or gets even less.</i></p>	<p><i>“Your education determines if you have sufficient knowledge to do the procedure. For example I am allowed to put a syringe or to change a catheter. In order to give a shot of insulin, you have to grab a skin fold, however the protocol dictates that this is not necessary anymore since new syringes are developed. But if someone is really thin, I do grab a skin fold in order to reach the muscle easier. But then I do not follow protocol based on my</i></p>

	<p><i>indicators such as: hospitality, hygiene and so on.” (Manager 7)</i></p> <p><i>“It’s a width area where a lot of things are possible. That forces us as an organization to make sure you do not just have one single concept but that you have multiple concepts to offer where clients can choose from.” (Manager 9)</i></p>	<p><i>That results in less hours available for those clients to provide sufficient care.” (Manager 9)</i></p>	<p><i>knowledge. It depends on the risk of the action.” (Nurse 3)</i></p>
Control of work processes	<p><i>“When I look for example at the procurement of incontinence pads we have once a while a post control to see if we are still within our budget for that post. If we are over budget we have to search for alternative, cheaper ways to purchase the incontinence pads”. (Nurse 4)</i></p> <p><i>“Since the hours for providing care are limited, we are looking for places where we can save money. For example, the structure of the organization is being re-organized. We cut of a few layers and develop towards autonomous teams.” (Manager 4)</i></p>	<p><i>“And besides, we hear from them: ‘if you perform in a normal way you get 90% of what is agreed on. If you do it better based on some quality indicator we pay 95%’. Yeah, then we are kind of forced to work on that. We have to achieve those goals because we are dependent on the money. Here in our work we experience that pressure and stress, especially when an audit is coming up. Then we have to pay attention to that.” (Nurse 2)</i></p>	<p><i>“I am working now for 20 years in the health care sector. I have the ability to judge which things are appropriate and which are not. But someone who just left school finds this way more difficult.” (Nurse 4)</i></p>

4.1.4 Power dependencies

As stated before in the theoretical framework, power dependencies between groups may also influence to what extent the different sides of a conflict are internally represented. The characterization of the different groups within the organization determine the way that members of those groups experience and respond to a possible conflict. That shows the relevance to analyze those group characteristics of professionals and managers. The analysis showed various ways that managers and professionals interact with each other in order to deal with pressures from each other or from external actors.

First of all, it seems that professionals have little power to directly influence the policymakers of the government from which the market based initiatives are coming from. At first, derived from their culture and pride, the professionals try to solve their problems themselves. Whenever this doesn't work the professionals communicate their possible concerns to their managers who also have little influence to modify the change initiatives. Therefore the professionals feel powerless which in the end results in compliance. Accepting the situation is easier reached among the relatively inexperienced professionals since they are used to the situation from the start of their career whereas the more experienced professionals still remember the work environment of their first part of their career which they usually regard as more positive:

“We are taking serious in our concerns, but it is not like something is going to change, it all continues. But you just have to try [...]. We express our concerns rather late, it's probably also part of our culture I guess.” (Nurse 3)

The managers also experience tension since they have to deal with the complaints and sometimes even criticism of the professionals about not solving the problems although the managers feel they cannot change those problems easily. A way to reduce the pressure from the professionals is to discourage them to complain or stating that their hands are tied and they are not holding something back but present all the transparency they can:

“They have to trust me when I say that there a no more hours available. I am holding back nothing. They shouldn't constantly ask me, that is a waste of time [...]. That is a way of friction. I have to make decisions that they not always appreciate. Usually those decisions are

about budgets. Then they question if there is not something else possible but then I have to say that nothing is possible. You cannot eat what doesn't exist.” (Manager 7)

However, when it comes to demands which are not focused on the budgets. The professionals may find a way to influence the managers. They form workgroups in order to cooperate with multiple professionals possessing different professions within the organization. Together they make a widely supported report in which they can influence the manager to make a stand towards the policymakers of the inspection. Usually the report develops recommendations for changing procedures or protocols which is then presented to the policymakers who develop these demands.

4.2 Nature of demands

As mentioned before in the theoretical framework, the nature of demands refer to the degree of negotiability of the demands exerted on the actors. The degree of negotiability may be rather fixed when it cannot be changed easily. The opposite would be the degree of negotiability of the demands are flexible and can be influenced by the actors. As described in the theoretical framework, demands can be exerted at the functional- and ideological level.. The level on which the demands are demonstrated may also influence to what degree the demands are negotiable. The next part will explain to what extent the nature of the demands that the professionals and managers face influences the way that professionals and managers experience and respond to them.

4.2.1 Demands at a functional level

Demands at a functional level refer to demands that prescribe by which means or courses of actions the actors should pursue their goals. After analyzing the interviews, it can be stated professionals experience functional demands in the form of protocols. As described before, protocols dictate them how to do their work on three fields: medical treatments, procedures in case of calamity or safety and hygiene. Protocols concerning medical procedures are less fixed than the other protocols prescribing more organizational processes. The reason behind this relates to the situation that the professional, from their professional logic, may discuss the protocol and also may co-develop them. Besides, professionals might deviate from the protocol when a certain situation demands another solution:

“You can look up the protocols in the computer where you also can ask a question [...]. I noticed a few things with the protocols what I thought wasn't right. Then you talk with the

person who is responsible for the protocol and the protocol got adjusted. That is a short line.” (Nurse 4)

Professionals find it harder to deviate from protocols that prescribe organizational processes. They also have no significant influence on the development of these protocols. That doesn't mean they do not have an opinion about how the protocols could be different but they lack motivation for trying to change or modify them because it is out of their control. The closest actor they pressure in order to change the organizational protocols is the manager, but the manager usually invokes on the fact that their hands are tight since the source of the protocol is usually another institution:

“Everyone is determining protocols. We follow them but also have an opinion about them although I think most people keep them for themselves [...]. Everyone does everything but we actually never think why we do it, if it is needed or helpful.” (Nurse 3)

The managers do not interfere with the medical protocols. However, concerning the organizational protocols the managers have the responsibility to implement and translate the protocol in the operational setting for the professionals. Concerning the organizational protocols the managers have some room for negotiability in order to adjust the protocol to the organization. However, this is little room since the protocols are usually not customized to the organization but are a product that is used by several, similar organizations. The managers also experience little room for 'decoupling' since the protocols are frequently and strictly checked by the inspection.

4.2.2 Demands at an ideological level

Demands at an ideological level prescribe which goals should be pursued. The professionals perceive pressure since the demands require different performance indicators than the professionals adhere to. For the professionals it is simple: derived from a professional logic their main goal is to provide health care for the client in combination with contribution to the well-being of the client. However, market based initiatives dictate that health care should be provided in the most efficient and cost reducing manner. As we saw before this may lead to resistance among the professionals. Professionals perceive they have to meet certain goals to show the external environment that they are doing their work well. Those goals can be an approval from the inspection indicating that all the processes are working as it

should be. Besides the approval of inspection it is important to achieve a good score at the ‘zorgkaart Nederland’ in order to show to potential clients how the quality of the organization is perceived by families of clients and clients themselves. However, providing good health care, seeking approval of the inspection, obtain a high score on the ‘zorgkaart’ are not indicators that have to be mutually exclusive. They can go hand in hand but the professionals experience this differently. They perceive those other goals as an distraction which is not contributing to the actual health care of the client:

“It just creates a false security, it says all the processes are done according to the plan, but in the end the only things that count is that the family of the client says: “you guys did a fantastic job.” (Manager 8)

Professionals experience almost no possibility to challenge the goal of reducing costs and providing health care in a more efficient manner. This lack of possibility is mainly due to the fact that they miss a short line to a position or person that is responsible for this development. This probably occurs since the development of market based thinking is initiated by the government. The managers, although they unroll the goals and means to achieve them, are also limited and bounded by the demands coming from the government by their inspection and assignation of the z.z.p. indicators.

So far this chapter discussed the internal representation and nature of demands in order to explain how professionals and managers experience and respond to market based initiatives. The next paragraph will integrate both perspectives into a comprehensive analysis which explains how managers and professionals perceive the market based initiatives and also how they can respond to them.

Table 4.2: Overview of the nature of demands in two elderly health care centre’s.

	Functional demands	Ideological demands
Professionals	<p><i>“We started with the E.C.D. in January. That is an electronic client file. That program forces us to rapport and document in a more clear and transparent way.” (Nurse 1)</i></p> <p><i>“We have all the files in the computer. Still the inspection want us to copy everything and make hardcopy’s because that</i></p>	<p><i>“To achieve our goal we have to reach a certain percentage of the ‘mic’ situations [...]. These percentages are also compared with other departments within the organization. We do not really see that. That is more something for the manager.” (Nurse 2)</i></p>

	<i>is conform the standard procedures.” (Nurse 2)</i>	
Managers	<i>“When mistakes are being made, you check the protocols to what extent they still align with the reality [...]. We have many moments that we get the protocols to check whether they are still right or not.” (Manager 6)</i>	<i>“I noticed some kind of hype where you prefer focusing on the ‘Zorgkaart’ rather than your own internal organization. That you go for the 8 or 9 on the ‘Zorgkaart’ instead of spending energy for the clients. Nowadays you spend a lot of energy at meeting the requirements of external actors.” (Manager 8)</i>

4.3 Responses of managers and professionals when experiencing institutional complexity.

This paragraph will describe how professionals and managers experience and respond to institutional complexity that have arisen from the introduction of market based initiatives by the government. Market based initiatives from the Dutch government come in many different ways and may directly or indirectly influence the managers and professionals in the elderly health care sector. Two different market based initiatives will be highlighted as situations where professionals and managers experience and respond to institutional complexity.

4.3.1 Institutional complexity as a result of setting financial boundaries by the government.

A first initiative from the government is the indication of the so called ‘Zorg Zwaarte Pakket’ (Z.Z.P.). Through indicating the budgets attached to the different categories, the government sets the financial boundaries within the elderly health care organizations have to operate. Since the budgets are becoming less and less compared to the expenses over the last few years (CBS, 2016) the financial boundaries become tighter which results in a significant impact on both the managers and professionals.

After analyzing the internal representation of cutting the financial budgets among professionals and managers, it can be stated that both managers and professional experience tensions. Professionals adhere strongly to the professional logic and their primary goal to provide the best possible care is pressured when the financial budgets are shortened. First of all the professionals experience an increase in the workload. Both nurses and managers point out that a low flexibility is taken into account when indicating the hours of health care the

clients may receive. However, this low flexibility of allocating the hours to the clients doesn't correspond with the uncertain and inflexible nature of providing health care. Especially the departments with severe clients experience escalations and calamities on a daily basis. This requires additional time for the professionals to work de-escalating and may also be accompanied with a certain level of stress since they are working alone or with little support. This results in less hours available to provide care for the client and professionals may experience that they cannot longer provide the amount of care that they would like to according their adherence to the professional logic. Managers, mainly guided by a market logic, do not experience pressures from cutting the financial budgets directly. Their mindset is already on lowering the costs and work more efficient. A decrease in the indication of the Z.Z.P. may increase the challenge the managers perceive to organize their work, however it doesn't conflict with the important goal of the managers as it is the case for the professionals. Another characteristic that causes a difference between managers and professionals is to what extent the actors are aware of the need for lowering budgets on an organizational level. Managers have an overview of the need for cutting the financial budgets whereas professionals not always see the need for constraining the financial budgets since they only look for the hours they spend on the clients and are unaware of the need for lowering the budgets on an organizational level.

After taking the power dependencies into account, the managers may experience pressures indirectly as a result of interaction with the professionals. Professionals feel they cannot influence the source of the initiative since the government is regarded as abstract and cannot be influenced directly in the perception of the professionals. Therefore they complain to their managers to express their dissatisfaction about the current situation although they realize it probably won't increase the amount of hours available. Managers do experience pressures since the professionals are complaining and experiencing job dissatisfaction. As a result absenteeism may rise which increases the pressure on the managers. However, a distinction can be made among the managers regarding their background or history of their career. Managers who have no background in the health care sector seem to be less affected by the complaints of the professionals. They keep the boundaries between the professionals and the managers more strict compared to the managers who have been professionals themselves. Those managers make clear that the professionals have their autonomy of their own profession as long as the manager is also trusted by the professionals that the manager also wants to get the best result for the professionals and clients:

“We keep it pretty strict. I make clear I have no understanding about providing health care, they have no understanding about the rest. As long as you are clear to each other if you do not understand something.” (Manager 1)

Managers who have been professionals as well in the health care sector tend to feel more compassion for the situation of the professionals and therefore make an extra effort to make the professionals aware of the new reality. This new reality means that health care nowadays has changed a lot compared to 10 or 20 years ago. This is mainly represented by the situation that, 10 years and longer ago, the work pressure was less high for the nurses. Besides the high work pressure, the nurses also had more time to spend on the well-being of the patients rather than only providing medical care. Accepting and getting used to the situation could be a difficult thing to do for the professionals. Especially the ones who are already for a longer time in the elderly health care and who still remember how the situation was before the change initiated by the Dutch government along the lines of the New Public management movement. This strategy of the managers is related to the bridging strategy as described by Smets et al. (2015) where parts of the market logic will be enacted in the professional logic in order to prepare the professionals to deal with the new reality.

When it comes to the nature of demands it can be stated that fixing the financial budgets are mainly ideological demands since it becomes a goal to lower the costs in the work of the health care organizations. Managers feel less urgency compared to professionals to actively respond to these demands besides complying to them. The demands are in line with their adherence to the market logic and they also see the need for this initiative. Besides, the manager also experiences no degree of negotiability concerning these demands. Professionals experience a low degree of negotiability of the conflicting demands. Professionals with less experience in the health care sector find it easier to comply with the demands compared to professionals who are working in the health care sector for a longer time. Professionals who work for a longer time in the health care sector got used to a way of working where they were always able to provide the required amount of care for the clients. Making this change to this situation where they cannot provide the same amount of care for a client frustrates the professionals. Professionals who just started recently with their job do not compare this situation with a former period and therefore experience less difficulty accepting the situation.

To sum up, professionals experience more institutional complexity compare to managers when it comes to the initiative of the government to lower the budgets attached to the z.z.p. belonging to the clients. Professionals find it hard to actively respond to these

demands due to the nature of demands but it can be stated that professionals who have a shorter history in the health care sector find it easier to accept the situation and comply to the conflicting demands compared to the professionals who have a longer track record in the health care sector.

4.3.2 Institutional complexity as a result of inspections by the government.

The second market based initiative of the government that results in situations of institutional complexity are the inspections to check whether the protocols and procedures are correctly followed in order to increase the accountability of the organization.

The analysis of the internal representation of these demands from the government among the managers and professionals showed that the initiatives creates tensions among the professionals since it conflicts with the professional logic in two different ways: professionals experience more bureaucracy where the professionals and they have to spend more time on registration and ancillary matters such as documenting every step in the working process although they prefer to spend time and energy on providing the health care for the clients. A second way in which the inspections create tensions is about how the inspections challenge the autonomy of the professionals concerning other tasks not directly related to the more difficult processes of providing care. The high amount of fixed procedures and protocols also dictate the professionals behavior for activities that are either not difficult or can be done according to the preference of the professionals. Since the professionals work according the fixed procedures, the autonomy and pride of the professionals are challenged. Managers however do not experience tensions directly in their work since the procedures help the managers to make performance indicators measurable and it is easier for them to evaluate the performance of the professionals. This process is in line with the market logic the managers are guided by. Indirectly, as with the initiative to constrain the financial budgets, they experience tensions in the interaction with the professionals since they perceive a less job satisfaction.

After analyzing the nature of these demands by the government a shift is found from functional demands towards ideological demands. When the protocols are about low risk medical activities, the professionals are able to deviate from the protocol whenever they think that their way is more suitable in a particular situation. However, a development shows that the no-medical demands are not longer just prescribing the behavior but also become goals that should be pursued. Managers tend to focus on performance indicators that are directly related to the procedures. This is a result of the influence of the inspection since they are able

to charge sanctions or even restrain budgets whenever the procedures are not followed as prescribed. This causes pressure for the managers to achieve good results according the performance indicators of the inspection. Therefore the professionals feel their performance is evaluated, not only by clients or family of clients for the quality of health care provided, but also if the procedures along the way are followed as demanded by the inspection. This may conflict with the core values of the professionals since a good score from the inspection doesn't mean that the quality of health care provided meets the standards of the professionals. The professionals not always see the contribution of pursuing a good score for the performance indicators of the inspection to the quality of health care. As seen in the first market based initiative the generation with more experience in the health care found it more difficult to adjust to the pressures of inspection. Especially when the demands of the inspection are on a ideological level, however when the demands from the inspection are exerted on a functional level the more experienced professionals are more confident to deviate from the protocols compared to relatively inexperienced professionals who are working more strict according to the protocols.

A clear strategic response is found among the professionals towards the ideological demands. Since they cannot influence the goals individually they form workgroups that include several professionals from different professions within the health care sector. Such a workgroup may for example include doctors, nurses and psychiatrists who cooperate by reporting their experiences towards the process of pursuing good results for the inspection. They collectively examine the protocols and procedures that do not significantly contribute to the quality of health care and present this report to the board of directors. This type of response is most closely related to the strategy of finding cooperative solutions as described by Kraatz and Block (2008) in chapter two. The results of these reports are also communicated to other health care organizations. The final results however remain unclear and possibly only creates awareness among policy makers of the tensions the professionals experience as a result of pursuing goals of the inspection to a large extent. Quotes for illustrating examples of the experiences and responses of managers and professionals towards the two market based initiatives by the government are shown in tables 4.3 and 4.4.

Table 4.3: Illustration of how managers and professionals experience and respond to institutional complexity as a result of setting financial boundaries by the government.

	Managers	Professionals
Internal representation	<p><i>“When the assigned hours are scanty it leads to high dissatisfaction, working pressure, high absenteeism and less fun in work among the nurses. Those kind of things.”</i> (Manager 8)</p> <p><i>“From above you feel the financial pressure and the demands to organize the processes in a good way. From below you experience pressure to hire more employees in order to create more tranquility and to let them do their work well. You always experience those pressures.”</i> (Manager 5)</p>	<p><i>“A lot of my tasks are about pursuing targets. Make sure you get a certain revenue so you get the financial support to cover the costs of the employees. This is more in my mind than I like.”</i> (Nurse 3)</p> <p><i>“Yes, that was really difficult since you notice that we are from a generation that realizes that not everything is possible anymore. New people in the health care sector do not know any better. But in those times, we had to cut off 140 clients. And in the beginning that was really difficult. Because when you are used to a certain way of providing health care it is really hard to tell the nurses they cannot do this anymore. Some people didn’t have problems accepting the new rules, but some people weren’t able to adjust themselves with the new situation.”</i> (Manager 3)</p> <p><i>“You have to imagine that nurses are usually not that charmed by working in an elderly health care centre [...]. Other kinds of health care are usually more interesting, the elderly health care is not that interesting to say it disrespectful. It is hard to attract new nurses from level 3 [...]. It is hard work and everything is bounded. If</i></p>

		<i>you want to work with your hart, then it becomes difficult. It is more pleasant to make more small talk with the clients, to dress them well but for the small talk is no room anymore. That makes this profession less interesting.” (Nurse 2)</i>
Nature of demands	<i>“The space you have to try something within the financial boundaries are limited. The care should be provided within the amount of hours that are assigned to a client. But when I go replace a lamp for the client, the available hours decrease. When I use more hours than assigned I am doing volunteer work. The moment you deliver structurally too much work you get in the red numbers.” (Manager 8)</i>	<i>“The health care plan provides a module where exactly is stated how many minutes a certain z.z.p. contains [...]. For every activity you write down how many minutes it takes and that has to be correct. So if you have for example 1600 minutes to spend on a client you keep track if you stay within those 1600 minutes. For example, if a client needs medicine three times a day, you can register three times two minutes” (Nurse 2)</i>
Responses	<i>“For me now it is important to prepare the people how to deal with a new reality. Otherwise the absenteeism will rise quickly.” (Manager 8)</i>	<i>“When you express how you feel, they really try to help you [...]. However, we usually express these concerns rather late. I think that is also part of our culture I guess.” (Nurse 3)</i>

Table 4.4: Illustration of how managers and professionals experience and respond to institutional complexity as a result of inspections by the government.

	Managers	Professionals
Internal representation	<p><i>“I noticed some kind of hype where you prefer to focus on the ‘Zorgkaart’ rather than your own organization. That you go for the 8 or 9 on the ‘Zorgkaart’ instead of spending energy for the clients. Nowadays you spend a lot of energy at meeting the requirements of external actors.”</i> (Manager 8)</p>	<p><i>“It’s already known for a while that if there are no volunteers or family members around, we have a big problem. Because then you miss the cherry on the cake, that cherry is now a very little one. It is a poignant situation but well... that is everywhere. But we still try to meet the norm of the inspection.”</i> (Nurse 2)</p> <p><i>“It’s a difficult process. Where lays your core business? Providing health care right? But there are so many ancillary matters we also have to deal with.”</i> (Nurse 1)</p>
Nature of demands	<p><i>“We receive aspects to improve from inspection that have to be improved as soon as possible. That puts a lot of pressure on the professionals. All the health care files had to be checked before a certain time and the employees had to follow a mandatory course. They didn’t like that so much.”</i> (Manager 6)</p>	<p><i>“It depends on the degree of risk that comes along with the action. Then your education determines if you have sufficient knowledge to do the procedure. For example I am allowed to a put syringe or to change a catheter. In order to give a shot of insulin, you have to grab a skin fold, however protocol dictates that this is not necessary anymore since new syringes are developed. But if someone is really thin, I do grab a skin fold in order to reach muscle easier. But then I do not follow protocol based on my knowledge. It depends on the risk of the action.”</i> (Nurse 3)</p>
Responses	<p><i>“In the end you are responsible for the quality. I can give a signal that they cannot see. I focus for example on the ‘mic’ situations [...]. I can send a signal to the professional to let them know something is going on but that is all I do. I let them know since I have the overview.”</i> (Manager 7)</p>	<p><i>“At the moment I am in “minder papier, meer tijd voor de zorg”. Then you look at the protocols and procedures [...]. We are looking at how we can make things better and more efficient.”</i> (Nurse 3)</p>

4.4 Summary of main findings

After conducting the analysis of the obtained data it can be stated that both the behavior of the professionals and managers are guided by a professional logic, a state logic and a market logic which is in line with the studies of Reay and Hinings (2005) and Goodrick and Reay (2011) since they showed that these three logics are usually present within the health care sector. However, the analysis showed that the managers and professionals adhere in different gradations to the three logics and that this gradation also differs from each other. A combination of the different degree of adherence to the institutional logics, the power dependencies between the groups and the nature of demands result in different experiences and responses among professionals and managers towards market based initiatives from the government which may create tensions within and between the groups of professionals and managers.

The interviews showed that the professionals strongly adhere to the professional logic which often results in tensions when market based initiatives are introduced since these initiatives are strongly grounded in a market- or state logic and show few characteristics that correspond with the professional logic. The analysis showed that the power dependencies between professionals and managers were rather low since both groups have a marginal influence on the initiatives from the government. Therefore, there was little incentive for both groups to influence each other since the expectations whether one of the groups could influence the market based initiatives were low. However, tensions did arise between the groups since they differ from each other concerning how to deal and respond to these initiatives.

During the analysis of the nature of demands, it became clear that this factor has a significant influence on how managers and professionals respond to the market based initiatives. It turns out that, when it comes to the introduction of protocols as part of the demand of becoming more accountable, professionals experience room for deviating from these protocols as long as these demands are about processes in their medical field. However, tensions are existing when those protocols prescribe how the organizational processes around the medical processes should be organized. These tensions arise since the professionals regard a part of those protocols as redundant and the professionals find it harder to deviate from these protocols than the one describing medical procedures. A last characteristic concerning these nature of demands that was found in the analysis is about how the professionals and managers experience the shift from demands first prescribing the courses of action towards the demands prescribing goals to pursue. In other words, professionals perceive that the

protocols and procedures do not longer serve as tools to do their work in a more effective manner but that these protocols become goals at itself. This shift from facing functional-towards ideological demands create tensions among professionals since they feel that their primary goal of providing the best possible care is undermined. It makes them they feel forced to comply to demands from external actors that, in the perception of the professional, not directly contribute to the quality of health care.

A second reason for increased tension due to the shift in the nature of demands is the decline of the negotiability the professionals experience when it comes to responding to these demands. They regard the goals as fixed which means the cannot easily be changed. A strategic response the professionals might undertake to deal with this situation is to collaborate with other professionals from different professions within the health care sector by forming workgroups. These workgroups develop reports which contains recommendations for the policymakers concerning how the organizational processes and procedures can be improved in order to increase the quality of health care. Furthermore, the reports contain the professionals' concerns to what extent their efforts to comply to those external demands are contributing to their main goal of providing the best care possible. Although this type of response has been proven to be successful in terms of adjusting protocols at a functional level. It is yet unclear to what extent the goals set the policy makers from the government for the health care organizations are modified by these reports from the workgroups. The professionals declared that they don't experience a change for that matter, at least not in the short term. They cannot state the influence on the long term yet.

The data of the interviews showed that the managers adhere less strong to one particular logic compared to the degree that the professionals adhere to the professional logic. This means that the managers in the two health care organizations, although they tend to adhere a bit stronger to the market logic in general, are not dominantly guided by the market logic to the degree as the professionals are guided by their professional logic. This relatively low adherence to the market logic is mainly due to the professional background some managers possess since they often have been professionals in the health care sector themselves. Furthermore, they do not experience institutional complexity to the degree that professionals do since they don't experience these tensions from the market based initiatives directly as much as the professionals perceive. However, managers do feel tensions in the interaction with professionals since the professionals put pressure on the managers to organize the work in such a way the tensions for the professionals will decrease. The managers experience little capacity to influence the demands of the government which generates a

strategic response among the managers which is similar to 'bridging' as described in the theoretical framework. In this study the managers try to import characteristics of the demands from the government which are based on both the state- and market logic in the professional logic as perceived by the professionals. This should lead to a situation where professionals adhere to a particular professional logic that also includes characteristics from the market- and state logic which should them also make aware that providing health care is only sustainable as long as it is done and organized in a more efficient way. A difference can already be seen between the nature of the professional logic of the more experienced professionals compared to the less experienced professionals who started working more recent. The less experienced professionals don't know better than that they have to adopt a wider perspective that exceeds the goal of providing the best are possible but also takes into account that it should be organized in an efficient manner.

5. Conclusion & Discussion

Pache and Santos (2013) emphasized on the lack of understanding in literature concerning how institutional logics are experienced within the organization by different groups of actors and how these groups respond to conflicting institutional logics. This lack of knowledge restrains the understanding of how organizations develop their strategic responses in situations of institutional complexity (Kraatz & Block, 2008). Therefore, a more profound understanding of the intra-organizational processes helps explaining the variety of responses that organizations adopt in order to deal with the institutional complexity. Since institutional logics aren't experienced and addressed homogenously throughout the organization, it is important to study different groups within the organization to analyze if there are any differences between the groups and how certain variables determine these differences (Greenwood et al., 2011). Therefore, this study analyzed how managers and professionals in two elderly health care organizations experience and respond to market based initiatives from the government. The results of this study were presented in the last chapter and is followed up by a conclusion and discussion in this last chapter. At first, this chapter provides a discussion on the main findings. This will be continued by a paragraph describing both the theoretical- and practical implications of this research. After this, the limitations will be discussed and the chapter ends with suggestions for future research.

5.1 Discussion on the main findings

The objective of this research is to understand more about how intra-organizational processes work within organizations. Therefore, this study focused on how managers and professionals within two elderly health care organizations experience and respond to situations of institutional complexity that have arisen from the introduction of market based change initiatives by the government. Furthermore, the purpose of this study is to examine if there are any differences regarding these experiences and responses between the managers and professionals. This leads to a contribution of the existing literature of how organizations, due to intra-organizational dynamics, experience and respond to institutional logics. This led to the following research question:

“How do managers and professionals within two elderly health care organizations experience and respond to situations of institutional complexity that have arisen from the introduction of market based change initiatives by the government?”

In order to provide a comprehensive answer to this question, several sub-questions were developed that together allowed the researcher to collect and analyze the data required for answering the main research question. The research took place at two elderly health care organizations where data was collected from both managers and professionals who operate in a highly institutionalized environment where they face divergent demands from multiple constituents.

After analyzing the data it became clear that both managers and professionals adhere to several institutional logics in their work but that they differ from each other to what degree one logic is more dominant than the other logics. As stated in the former chapter, the professionals tend to show a stronger adherence to their dominant logic compared to the managers' adherence to their dominant logic. This finding is in consonance with studies of Goodrick and Reay (2011) and Thornton et al. (2005) who showed the strength of the adherence of professionals to the professional logic.

A crucial variable, influencing the responses of the professionals and managers to institutional complexity, turned out to be the nature of demands which is in line with the study of Pache and Santos (2010). This research showed that demands, which at first seem negotiable since they are exerted on a functional level, can make a shift towards ideological demands although the content of the demands remain the same. This results in less negotiability and therefore in more institutional complexity for the actors facing these demands. However, Pache and Santos (2010) have no attention for the possible shift where functional demands may become goals at itself. This study showed that the protocols may change its nature by becoming goals at itself which means professionals couldn't deviate from these goals although they were used to have a certain agency, derived from their professional logic, to deviate from these same demands. In line with the studies of Pache and Santos (2010) and Besharov and Smith (2014) the ideological demands were less negotiable which may create more tensions. These tensions seem especially the case for the group of professionals since they have strong values concerning the goals they should pursue.

The influence of the nature of demands and internal representation were expected before collecting and analyzing the data. However, another factor that stood out after the analysis influencing the experiences and responses of the managers and professionals is about the capacity of them to actively respond to the conflicting demands. This study showed how a lack of capacity constrained the professionals and managers to adopt strategic responses. This finding is not new in the literature since Detert and Pollock (2008) also stressed out the

relevance of taking the capacity of actors into account when it comes to analyzing how they develop responses in situations of institutional complexity.

The lack of capacity that professionals and managers experience also contributes to the professionals' response to collaborate with other professionals from different professions within the health care sector. This type of response where cooperative solutions are developed has been described by Kraatz and Block (2008). However, they focused on how organizations may adopt this strategy whereas this study focused on how groups of professionals adopt this strategy to cope with conflicting demands.

Furthermore, this study showed how managers try to import outputs from the state- or market logic into the professional logic of the professionals. By doing this the manager tries to lower the tensions that arise among the professionals and therefore indirectly also lowers the tensions that affect the managers. This type of response is similar to what Smets et al. (2015) call 'bridging'. Their study showed how individuals made competing logics compatible with each other by importing outputs from one logic into their enactment of the other. This is similar to the response found with the managers in this study. However, this study has one extension to the study of Smets et al. (2015) since managers 'bridge' the output from one logic into another logic across groups since they transfer the output from the state- and market logic into the professional logic experienced by the professionals. This is different from the study of Smets et al. (2015) where they only described how individuals imported important aspects of different logics for themselves whereas this study showed that the managers imported important aspects from the market- and state logic in the professional logic of the professionals. To sum up, this study shows that, just as in the study of Smets et al. (2015), bridging is a possible response in order to deal with situations of institutional complexity. The extension this study provides to the study of Smets et al. (2015) is the aspect that actors from one group may also bridge important aspects of a certain logic into the logic of another group.

All together, this study builds further on the literature of authors such as: Thornton and Ocasio (2008), Greenwood et al. (2011), Pache and Santos (2010), Smets et al. (2015) and Detert and Pollock (2008). This study takes the intra-organizational processes into account which explains how institutional complexity is perceived within the organization and how strategic responses are developed by actors within the organization in order to deal with the institutional complexity they might face. Taking a closer look on these intra-organizational processes shows that institutional complexity is experienced at an individual level like McPherson and Sauder (2013) suggest in their study. However, the responses are developed

and made by groups. Within the groups the individuals show little differentiation among each other concerning the responses they exert. Within the group of professionals a distinction can be made, regarding the differentiation in responses, by the degree of experience they possess. Still, the professionals consisted of subgroups when it comes to formulating responses when facing institutional complexity.

The next paragraph will contain a discussion concerning the implications of this study. This will be analyzed on a theoretical- and practical level.

5.2 Implications

5.2.1 Theoretical Implications

Findings of this research contribute to the literature of how institutional logics are distributed within the organization across different subgroups. As Pache and Santos (2013) pointed out, there is still a lack of understanding concerning how institutional complexity is experienced and responded to within the organization. This study showed the relevance for more research on this topic as the findings show that intra-organizational processes have a significant influence on how organizations deal with conflicting logics. Building further on Pache and Santos (2010) this study provides more insight between the interaction of the nature of demands and how these demands are internally represented by managers and professionals within the elderly health care sector. Especially the shift that was found from functional demands towards ideological demands shows that demands itself may differ from nature although the content of the demands may not have changed.

Furthermore, this thesis shows to what extent the capacity or a lack of capacity influences the responses of the actors in the case of institutional complexity since the managers and professionals are unable to respond in such a way that they can significantly alter the demands or even ignore the demands. This lack of capacity in this particular situation is due to how the health care sector is organized around the elderly health care centre's where the demands are coming from the government. It shows that ,when focusing at intra-organizational processes, also the institutional context should be incorporated in the analysis of how institutional complexity is perceived within the organization. Finally, regarding the strategic responses of professionals towards institutional complexity this study shows that professionals also may collaborate with other professionals outside of their organization. Although the collaborators are closely related to the organization, it shows again the relevance for also assessing the external environment of the groups in order to determine how they can respond to institutional complexity.

5.2.2 Practical Implications

Besides theoretical implications this study also implies practical implications. These practical implications may be relevant for professionals, managers, decision makers from the government, the elderly sector within the health care sector and other highly institutional environments where plural logics exist.

First, this study showed how professionals may response to conflicting demands although they perceive little capacity to influence these conflicting demands. By collaborating with other professionals from other professions within the health care sector they manage to influence the decision makers from the government. However, the actual effect of this influence is not known yet but it shows ways for professionals from outside the two elderly health care organizations to influence the conflicting demands although they perceive little capacity to do so. This response of the professionals might be relevant for managers to know as well since they might stimulate or facilitate the professionals to develop this collaboration since it may be beneficial for the managers as well when the perceived tensions of the professionals decrease.

The practical relevance for decision makers of the government is about the nature of demands they pose on the elderly health care organizations that affect the professionals. When typical functional demands such as protocols become ideological demands, it creates tensions among the professionals. These tensions lead to job dissatisfaction which may possibly undermine the effectiveness of the professionals in their work. Therefore, decision makers should, when they aim to reduce these tensions of the professionals, look carefully to what extent the demands are exerted on a ideological- or functional level.

The last practical implication concerns the ageing population in the Netherlands. The elderly sector, as part of the health care sector, increasingly becomes more important over time due to an ageing population in the Netherlands. In order to make sure that the costs of this part of health care don't rise above the limits, it becomes more important for decision makers to introduce initiatives which are not counterproductive. Therefore it is relevant for the decision makers to gain a more profound understanding about the elderly sector in order to pose demands on managers and professionals that create less institutional complexity.

The next paragraph will discuss the limitations that come along with this study.

5.3 Limitations

Although criteria such as validity and reliability have been taken into account, a few limitations still exist in this research. This research took place within the elderly health care

sector and therefore lacks generalizability to make statements about the whole health care sector or elderly health care sector for that matter since only two cases have been subject of the research. Furthermore, the two health care centre's are both active in the intramural care whereas other professionals and managers focus on extramural care which may influence the experiences and responses of these actors towards institutional complexity.

In total have nine managers been interviewed and four nurses. This a small amount of respondents to make generalizable statements. Besides, it should also be taken into account that the professionals and managers in this research may not be standard professionals or managers and are therefore difficult to compare with professionals or managers in other sectors. The reason behind this lies in the fact that most managers in this research have a background in the health care sector, often as a professional as well. This means that these managers are less likely to adhere as strong to a market logic compared to a manager from another sector where they haven't been professionals themselves. A similar statement can be made regarding the nurses in this research. They might have less stronger professional values compared to doctors and perhaps even compared with the nurses who work in the hospitals. The nurses in the interviews stated that being a nurse in the elderly sector is often regarded as less interesting and demanding which may create a difference between the nurses in hospitals regarding the adherence to the professional logic. Besides, managers and professionals with a higher capacity to respond to conflicting demands may also show higher degrees of power dependencies compared to the power dependencies found in this research.

5.4 Future research

Derived from the limitations of this study, future research can be done to build further on this research and to overcome these limitations. This research focused on the effects of the interplay between the nature of demands and internal representation on how managers and professionals experience and respond to institutional complexity. However, it turned out that the factor capacity is also of importance when it comes to assessing the behavior of groups of individuals. Therefore research should be followed up where capacity is incorporated in the analysis as a variable together with the nature of demands and internal representation. This should lead to more in depth knowledge concerning the role of the capacity factor in the interplay with the nature of demands and internal representation.

Furthermore, this research only studied the main proponents of the market- and professionals logic but didn't conduct interviews with the main proponents of the state logic such as the decision makers from the government. Collecting data from those respondents

might provide a more comprehensive view of how the demands are perceived by them and what tensions they perceive from a professional- or market logic. Derived from incorporating the proponents of the state logic would it also be interesting to see how the collaborating tactic of the professionals influences the decision makers of the government.

Another interesting aspect that deserves further research is about the long term effects of the reports that the professionals by cooperation developed in order to influence the decision makers from the government. This study showed that the reports didn't have a noticeable effect on ideological demands in the short term but that it is unknown if it has an effect in the long term. Therefore, a longitudinal research focusing on the long term effects of such reports developed by the professionals could provide a more profound insight for that matter. This could be relevant insight to gain since it helps the professionals to evaluate their actions and also helps the decision making whether they should undertake such activities.

Methodologically, future research could extend this research by collecting data from more respondents. In order to increase more generalizability it is interesting to incorporate multiple sectors within the health care sector or other highly institutionalized environments where managers and professionals face institutional complexity as a result of the introduction of market based initiatives. By incorporating different sectors it becomes interesting to distinguish what group characteristics generate differences and similarities among the groups of actors towards their experiences and responses. At last could, besides the group characteristics, also be examined how the different institutional environments influences the groups of individuals on how they perceive and respond to institutional complexity.

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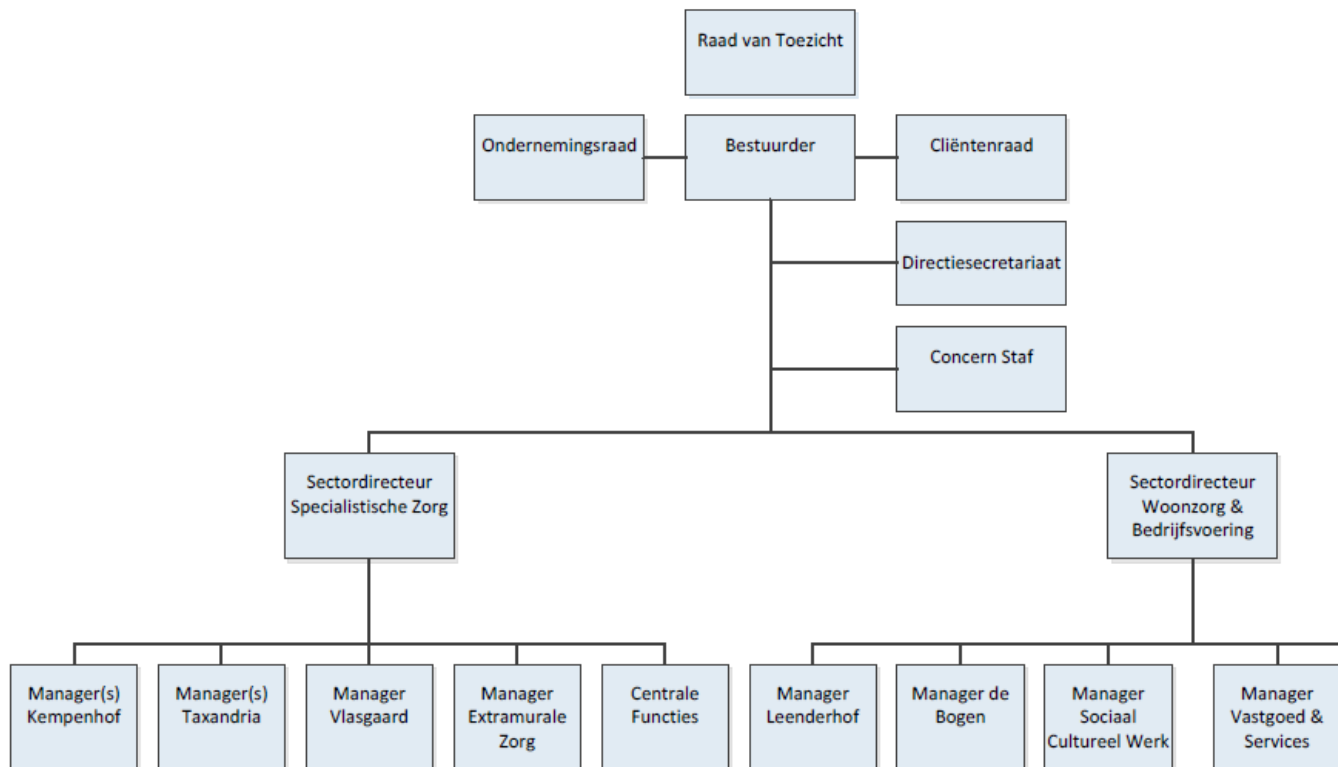
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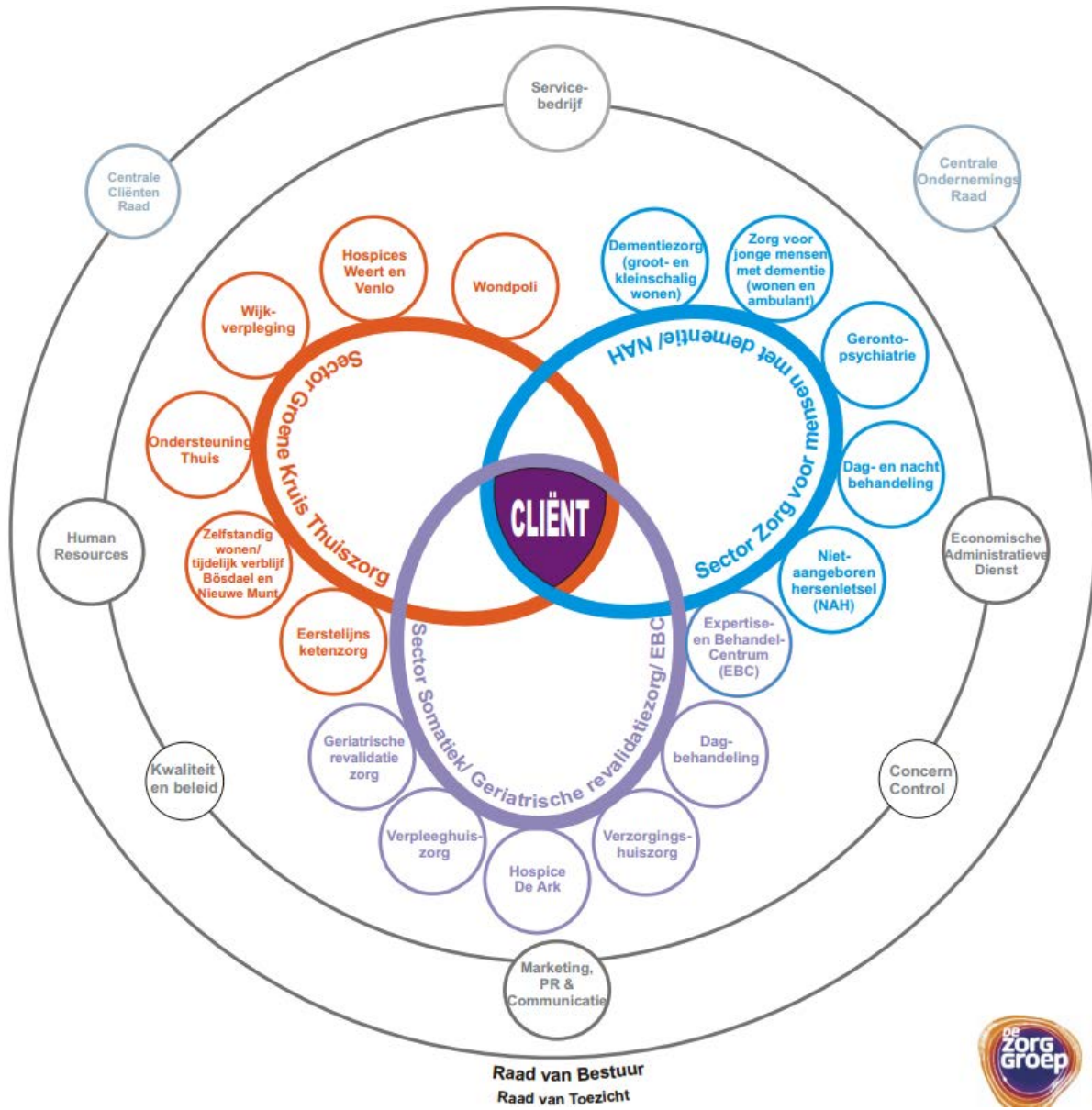
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Appendices

Appendix 1A: Organization chart 'Valkenhof'.



Appendix 1B: Organization chart 'De Zorggroep'.



Appendix 2A: Interview topics and questions (Professionals)

Topics	Interview Questions
Introductie	<ul style="list-style-type: none"> • Introductie van het onderzoek, korte uitleg over onderzoeker (studie, achtergrond enzovoorts) • Korte bespreking interviewtopics en interviewprocedure (waaronder goedkeuring voor opname interviews en transcriptinzage na afloop) • Korte bespreking privacy geïnterviewde
Algemene informatie respondent	<ul style="list-style-type: none"> • Wat is uw leeftijd? • Wat is uw educatieve achtergrond? • Wat is uw functie binnen de organisatie? • Kunt u een beschrijving geven van uw huidige functie?
Inleidende vragen	<p>Allereerst vertelt de onderzoeker hoe en waarom marktwerking werd geïntroduceerd in de zorg en andere sectoren in Nederland.</p> <ul style="list-style-type: none"> • Wat verstaat u onder marktwerking binnen uw organisatie? <ul style="list-style-type: none"> - Kunt u hier voorbeelden van geven? • Hoe ervaart u de marktwerking binnen uw organisatie? <ul style="list-style-type: none"> - Kunt u hier voorbeelden van geven? - Wat vindt u van marktwerking binnen uw organisatie? - In hoeverre draagt marktwerking positief bij aan uw organisatie? Kunt u hier een voorbeeld van geven? - In hoeverre kan marktwerking een negatieve invloed hebben op de organisatie? Kunt u hier een voorbeeld van geven?
Adherence to market logic	<ul style="list-style-type: none"> • In hoeverre ervaart u dat u binnen uw functie wordt geleid door marktwerking? Hoe ervaart u marktwerking binnen uw functie? Kunt u een voorbeeld geven van een situatie waar marktwerking een directe invloed heeft op uw functie? <p>Voorbeelden waar de onderzoeker specifiek naar kan vragen zijn:</p> <ul style="list-style-type: none"> - Gebruik van protocollen van bedrijf - Patiënten worden als cliënten gezien met een bijbehorende monetaire 'waarde'. (Zorg zwaarte pakketten) - Er vindt concurrentie plaats met vergelijkende functies van andere organisaties.

<p>Adherence to professional logic</p>	<ul style="list-style-type: none"> - (meetbare) doelen stellen • In hoeverre kan marktwerking een positieve bijdrage leveren aan uw functie? Kunt u hier een voorbeeld van geven? • In hoeverre kan marktwerking spanningen met zich mee brengen voor u? <ul style="list-style-type: none"> - Kunt u hier een voorbeeld van geven? - Hoe gaat u om met die spanning? - In hoeverre deelt u deze spanning met uw collega's of het management team? • In hoeverre kunt u zich sterk vasthouden aan marktwerking? Kunt u voorbeelden noemen? • In hoeverre kunt u afstand nemen van marktwerking? Kunt u voorbeelden noemen? <ul style="list-style-type: none"> • In hoeverre ervaart u dat u binnen uw functie wordt geleid door waarden uit de verpleegkunde? • Kunt u situaties noemen waarbij deze waarden in het gedrang kunnen komen? Kunt u situaties noemen waar waarden uit de verpleegkunde in het gedrang komen door marktwerking? <ul style="list-style-type: none"> - Hoe gaat u daar dan mee om? - In hoeverre of in welke situaties kunt u zich sterk vasthouden aan de waarden vanuit de verpleegkunde? - In hoeverre en in welke situaties kunt u afstand nemen van verpleegkundige waarden? - In hoeverre praat u hierover met uw collega's of management? Wat kunnen zij voor u betekenen als u met deze spanningen om moet gaan? <p>Voorbeelden indien de respondent zich een beeld moet vormen van waarden uit verpleegkunde:</p> <ul style="list-style-type: none"> - Focus op relatie met patiënt - Doel is om de beste zorg te verlenen, ongeacht de kosten.
<p>Presence of state logics</p>	<ul style="list-style-type: none"> • Hoe ervaart u de invloed van de overheid binnen uw functie? Kunt u hier voorbeelden van geven? <p>Voorbeelden waar de onderzoeker naar kan vragen:</p> <ul style="list-style-type: none"> - inspectie

<p>Nature of demands</p>	<ul style="list-style-type: none"> - wettelijke normen - wettelijke procedures • In hoeverre ervaart u binnen uw functie spanningen tussen verpleegkundige overwegingen en overwegingen die samenhangen met de marktwerking? Kunt u hier een voorbeeld van geven? Waar gaan deze spanningen over? <ul style="list-style-type: none"> - In hoeverre hebben spanningen betrekking op de te behalen doelen? - In hoeverre hebben spanningen betrekking op de manier waarop je de doelen wilt behalen? - Hoe gaat u met deze spanningen om? - In hoeverre zijn uw collega's of andere functies betrokken in dit spanningsveld? - In hoeverre heeft u interactie met uw collega's wanneer er spanningen ontstaan?
<p>Power dependency</p>	<ul style="list-style-type: none"> • Kunt u aangeven in hoeverre u invloed kan uitoefenen op initiatieven die op marktwerking zijn gericht? Kunt u hier een voorbeeld van geven? <ul style="list-style-type: none"> - In hoeverre kan dit spanningen opleveren? - Hoe gaat u met deze spanning om? - Welke functies hebben een aandeel in deze spanning? • Kunt u aangeven in hoeverre jullie als verpleegkundigen invloed kunnen uitoefenen op initiatieven die op marktwerking zijn gericht? <ul style="list-style-type: none"> - Hoe kunnen jullie je als groep zodanig opstellen om meer invloed te krijgen op initiatieven die op marktwerking zijn gericht? Kunt u hier een voorbeeld van geven?
<p>Tot slot</p>	<ul style="list-style-type: none"> • Zijn er nog opmerkingen die u wilt maken met betrekking tot het onderzoeksonderwerp?

Appendix 2B: Interview topics and questions (Managers)

Topics	Interview Questions
Introductie	<ul style="list-style-type: none"> • Introductie van het onderzoek, korte uitleg over onderzoeker (studie, achtergrond enzovoorts) • Korte bespreking interviewtopics en interviewprocedure (waaronder goedkeuring voor opname interviews en transcriptinzage na afloop) • Korte bespreking privacy geïnterviewde
Algemene informatie respondent	<ul style="list-style-type: none"> • Wat is uw leeftijd? • Wat is uw educatieve achtergrond? • Wat is uw functie binnen de organisatie? • Kunt u een beschrijving geven van uw huidige functie?
Inleidende vragen	<p>Allereerst vertelt de onderzoeker hoe en waarom marktwerking werd geïntroduceerd in de zorg en andere sectoren in Nederland.</p> <ul style="list-style-type: none"> • Wat verstaat u onder marktwerking binnen uw organisatie? <ul style="list-style-type: none"> - Kunt u hier voorbeelden van geven? • Hoe ervaart u de marktwerking binnen uw organisatie? <ul style="list-style-type: none"> - Kunt u hier voorbeelden van geven? - Wat vindt u van marktwerking binnen uw organisatie? - In hoeverre draagt marktwerking positief bij aan uw organisatie? Kunt u hier een voorbeeld van geven? - In hoeverre kan marktwerking een negatieve invloed hebben op de organisatie? Kunt u hier een voorbeeld van geven?
Adherence to market logic	<ul style="list-style-type: none"> • In hoeverre ervaart u dat u binnen uw functie wordt geleid door marktwerking? Hoe ervaart u marktwerking binnen uw functie? Kunt u een voorbeeld geven van een situatie waar marktwerking een directe invloed heeft op uw functie? <p>Voorbeelden waar de onderzoeker specifiek naar kan vragen zijn:</p> <ul style="list-style-type: none"> - Gebruik van protocollen van bedrijf - Patiënten worden als cliënten gezien met een bijbehorende monetaire ‘waarde’. (Zorg zwaarte pakketten) - Er vindt concurrentie plaats met vergelijkende functies van andere organisaties.

<p>Adherence to professional logic</p>	<ul style="list-style-type: none"> - (meetbare) doelen stellen • In hoeverre kan marktwerking een positieve bijdrage leveren aan uw functie? Kunt u hier een voorbeeld van geven? • In hoeverre kan marktwerking spanningen met zich mee brengen voor u? <ul style="list-style-type: none"> - Kunt u hier een voorbeeld van geven? - Hoe gaat u om met die spanning? - In hoeverre deelt u deze spanning met uw collega's of andere werknemers zoals verpleegkundigen? • In hoeverre kunt u zich sterk vasthouden aan marktwerking? Kunt u voorbeelden noemen? • In hoeverre kunt u afstand nemen van marktwerking? Kunt u voorbeelden noemen? <ul style="list-style-type: none"> • In hoeverre ervaart u dat u binnen uw functie wordt geleid door waarden uit de verpleegkunde? • Kunt u situaties noemen waarbij deze waarden in het gedrang kunnen komen? Kunt u situaties noemen waar waarden uit de verpleegkunde in het gedrang komen door marktwerking? <ul style="list-style-type: none"> - Hoe gaat u daar dan mee om? - In hoeverre of in welke situaties kunt u zich sterk vasthouden aan de waarden vanuit de verpleegkunde? - In hoeverre en in welke situaties kunt u afstand nemen van verpleegkundige waarden? - In hoeverre praat u hierover met uw collega's of andere werknemers zoals verpleegkundigen? Wat kunnen zij voor u betekenen als u met deze spanningen om moet gaan? <p>Voorbeelden indien de respondent zich een beeld moet vormen van waarden uit verpleegkunde:</p> <ul style="list-style-type: none"> - Focus op relatie met patiënt - Doel is om de beste zorg te verlenen, ongeacht de kosten.
<p>Presence of state logics</p>	<ul style="list-style-type: none"> • Hoe ervaart u de invloed van de overheid binnen uw functie? Kunt u hier voorbeelden van geven? <p>Voorbeelden waar de onderzoeker naar kan vragen:</p>

<p>Nature of demands</p>	<ul style="list-style-type: none"> - inspectie - wettelijke normen - wettelijke procedures <ul style="list-style-type: none"> • In hoeverre ervaart u binnen uw functie spanningen tussen verpleegkundige overwegingen en overwegingen die samenhangen met de marktwerking? Kunt u hier een voorbeeld van geven? Waar gaan deze spanningen over? <ul style="list-style-type: none"> - In hoeverre hebben spanningen betrekking op de te behalen doelen? - In hoeverre hebben spanningen betrekking op de manier waarop je de doelen wilt behalen? - Hoe gaat u met deze spanningen om? - In hoeverre zijn uw collega's of andere functies betrokken in dit spanningsveld? - In hoeverre heeft u interactie met uw collega's wanneer er spanningen ontstaan?
<p>Power dependency</p>	<ul style="list-style-type: none"> • Kunt u aangeven in hoeverre u invloed kan uitoefenen op initiatieven die op marktwerking zijn gericht? Kunt u hier een voorbeeld van geven? <ul style="list-style-type: none"> - In hoeverre kan dit spanningen opleveren? - Hoe gaat u met deze spanning om? - Welke functies hebben een aandeel in deze spanning? • Kunt u aangeven in hoeverre jullie als managers invloed kunnen uitoefenen op initiatieven die op marktwerking zijn gericht? <ul style="list-style-type: none"> - Hoe kunnen jullie je als groep zodanig opstellen om meer invloed te krijgen op initiatieven die op marktwerking zijn gericht? Kunt u hier een voorbeeld van geven?
<p>Tot slot</p>	<ul style="list-style-type: none"> • Zijn er nog opmerkingen die u wilt maken met betrekking tot het onderzoeksonderwerp?