Paper for the 22nd EGOS Colloquium, Bergen 2006

Sub-theme 21: Forms of Organizing in Health-Care Services
Convenors: Americo Cicchetti, John R. Kimberly and Thomas D'Aunno

Finn Borum[1]: Revitalizing a dormant institution? Contestation and innovation around Health Centres in the reshaping of a National Health Care System.

Introduction

This paper's empirical focus is the creation of health centres (HCs) as one of the elements of a major ongoing Danish administrative reform which also implies the reshaping of the health sector. HCs has been promoted by the reform as a means to attain a more coherent and client oriented national health care system. However, different actors have made quite different interpretations of HCs, and expressed differences of opinions about who should be responsible for them. This case of a contested restructuring of an organizational field will be used as basis for addressing aspects of institutional change within mature professionalized fields.

Previous models of institutional change (Tolbert & Zucker, 1996; Greenwood, Suddaby & Hinings, 2002) have situated theorization (Strang & Meyer, 1994) as a process happening after the innovation of new organizational forms or modes of operation, and in line with Strang & Meyer focussed on theorization as facilitating or conditioning the wider diffusion of new forms and practices:

"By theorization we mean both the development and specification of abstract categories and the formulation of patterned relationships such as chains of cause and effect. Without such general models, the question of similarity is unlikely to gain force. And without such models, the real diversity of social life is likely to seem as meaningful as are parallelisms...
In part, theorization increases perceived similarity by simplifying the phenomena ... And as organizational practices and structures are simplified and generalized, they can more easily be appropriated... Theorization also expands diffusion by providing causal accounts. Many theoretical models are effectively functional, providing explanations of why all sorts of components are necessary to each other and to actors and collective goals." (Strang & Meyer, 1994:104)

The present analysis wants to expand these previous conceptions of the role of theorization and argues that the role of theorization in processes of institutional change is dependent upon the characteristics of the organizational field within which change is happening. The argument is substantiated by demonstrating that theorization in the specific case is in fact an important element of the innovation phase, i.e. a condition for the creation of divergent new organizational forms and practices. Innovation in a mature organizational field with strong regulative forces and professions (DiMaggio & Powell, 1991) is not an independent local activity. Within such fields the role of theorization is not limited to serve as a means for the wider diffusion of innovations, but it is an important element of the innovation process or pre institutionalization stage as well.

[1] CHM/Center for Health Management, Copenhagen Business School. E-mail: fb.ioa@cbs.dk.

In line with Strang & Meyer's broad formulation "theorization" is not a term reserved for scientific activities, but a generic term for the formulation of patterned relationships, causal accounts and functional explanations. Theorizations need not be based on a strong empirical basis (or any), and their cause-effect accounts and functional considerations may be more or less convincing. It is thus the explicit formulation of an argumentation – and not its quality – which in this analysis is applied as the criteria for a theorization. Furthermore, theorization is not assumed to be an activity separated from politics. Theorization is interested, politics is built into categorizations and arguments, and professional projects are both occupied with solution of tasks and control of jurisdictions (Larson, 1977). Several actors may be theorizing and proposing different causal accounts and functional explanations, and theorization needs not lead to the creation of a generalized perceived similarity that facilitate the diffusion of a new organizational form.

As the effects of an innovation hardly can be proved beforehand, the analysis will focus on theorization as a means of justification of ideas and innovations – in other words as an element in legitimation strategies (Oliver, 1991; Suchman, 1995). This is in line with a basic conception of organizational fields as fields of resources and opportunities with a structure of control and rules of interaction (Bourdieu & Passeron, 1970:33; Brint & Karabel, 1991:355; Hoffmann, 1999:352; Borum, 2004) within which restructuring challenges the established order, and leads to contestations (Borum & Sahlin-Andersson, 2006), which may include both operational and structural conflicts (Molnar & Rogers, 1979).

It will be argued that theorization within mature organizational fields is a necessary condition for innovation, but that theorization in relation to the pre institutionalization stage promotes divergent organizational innovations – in contrast to what previously has been argued as its function in relation to later stages of diffusion and institutionalization - cf. the two previously formulated models reprinted below:

Insert Figure 1 here (Appendix 1)

The empirical case

A major administrative reform has been underway in Denmark since the late 90ies, when discussions started concerning the counties' and municipalities' ability effectively to provide public services – taking into consideration the demographic, technological and infrastructural changes that had happened since their creation by a national administrative reform in 1970. Discussions and analyses have been many and heated, as a reform not only touches upon many sectors of economic activity, but also the fundamental issue of centralization versus decentralization – should Denmark have regions (and how many)? How large should the municipalities be in order both to secure local democracy and quality of services? What tasks should be solved at what level – national, regional and local?

October 2002 the present liberal government established a "Strukturkommission", which January 2004 published a voluminous report. Besides "Hovedbetænkning" (Strukturkommissionen, 2004) of 773 pages it comprises 15 sector analyses, among these one (168 pages) for the health sector – "Sektoranalyse på sundhedsområdet" (Sector Analysis of the Health services), which was published

April 2003. Very simplified, the core of the commission's analyses and argumentation dealt with the question of what population size was necessary to secure a "sustainable" basis for the effective solution of the public sector's many different tasks. The political and economic importance of the health sector and its infusion with science and technology made it an exemplary case of efforts to and difficulties encountered in establishing causal links between population size and quality of services (Borum, 2006). It also pushed up front the centralization/decentralization issue, in questioning the future of the counties which had hospital services as their most important single task, and a high degree of autonomy concerning how to manage these.

A hospital commission's report raised the health sector regime as an issue in 1997, and a 2003 report from an advisory committee to the Ministry of the Interior and Health reiterated this. The following "Sektoranalyse på sundhedsområdet" (2003) expanded the analysis of different models, among these the municipalities taking over the hospital services. It mentions (as did the previous report) the Finnish model with the municipalities as responsible for hospital management, and for Health Centres (HCs) with 30-50 beds. From then on HCs become an important concept in the de- and pre- institutionalization of the health services, and one of the foci of all the field's main actors. Table 1's (see below) list of the articulations about HCs shows that not only the regulatory instances – Ministry, National board of Health, Counties and Municipalities – but also all of the important professional associations – physicans, nurses, physiotherapists, erogonomists, midwives etc – have been articulating their views in relation to HCs.

In June 2004 the commission report was followed up by an agreement between the government and a right-wing party on the present major structural reform (Regeringen, 2004). It merges the present fourteen tax-collecting counties and the Copenhagen Hospital Services, which since 1970 have been responsible for the hospital services, into five regions as per January 1st 2007. The present 289 municipalities were also put to the task of merging into larger units with at least 20.000 citizens, subsequently resulting in the reduction of their number to 98. After the counties' disappearance only the state and the municipalities will be collecting taxes, while the future regions' activities will primarily be financed by the state, but with a contribution from the municipalities. The regions will continue to have as main task management of hospital services and general practitioners (GPs), which though running independent practices are heavily dependent upon the counties via negotiated agreements and regulations of their activities. The municipalities, that until now have been responsible for the paramedical primary health services (including home nursing services and residential homes) only, are intended via their financial contribution to become new actors in relation to the hospital sector.

Furthermore, the municipalities' establishment of Health Centres is intended to serve as an important means in the construction of a more coherent national healthcare system (Regeringen, 2004:34-35):

"Local health promotion and prevention are to be in focus. The municipalities should be able to create new solutions within in particular prevention and rehabilitation, for instance health centres.

Furthermore it should be considered – to the extent the regions close down hospitals – to utilize the available capacity to establish and develop new local solutions to the tasks of care, prevention and rehabilitation. This could be as health centres, that also could be established in partnerships with the health regions. It will be specified how the municipalities can be given the opportunity and time to react on decisions to close down hospitals and to design the local services to fit with the other

health services."

This attributes to the HC concept both the function of a linking pin between regional hospital services and local health services, and a frame for local innovations in relation to a wide range of health challenges.

Propositions

The present analysis has as primary objective to contribute to the discussion of process models of institutional change. More specifically, it will focus on specific elements and relations of the stage model of institutional change formulated by Greenwood, Suddaby & Hinings (2002), which refines the previous model of Tolbert & Zucker (1996) - in particular by incorporating and developing the "theorization" argument of Strang & Meyer (1993).

A reading of the present empirical case according to this model (Figure 1 above) would be that the Danish structural reform is equivalent to "a precipitating jolt" (Stage I), which has been followed by a deinstitutionalization (Stage II) comprising the ascendance of larger, merged municipalities as stronger players with the health sector, that are assumed to act as institutional entrepreneurs by establishing health centres (HCs). Even though HC is not a new concept, the municipalities' creation of health centres is less characterized by copying existing models, and more by innovative efforts (Stage III) which are encouraged by the state's allocation of specific funds to their experiments with different forms of HCs.

However, it is not only the municipalities which engage in the innovation processes around health centres. Most professional associations, the counties' and the municipalities' associations, the National Board of Health and opinion leaders have been articulating their views on the health centres to be in articles, reports and on web sites. The present analysis will utilize this to follow the call for further research of Greenwood, Suddaby & Hinings' (2002:76)
"We excluded how professionals talked to recipients outside their profession. More attention should be given to how communities project their identity to others and to the processes used in negotiation with them."

The present analysis will thus not be confined to intraprofessional processes but investigate interprofessional and interorganizational relations in a mature, complex field under restructuring: politicians, regulators, professional associations, established actors (counties) and new players (municipalities) within the health field – and how these through theorizations try to influence the shaping of a new organizational building block and to make it serve different purposes.

Organizational fields' age and composition have great importance for the role theorization plays in relation to innovation. In fields' early years innovation may happen without any theorization taking place, except in the heads of, or in conversations between, entrepreneurs. The early years of the wind mill industry in Denmark is an example of this, where more explicit theorization has followed practical innovation (Karnøe, 1995). In a mature field which houses many specialists and well-established professions, pressures towards theorization prior to putting a new form or practice into action will be strong. Professional knowledge, practices and jurisdictions are underpinned and justified by written documents in many shapes. Established practices and organizational forms can be defended by reference to prescripts for "best practices" and evidence supporting their

effectiveness. Innovations that challenge the field's existing order by potentially displacing the demarcation line between professions have to be theorized and argued in writing in order to be processed and to have a chance of being put into action. If furthermore the field is embedded in the public sector – as is the case of the Danish health services – the pressure towards theorization as a precondition to innovation is strengthened towards becoming an obligation. Commission work is institutionalized as an ingredient in reforms and not only produces theorizations itself, but also motivates actors to theorize in order to further their points of view and interests.

In expressing their views, the actors have both engaged in specification of the general organizational failing health centres are assumed to remedy, and in justification of general models for health centres. I.e. that theorization of the health centres is not following the innovation process as a subsequent stage IV, but is part of the articulations in the innovative pre institutionalization process (stage III).

Hence proposition 1:

In a mature professionalized field the theorization of a new organizational form is inseparable from the innovation process, and is a precondition for exerting institutional entrepreneurship.

However, the theorizations of the health centres do not seem to converge but to promote divergent organizational innovations. This is in line with d'Aunno, Succi & Alexander's (2000:684) hypothesis 7b "*Legislation that provides resources to support organizations' use of alternative templates will promote divergent change"*. But the source to divergence is not only the state's encouragement to experimentation with health centres as part of a major reform, but also the fact that the field of health services encompasses many different professional orientations and convictions about how important sector problems may be resolved.

Proposition 2:

In a mature professionalized field under restructuring, the divergence of a new organizational concept is promoted by the variety of problems/failures, client categorizations, justifications, and demarcations of domains it can be brought to relate to.

Methods

The analysis is based on secondary sources related to

1. the field of health services
2. the ongoing national administrative reform
3. articulations about health centres.

The first, and most of the second category, has been generated during research conducted in the years 1999-2004 (FLOS 2004), while the third is the result of investigations that started 2005. Even though only secondary sources are referred to, they are the results of the author's "field ethnography". This includes "hanging out" on the boarderline of the health field for several years. This includes both participating in many conferences and seminars (sometimes in active roles), site visits, interviews and talks with field actors, and regular reading of the field's journals and health news services.

This has slowly led to the identification of what may be regarded as central articulations, that have been corroborated and adjusted through the reading of others' analyses of the health field, the administrative reform and health centres in Denmark.

Proposition 1: In a mature professionalized field the theorization of a new organizational form is inseparable from the innovation process, and is a precondition for exerting institutional entrepreneurship.

Health centres is not a new concept, neither internationally nor in the Danish context where it can be traced back to the late 70ies and in particular the 80ies. With inspiration from the international health care field and WHO it was launched as a possible solution to the problems of coordination and collaboration within the health sector – both between the primary and secondary sector, and between the different professional groups, as illustrated by the following early attempts of definition:

"Health centre has lately been used as a term for efforts of coordination and collaboration. The trend is that more HCs will be established in the near future, located in previous hospitals and residential homes.
A HC is not an unambiguous concept, but in most cases it designates that several groups of health professionals work closely together, and in most cases under the same roof. The HC concept has not been unequivocally defined regarding organization, structure and contents – neither in Danish nor in foreign literature." (Jacobsen, 1988:3)

"A HC designates an organization of social and health functions that are physically integrated in the same buildings. The activities are based on formalized multi-disciplinary collaboration in order to serve the preventive health work in the local area and to coordinate the local supply of health services." (Jacobsen, 1990:22).

However, no consensus was attained about a specific health centre model in spite of several attempts of theorization (Jacobsen, 1988; DSI, 1990; Krogstrup, 1990). Several quite different health centres were established, but the following years did not lead to the selection and diffusion of one type.

A recent analysis of health centres (Vinge, Vested & Ankjær-Andersen, 2004:8-9) has proposed a typology for the present population of health centres, which reveals that HC has been used as a term for quite different types of organizations, and that both counties, private actors (GPs), and municipalities have been active as institutional entrepreneurs:

HCs established in closed-down local hospitals (Counties)

HC established as large (interdisciplinary) GP houses (Private)

Extended residential homes (Municipalities)

Nurse based organizations (Municipalities)

The generic concept of "health centre" thus appears to have been used for quite different purposes. By the counties to "keep alive" and fill out the buildings of closed down small hospitals (Borum 2005), by independent GPs in some cases as a frame for collaboration and facility sharing, while the municipalities have used them to extend the services of residential homes or to establish nurse clinics.

Health centres appear to have been a "dormant institution" until 2002 when the political debate and commission work preparing the ongoing national administrative reform gained momentum. The population of so called health centres did only grow slowly to 40-50[2], continued to be characterized by divergent forms, and lived quietly, as witness the modest number of articulations (articles, notes and books) around HCs in the years 1991-2002:

Field Actors / Year	1984-86	1987	1988	1989	1990	**1991-2002**	2003	2004	2005	**Total**
Physicians			3				10	3	1	**17**
Nurses		1	2	1		4	4	15	3	**30**
Physiotherapists				1		1		6	3	**11**
Social workers Ergonomists Midwives									3	**3**
The Health Cartel							3		1	**4**
Administrators Managers						1	1	1	5	**8**
Counties and their association	2	1			1	2	3	4	5	**18**
DSI (Institute of Health) - affiliated to counties	3				1	1		2	1	**8**
Municipalites and their association	1	1	3	1	2		1	2	6	**17**
Ministry and National Board of Health								2	2	**4**
The Press				1	1	2	3	4	5	**16**
Patient Associations						1			2	**3**
Total	**6**	**3**	**8**	**4**	**5**	**12**	**25**	**39**	**37**[3]	**139**

Table 1: Publications on Health Centres 1984 - June 2005[4]

[2] Author's estimation. The DSI (2005) bibliography lists 9 County HCs and 20 Municipal HCs (planned HCs excluded). According to a 2004 survey (KL) 37 municipalities had established a HC or expected to do so in 2005. The number of private (GP) HC's is not stated.

[3] The 2005 count only covers the first 6 months. A simple pro rata adjustment would double the 2005 total to 74.

[4] Based on the DSI (2005) bibliography which includes articles from seven important Danish health sector journals, articles and books from three national databases and from Google, reports, articles and press news.
14 items have been excluded from this table (among these speeches, dias presentations, conference/seminar announcements, WHO publications). All remaining items have been counted as one in the table. The items have been attributed to actors according to either editorial responsibility of journal in which they appeared or stated authorship.

The table shows a drastic change in this picture from 2003 with nurses as the most articulate actor, followed by counties, municipalities, physicians, the press and physiotherapists. The articulations around the health centres has continued to grow in scale and scope. An indicator of this is that an internet search the 10th May 2006 on the word "sundhedscentre" (Danish for "Health Centres") yielded about 17.900 hits.

The present reform's intentions of better quality and coherence of health services across institutions represent both possibilities and threats to different groups of health professionals. The nurses appears to have taken the lead on health centres as an opportunity within the municipal sector, in which physicians are rare. They seem to have been pursuing a more manipulative strategy (Oliver, 1991) and to seek pragmatic legitimacy (Suchman, 1995) through coalition building, responding to reform need, and selection of new market opportunities. Furthermore the Danish Nurses' Council is the most important union of the fourteen grouped in "The Health Cartel" to which also physiotherapists, social workers, ergonomists and midwives belong.

The physicians' articulations seem more to be responses to the other actors' articulations, which represented threats to the physicians in terms of contesting the GPs traditional gatekeeper role in the health sector. Their strategic reactions seem more defensive, attacking the theorization of the Health Cartel and ideas behind the creation of health centres to be neither based on sufficient evidence nor existing expertise, and arguing that they might lead to further complication of the structures within the health sector. The physicians seem mostly to be using moral and cognitive legitimation strategies.

The reform also put pressure on the counties' role in relation to the health sector, while the new, larger municipalities as ascending actors within the health sector were in search of a platform for action. The counties seem both to have been using defensive and compromising strategies, and to try to maintain and repair previously gained legitimation.

These many articulations have until now not led to convergence around a model for Health Centres, and the commission report providing the analyses which argued for the need for administrative reform only provided a very broad conceptual frame for the collaboration between health professionals, organizations, authorities, and private and public sector, which did not impose restrictions on the future interpretations:

"A physical or organizational frame for multi-disciplinary collaboration on (non-specialized) health related services, typically physically located together. The HCs' different groups of health professionals are not necessarily subordinated the same management, nor the same public authority. Furthermore a HC can also include private suppliers, among these those known from the public health insurance system." (Sector analysis of health services , 2003).

While Table 1 above truncated all types of publications into item counts, the imperative of theorization becomes more visible when publications from main actors around health centres during the years 2003-2005 are selected. The DSI (2005) bibliography, the interpretations of the Health Centre debate provided in Vinge, Vested & Ankjær-Jensen (2004:12-16), Møller Pedersen (2005:396-399), Albret (2005:6-7) and the author's own research has led to the identification of the following sequence of important "Health Centre articulations" (after the April 2003 "Sector analysis of health services" from the health field's central actors:

2003-05 Counties: All want Health Centres (Mandat 2003 nr.5:8-12)
Argues against HCs as “minihospitals”, against the “Finnish model” promoted in the “Sektoranalyse på sundhedsområdet” and to separate the GPs from the counties and to weaken their links to hospitals. Warning against regarding the HCs as a cure-all. The chair of the GPs and a professor in general medicine contributes.

2003-06 Health Cartel: Sundhedscentre – New ways to more health for money.
Argues for HCs as primarily managed and run by paramedicals, with nurses as the dominant health profession.

2003-06 Physicians: Ugeskrift for læger, issue 26, 35 & 46 (3 editorials + 6 articles)
2003-08 Defence for GPs as gatekeepers – as a reaction to Sundhedskartellets allusions to “walk-in-centres” run
2003-11 by nurses. Questions whether physical grouping of health professionals or strengthening of networks is most effective. Argumentation against the Finnish model and HCs as “minihospitals”. HCs have to be fitted into the existing health service structure.

2003-09 Municipalities: The chair of KL states in a special edition of “News from the KL board”
as a comment to “The political process after the commission” the central role of the municipalities in relation to health services. HCs are elaborated as an important means to link to hospitals and GPs and to serve as a concept which allows for the adaptation to varying local needs. It is underlined that HCs are not to become “minihospitals”.

2003-09 Counties, Sundhedskartellet og Lægeforeningen (Phycisians Association): In a joint announcement
”The coherent health services should be further developed, not freezed” the parties express agreement on the need for development of the health organization, and that HCs are one of the many possibilities, but that they have to be adapted to local needs.
In a 12 pages note is outlined some of the needs and organizational innovations, HCs should relate to.

2004-06 DSI report to Frederiksborg County
Argues for the need to find a specific model for HCs, and proposes to focus HC on services to chronically ill persons.

2004-12 Ministry: letter to the municipalities.
50 mio DCr have been allocated by government in 2005 to support experiments with Health Centres. At least one centre in each of the five new regions will be supported.
Dead-line for applications: 1st February 2005.

2005-01 Municipalities: 61 municipalities forward 63 applications to Ministry.

2005-04 Municipalities: KL produces a mapping the municipalities’ existing and planned health services.
Focus on Health Centres. Characterization of motives behind establishment, types and examples of centres.

2005-05 National Board of Health & municipalities: Meeting entitled “Prevention, promotion of health, and rehabilitation in municipalities – future collaboration between National Board of Health and municipalities.” The summary report from the meeting emphasizes the need for and good will to future collaboration as consequence of the administrative reform and the new health law.
A presentation of the CEO of Copenhagen Municipality puts forward an example of a HC focussing on the chronically ill.

2005-07 Counties: (Mandat nr 7/2005) ”Health Centres without goals and ends”
Argues for the need to find more specific models for HCs and expresses doubts about the municipalities’ abilities to handle the HC experiment

2005-08 Ministry: 18 HCs are selected to receive 100 mio DCr as grants-in-aid to

> "…visionary and varied HC projects… The new HCs are established as experiments that shall produce knowledge on – and inspiration to – how the municipalities can solve their new health tasks to the benefit of the citizens." (Press announcement from Ministry)

2006-02 SIF (State Institute of Health) "Health Centres in the municipalities." Status note (20 p.) om target groups, organizing and types. First element in the evaluation of the 18 HCs that have received grants-in-aid: target groups, organizing and types.

The first five articulations of this sequence have as important themes demarcation of the territories of regions and municipalities. It results in the actors distancing themselves from the Finnish system of municipal health services, and establishing the truce that HCs are not to become "minihospitals", and that GPs should not be removed from the regions' auspices.

During spring-summer 2003 the physicians articulate their points of view in editorials and several articles. These represent almost exclusively a defensive strategy in relation to HCs. The Finnish HCs and the Finnish system with municipalities responsible for hospitals is characterized as below Danish standards. The Health Cartels publication on HCs is characterized as nurses' imperialist strategy, and as offering neither a precise nor a convincing HC definition. GPs are described as being independent and individualistic and against joining larger HCs. The only sensible interpretation of HCs seems to be centres for chronically ill persons which, however, have to be fitted into the existing system of health services. HCs do not represent an answer to the present and future health challenges.

However, the conflicting views of the different health professionals end up being put in parenthesis and the parties reconciled in a joint declaration September 2003 which stipulates as unifying goals the actors' will to needed health organization development - and the need for local adaptation of the HC concept.

The same interpretation of the HCs to be is later supported by the Ministry of Interior and Health in its call for and selection of applications for grants to local HC experiments (2004-12). Health Centres in 2006 are characterized by divergence and not by standardization.

But this more experimental approach is based on a selection of proposals, which obliges the municipalities to theorize in terms of producing a convincing argumentation, to engage in evidence-based learning, willingness to communicate and share their experiences, and also to participate in an evaluation exercise by SIF (State Institute of Health) to be completed by August 2008. The next years will thus witness divergent local innovation, which has been legitimized through the definition of an experimental stage. This is more to be regarded as an unresolved controverse than a permanent state – there are proponents and opponents to the experimental approach, and there are advocates for confining HCs to a more specific model. DSI, the counties, and indirectly the National Board of Health theorize HCs for chronically ill as the model which ought to given priority. The surrounding debate in journals and in the press (see Albret, 2005) is also sceptical towards the municipalities' experimental approach, referring to the smaller municipalities' limited experiences and personnel resources.

Theorization in the innovation stage

This two years' sequence of selected HC articulations substantiates that theorization takes place in the innovation stage, and that it precedes the creation of new organizational forms. Theorization

appears not only to be a condition for exerting institutional entrepreneurship, but also to be utilized in defence of established institutions.

Interest articulation and demarcation of control and territories seem to be intertwined with and difficult to separate from “functional health services” types of argumentation. Some of the theorizations will be selected for further analysis in the next section in order to scrutinize the arguments built into the theorizations of HCs, and the differences between these.

Proposition 2: In a mature professionalized field under restructuring, the divergence of a new organizational concept is promoted by the variety of problems/failures, client categorizations, justifications, and demarcations of domains it can be brought to relate to.

Five theorizations have been selected from the above sequence of articulations:

2003-06 The Health Cartel’s publication, which represents the paramedical professions’ attempt to make a first comprehensive HC theorization.

2003-09 The joint declaration of the counties, the Health Cartel and the Physicians.

2004-06 The DSI-report to Frederiksborg County that theorizes HC as a specific model, centres for chronically ill persons. This can be regarded as a county theorization of HCs.

2005-04 The municipalities’ categorization of existing HCs and attempts at theorization of HCs.

2004-12 The ministry’s call for HC project proposals
and the subsequent
2006-02 SIF categorization of the 18 selected municipal projects.

The analysis of these articulations has as objective to identify differences between the HC theorizations, and contradictions and controversies between the different actors. First, it will identify the organizational failings, problem or issue the articulation addresses. How HC is theorized as a means to problem solving will then be analyzed by identifying the user (patient/client) categories constructed in order to support the specific HC interpretation, and the types of justification utilized for the proposed innovation. Finally the demarcations of jurisdiction between professions and authorities connected to the proposed HC innovation will be identified. Together these dimensions provide a basis for concluding whether the theorizations promotes divergence or convergence in the innovation stage and whether controversies are resolved or remain.

Table 2: Overview of the selected theorizations' main dimensions.

Actor	Failing/problem		User categories (Patient/client)	Justifications	Demarcations
Health Cartel 2003 -06	Coordination and coherence between sectors Flexibility/adaptation to varying needs Holistic health care		Child families/ young persons Labour force Chronically ill/ handicapped Old/very old	Health promotion and prevention Innovation More value for money Experience	HCs without physicians Staffed with competent Cartel members
Counties & Health Cartel & Physicians 2003 -09	Reform's threat to the present health system's coherence and current development projects HC as an imposed standard concept, not adapted to needs		Old persons with need of continued rehabilitation passing between hospitals and municipal services Chronically ill Life style related illness	Experience, competences. Examples of realized innovations Agreement between main actors	GPs as gatekeepers All physicians (also GPs and private specialists), hospitals and HCs under same (regional) authority
DSI 2004 -06	Chronical diseases as an increasing problem due to demographic trend (aging population)		COL and diabetes chronically ill (life style related)	More rational and coherent patient pathways Improved quality Efficency Response to future needs and present institutions	County HCs for chronically ill 3 variants (all without beds): one (basic) without physicians; two with out-patients' clinic; one with GPs involved
Munici-palities 2005 -04	HC as a frame for local health services What can be learned from existing (and planned) HCs?		Health promotion "Healthy cities" (WHO) Prevention: children and young persons Rehabilitation Patient focussed prevention and rehabilitation	Creation of local jobs and health services to compensate for closing down of local hospitals Expansion of existing services Health promotion and prevention	HC as a flexible concept adapted to other municipal services, regional services, GPs, and voluntary associations
Ministry 2004 -12 ---------- Munici-palities 2006 -02	Municipalities' new responsibilities impose new forms of organizing based on documentation, evidence and dissemination of experiences		Care Prevention Rehabilitation ------------------ Several target groups Citizens: health promotion and prevention Socially vulnerable Chronically and life style related ill Rehabilitation	Coherent services and patient pathways ------------------ Coherent services and patient pathways Methods/model development Reduced hospitalization Improved health Quality Cost reduction	HCs as municipal experiments HC flexibility and fit with GP and Hospital services ------------------- Collaboration between several health proff. (physicians partaking in almost half) Collaboration: Hospitals 1/3 GPs 1/3 Region 1/5 NGO 1/10

The **Health Cartel**, that comprises the nurses' and eleven other paramedical health associations was the first to produce a theorization following the "Sector Analysis of the Health services" (2003-04).

The failings of the present health organization stipulated are broad and reiterate concerns that have been discussed in relation to health services during the last thirty years (Seemann, 2001), but still are on the political and professional agenda of today: Coordination and coherence between sectors, flexibility and adaptation to varying needs, and a holistic health care system.

The following categories of patients/clients are mentioned as the ones to be served by the HCs: child families and young persons, the working force, chronically ill and handicapped persons, and old and very old persons.

Innovation and more value for money are stated in the publication's heading as the outcomes of HCs, in particular by furthering health promotion and preventive measures, coordination between sectors (element of the failings is also a means to its solution), and technological and medical innovations. HC is described as a flexible concept, and no specific organizational formula is proposed. Instead examples of services to each of the four client types stipulated are provided. The report emphasizes the practical experience of the Cartel's health professionals, and further substantiates this by giving examples of existing health centres and their activities. Furthermore several international HC experiences which might serve as inspiration for the Danish context are provided.

The HCs are demarcated as the territory of the Cartel's health professionals. The examples of health centres provided are or can be run by paramedical staff, that link up to physicians located in hospitals and general practice – that both belong to the counties' auspices. GPs are only mentioned once as attached consultants to HCs in order to provide service to the work force at "odd hours".

The **Counties** provide the next theorization (2003-09), which can be seen as a response to three preceding declarations: the "Sector analysis of health services" (2003-04), the municipalities' (2003-09) statement about the central role of the municipalities in relation to health services with HCs as an important means to serve varying local (municipal) needs and perhaps to substitute hospitals and GPs, and the theorization of the Health Cartel (2003-06). The declaration is co-signed by the phycisians' associations and the Health Cartel and appears as a truce around HCs.

Its problem statement differs significantly from the previous one. The existing health care system is described as good and providing coherent services to patients that, however, are at risk being deteriorated by the ongoing structural reform, and by HCs if these are implemented as a new standard concept. The main means to solve the problem is to preserve the existing system, but to continue to develop it through the many initiatives (seven are mentioned) already taken. From this view HCs are only to be established if and when they can be fitted into the system and adapted to local needs.

Two of the patient/client categories stipulated overlap the Health Cartel's theorization – chronically ill and old persons. But the two broad categories "child families" and "working force", that can be seen as contesting the GPs domain are not mentioned, while the new broad category of life style related illness that calls for new preventive measures is added.

The justification is formulated as authority speaking, emphasizing references to experience, continuity and examples of innovation, and downplaying the need for a major reform - and in particular to invent a new concept such as HC.

One important demarcation made by this theorization is between counties and municipalities. Even though the latter are to become stronger actors in relation to the health services, hospitals and physicians are still to be under the regions' auspices. Another is to contest that HCs should be run by municipalities only. In order to secure coherence they may be placed under regional authority also – cf. that the counties already run some HCs.

The (2004-06) report from **DSI** (Danish Institute of Health, owned by the counties) offers a theorization of a specific model for HCs which can fit into the county regime as a means for responding to the needs of an aging population. HCs for chronically ill targeted at primarily COL (chronic obstructive lung disease) and diabetes is argued to be a proactive reaction to changing patterns of illness due to demographic trends.

Even though the report was made for a specific county, it is an ambitious attempt to both make a status of the existing HCs (cf the classification cited earlier) and the present discussions of HCs, and proactively to formulate a model for HCs which make them fit functionally into the existing health services. This is in contrast with the dominant experimental approach encouraged by the municipalities and the ministry, but in accordance with the ideas of the National Board of Health (2005-05) and spokesmen of general medicine (Olesen, 2005).

By focussing on a model for HCs under county auspices, the report explicitly makes the demarcation that HCs not is the privileged domain of the municipalities, and implicitly proposes a science-based design approach which is in contrast to the ministry´s encouragement of the municipalities to pursue an open-ended experimental approach to HCs.

The municipalities association (KL) around the same time offers another theorization (2005-04), which is based upon a survey-based mapping of the municipalities' HCs. No traditional problem or failure is stated, but the report represents an effort to deduct lessons from the variety of HCs already run by the municipalities. HCs are described as a flexible concept that not only can be adapted to fit into municipal services, but also can serve as a building block to further the collaboration with regions, GPs and NGOs.

HCs are described as often being established in connection with the WHO programme "Healthy Cities" ("Sund By Netværk" in Denmark) with as objective to promote health, and prevention in relation to children and young persons. Patients are mentioned as a target group for rehabilitation and prevention.

As justification for municipal HCs is both referred to maintenance of local jobs and services to compensate for the problems created by the counties' closing down of local hospitals, and expansion and improvement of services and health promotion.

There is a clear demarcation in that the report only focus on municipal HCs. The counties are only mentioned as responsible for hospital services and GPs to which municipal HCs represent a flexible means for creating a coherent health system.

The ministry's call for projects to the municipalities (2004-12) with the incentive of 50 mio. DCr support is a two page letter. It states as problem the need to develop new organizational forms as a consequence of the municipalities' new health responsibilities. The means are experiments with HCs, which should be based on documentation and evidence and imply the dissemination of experiences to other municipalities. Care, prevention and rehabilitation are mentioned as the health service areas within which a potential exists. Coherent services and patient pathways are stipulated as the desired outcome, and the HCs should be flexible and fit with GP and hospital services – and with social services as well. The main demarcation built into this theorization is that HCs are confined to be the domain of municipalities.

The municipalities' responses to this call for experiments are divergent, as reflected in SIF's (State Institute for Health) classification of the selected 18 proposals for HCs according to their target groups (2006-02):

1. Health coordination: Several target groups
2. Citizens: prevention and health promotion
3. Socially vulnerable
4. Chronically and life style related ill
5. Patient rehabilitation before and after hospitalization.

The argumentation for the expected benefits evokes the ones mentioned in the call: coherent services and patient pathways, methods- and model development, reduced hospitalization, improved health quality, and cost reduction.

The proposed municipal HCs emphasize collaboration between several health professions, and physicians are partaking in almost half of the centres. They are also based on collaboration with other authorities: hospitals (1/3), GPs (1/3), Regions (1/5) and NGOs (1/10) and thus seem to soften up lines of demarcation.

Differences between problem statements

After the Health Cartel's statement of the broad problem of coordination between sectors, that has been up for discussion during decades, the counties take the initiative to a reformulation which essentially is a defence of the existing health system's merits. This turns the ongoing reform into a "systems threat" as it might deteriorate the functioning of a coherent health sector, in particular if the HCs are not made to fit into the established system of health services. The subsequent DSI report's singling out of chronic diseases and proposal to define HCs as a targeted response to these is in line with this problem statement.

The municipalities and the ministry use problem formulations that bear more resemblance with "system failure". There is a need for reform, the local health services have to be developed, and experimentation and organizational learning is needed, not incremental redesign. HCs are a means for innovative activities and the development of new organizational forms, they are a vehicle for reforming the present health system.

User categorizations

The different categories of patients and clients evoked support the problem statements. The Health Cartel, the municipalities and the ministry stipulate the broadest categories, child families/young persons, the labour force and citizens, that opens a field of opportunities for theorization of HCs.

In contrast, the counties and DSI concentrate on specific illnesses and patient trajectories to and from hospitals, that narrow down HC theorization.

Types of justifications

The broad problem statements and user categories are supported by broad justifications in terms of expected future outcomes. The health Cartel evokes innovation and more health for money, the ministry coherent services. The municipalities join these formulations and expand them with local economic/labour related arguments that not are strictly related to health.

The counties' justification is of another type, as it mainly refers to examples of earlier and ongoing innovations (as did the Health Cartel), existing competencies and agreement between main actors regarding how to improve the established system of health services.

The most focussed problem statement, chronic diseases, is also justified by reference to broad expected outcomes in terms of coherent patient pathways, quality and efficiency. However, DSI consecrates most effort to establish a detailed, evidence-based argumentation linked to the specific user types in order to substantiate the expected outcomes. In this context the National Board of Health and expertise within general practice is enrolled to support the argumentation.

Demarcations

The Health Cartel's report implicitly makes HCs the domain of other health professions than physicians. Subsequently, in the counties' declaration this demarcation seems to be replaced by a truce between the major health professional groups. This truce is also reflected in the ministry's call for municipal projects and the selected municipal HC proposals in which physicians play a role in almost half, and one third are based on collaboration with GPs.

The other important demarcation regards whether the counties (and future regions) or the municipalities should be the authority responsible for the design and operations of the health centres. The counties launch their theorization of HCs and in this way contests that HCs should be the privileged domain of the municipalities. In contrast, the ministry and the municipalities pursue an interpretation of HCs as local projects and a frame for the municipalities' development of new organizational forms and competencies.

Controversies around HCs

The analysis of the selected theorizations make a polarization and an unresolved controversy appear around HCs between established designers and ascending experimenters. The counties (future regions) argue for HCs to be turned into a marginal redesign of the existing health system – with HCs for chronically ill as a specification. Support for this is found at other established actors, the National Board of Health and expertise in general practice, that together with the counties posses the needed and established competencies to carry out this organizational redesign.

The ministry and the municipalities share another interpretation according to which HCs are a needed vehicle for innovative activities in relation to the health sector. HCs are occasions for the invention of new forms of organizing that may point towards new ways of attacking the fundamental problems of the health system's coherence, quality and efficiency. Local experimentation and not centralized design is needed in order to make the reform's intentions come true.

The HC theorizations' demarcations identify two structural conflicts around health centres. The first is jurisdictional between physicians and the other groups of health professionals. After a first attempt to exclude the physicians from the HCs, a truce seems to be established that leaves open what professional groups can participate in and manage the specific HCs. The second concerns which authority should design and control the HCs – the future regions or the new municipalities. This conflict seems unresolved between two groups of actors pursuing different strategies: the offensive of the ministry and the municipalities, against the counties' defensive which has some support from the National Board of Health and medical expertise.

"Health centre" is thus not confined to being a question of local innovations and diffusion of organizational forms. It is an element in a major ongoing reform of the health field, which marks a rupture of a previously established truce between the field's central actors (Borum, 2004). As a concept open for theorization, HC becomes a possible means to the restructuring of the health field. This is reflected in the different types of legitimation strategies pursued by the actors. The reformers (ministry) and the ascending actors (municipalities) pursue an offensive, manipulative strategy while the established actors (counties and main health professions) pursue more reactive and defensive strategies (Oliver, 1991). While the offensive reformers seem mostly to rely on creating general and pragmatic legitimaticy, the counties' efforts to defend and repair their legitimation covers the whole repertoire of a maintenance legitimation strategy (Suchman, 1995:600): general protection of accomplishments, pragmatic protection of exchanges, authoritative and professional moral protection of propriety, and attempts to cognitive monitoring how the present situation is to be understood.

The different theorizations of HCs have not led to convergence, but divergence – as is reflected in the variety of organizational forms to be created. Health centres are both contested as a concept and as organizational forms. A main line of conflict emerges between "systems adjusters" and "system redesigners" that can be summarized in the following table:

	System adjusters	**System redesigners**
Problem Statement	Reform and HCs = "System threat"	Reform and HCs = response to "System failures"
User categories	Specific chronic diseases	Citizens (broad health issues)
Justifications	Experience HC fitted into system	Experimentation and learning HC as a laboratory
Demarcations **--------------------** **Truce established Between**	Regional authorities as HC designers ------------------------------ Physicians	Municipalities as HC entrepreneurs ------------------------------------ Other Health professionals

Table 3: Unresolved controversies between HC theorizations

Conclusion

Two propositions have been investigated, and both have been supported by the empirical analyses.

They provided evidence that institutional entrepreneurship was exerted by all of the field's major actors, but that they made different theorizations of the same organizational concept – Health Centres - in order to make it serve different ends. The actors' number of articulations increased significantly during a three years period, and seems to continue to grow. This can be explained by reformers using the concept as a means to encourage different organizational innovations, and that different interpretations of it not only concern the functional activities of health services, but also may lead to displacements of professional jurisdictions and the control structure of the organizational field.

The *first proposition* demonstrated that theorization played an important role in relation to the innovation phase. All the parties engaged in theorization activities prior to innovation in order to exert influence on the creation of new organizational form(s) through different types of strategies. Different problems may be defined and selected for solution, and different types of experiences brought to bear evidence to what organizational innovation will be effective. Even in a field driven by the quest for evidence, the possibilities for construction of chains of cause and effect are many – in particular when many professional orientations are present.

Within a mature and professionalized organizational field theorization seems to be a necessary, albeit not sufficient activity – a sort of threshold to pass – for actors who want to participate in the innovation process.

The *second proposition* expanded on the factors that in mature professionalized fields under restructuring tend to make theorization processes support divergence of new organizational forms.

Theorization was identified in two quite different variants: system defenders' efforts to confine the innovation to standardized functional adjustments of the present system, while system reformers theorize HCs as a means to create experimentation and redesign of the overall system through new and divergent organizational forms. Theorization prior to creation is not only a question of functional considerations and justifications, it also linked to questions about jurisdictions and control.

Different field actors formulate different problems or organizational failings that reflect their positions in relation to the field: established central actors defending existing structures, and ascending peripheral actors and reformers challenging these. The actors create theorizations that are flavoured by their experiences and professional and regulative projects. The justifications they create emphasize particular categorizations (images) of patients/clients that fit with their problem definition and the proposed organizational forms.

Hence, in mature professionalized organizational fields, theorization is not only serving the diffusion stage, but plays an important role in relation to earlier stages of institutional change. Theorization is already occurring in the de- and pre-institutionalization stages. Instead of regarding theorization as a separate stage with the limited function of furthering the diffusion stage, it seems fruitful to regard it as an activity present in and influencing all of the stages of institutional change – but performing differently within them.

Based on the present analysis theorization in relation to the *deinstitutionalization stage* is an important element in the legitimation strategies of both “institutional entrepreneurs“ wanting to reform the field, ascending actors who want to become players in the field, and for defenders of the field’s institutional order. In the *preinstitutionalization stage* theorization is a condition for the creation of new organizational forms, as *innovation* within a mature professionalized field under restructuring not is an independent local activity, but a controversial field activity subjected to both regulative and professional influences. During these early stages field actors use theorization to promote different problem definitions and corresponding solutions that reflect their different orientations and interests - with as likely outcome the creation of divergent organizational forms.

References

Albret, Poul (2005) Alle taler om sundhedscentre – ingen ved hvad de skal lave. *Mandag Morgen* nr. 22, 13th June 2005:5-9.

Borum, Finn (2006) The justification of administrative reform. Paper presented at the SOND workshop, Uppsala Universitet 25-26 april, 2006.

Borum, Finn (2005) Sygehuset – en Omstridt Institution. *Nordiske Organisasjons Studier* 2-2005:114-133.

Borum, Finn (2004) Means-end Frames and the Politics and Myths of Organizational Fields. *Organization Studies* 25(6):897-921.

Borum, Finn & Sahlin-Andersson (2006) Institutional Configurations and Processes of Contestation. Working Paper. Uppsala/Copenhagen.

Bourdieu, Pierre & Jean-Claude Passeron (1970) *La Reproduction - éléments pour une théorie du système d’enseignement.* Paris: Les Editions de Minuit.

Brint & Karabel (1991) Institutional Origins and Transformations: The Case of American Community Colleges. In Powell, W. & P.J. DiMaggio (Eds.) *The New Institutionalism in Organizational Analysis.* Chicago: University of Chicago Press (p.337-360).

D’Aunno, Thomas, Melissa Succi & Jeffrey A. Alexander (2000) The role of Institutional and Market Forces in Divergent Organizational Change. *Administrative Science Quarterly*, 45(2000):679-703.

DiMaggio, P. & W. Powell, (1991) The iron cage revisited: Institutional Isomorphism and

Collective Rationality in Organizational Fields. In Powell, W. & P.J. DiMaggio (Eds.) *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press (s.63-82).

FLOS - Forskningscenter for Ledelse og Organisering i Sygehusvæsenet (2004) Forskning i sygehuse under forandring. København: Nyt fra Samfundsvidenskaberne.

Greenwood, Royston, Roy Suddaby & C.R.Hinings (2002) Theorizing change: The Role of Professional Associations in the Transformation of Institutionalized Fields. *Academy of Management Journal* vol. 45, No. 1:58-80.

Hoffmann, A.J. (1999) Institutional Evolution and Change: Environmentalism and the U.S. Chemical Industry. *Academy of Management Journal*, 42/4:351-371.

Indenrigs- og Sundhedsministerens Rådgivende Udvalg (2003) Sundhedsvæsenets organisering – sygehuse, incitamenter, amter og alternativer. Copenhagen: Statens Information.

Indenrigs- og Sundhedsministeriet (2004) Aftale om strukturreform. Copenhagen: Indenrigs- og sundhedsministeriet, 1. kontor.

Indenrigs- og Sundhedsministeriet (2004) Strukturkommissionens betænkning, nr.1434, januar 2004. Copenhagen: Indenrigs- og sundhedsministeriet, 1. kontor.

Jacobsen, Eva Thune (1990) Sundhedscentre i lokalsamfundet. Konferencerapport. Copenhagen: DSI Dansk Institut for Sundhedsvæsen.

Jacobsen, Eva Thune (1988) Sundhedscentre som tilbud i lokalmiljøet. Copenhagen: DSI Dansk Institut for Sundhedsvæsen.

Karnøe, Peter (1995) From Theorizing on Industrial Policy to Innovation Practices at the Company level in Andersen, Ib, Finn Borum, Peer Hull Kristensen & Peter Karnøe: *On the Art of Doing Field Studies.* Copenhagen: Handelshøjkolens Forlag:79-112.

Krogstrup, Hanne (1990) Nibe Sundhedscenter. Rapport nr.5. Nibe Kommune.

Larson, M.S. (1977) The Rise of Professionalism: A Sociological Analysis. Berkeley: University of California Press.

Molnar, J.J. & D.L.Rogers (1979) A comparative model of interorganizational conflict. *Administrative Science Quarterly,*Vol.24, no.3:405-425.

Møller Pedersen, Kjeld (2005) Sundhedspolitik. Odense: Syddansk Universitetsforlag.
DSI, 2005

Olesen, Frede (2005) Sammenhæng og omsorg for kronisk syge patienter. Tidsskrift for Dansk Sundhedsvæsen marts /2/2005:53-57.

Oliver, Christine (1991) Strategic responses to institutional processes. *Academy of Management Review* vol. 16, No. 1:145-179.

Seemann, Janne (2001) Integrative og disintegrative kræfter i det danske sundhedsvæsen. Arbejdspapir til Skandinavisk Temaseminar "Sygehus- og Sundhedsvæsenets ledelse og organisering". Aalborg University: Institut for Sociale Forhold og Organisation.

Strang, D. & Meyer, J.W. (1994) *Institutional conditions for diffusion.* In Scott, R.W. & J.Meyer (eds.) *Institutional Environments and Organizations.* Thousand Oaks, California: Sage Publications (pp.100-112).

Strukturkommissionen (2004) Strukturkommissionens hovedbetænkning. Copenhagen: Indenrigs- og Sundhedsministeriet, 1. Økonomiske Kontor.

Strukturkommissionen (2003) Sektoranalyse på sundhedsområdet (Sector Analysis of the Health services). Copenhagen: Indenrigs- og Sundhedsministeriet, 1. Økonomiske Kontor.

Suchman, Mark C. (1995) Managing Legitimacy: Strategic and Institutional Approaches. *Academy of Management Journal* vol. 20, No. 3:571-610.

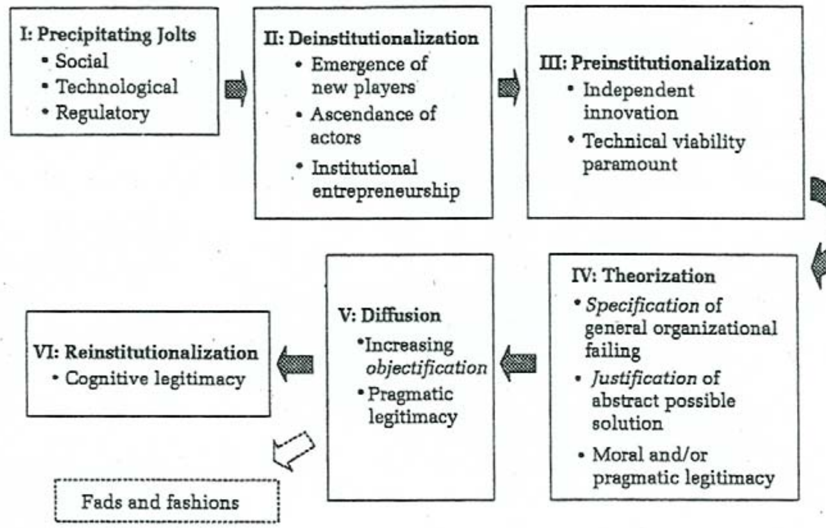
Sygehuskommissionen [the Hospital Commission] (1997) 'Udfordringer i Sygehusvæsenet' Betænkning fra Sygehuskommissionen. Copenhagen: Betænkning nr. 1329.

Tolbert, Pamela S. & Lynne Zucker (1996) The Institutionalization of Institutional Theory in Clegg & Hardy (eds.) Handbook of Organization Studies. :175-190

Vinge, Sidsel, Stine Hougaard Vested & Anni Ankjær-Jensen (2004) Sundhedscentre i Frederiksborg Amt. Copenhagen: DSI Institut for Sundhedsvæsen.

Appendix 1: Models of institutional change processes

Reprinted from Greenwood, Suddaby & Hinings (2002:60)



Reprinted from Tolbert & Zucker (1996:182)

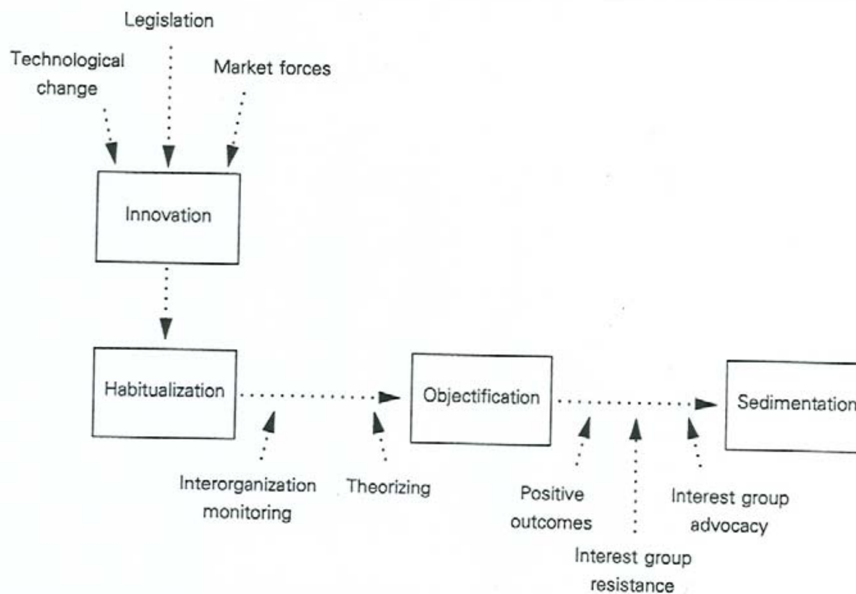


Figure 1 *Component processes of institutionalization*