Entrepreneurial actors between two systems of norms - Profound and professional quality knowledge in Swedish health care

Abstract
In an imprecise sense, quality has always been an issue for health care and its actors. This paper places entrepreneurial actors in an institutional environment in health care. The purpose of the paper is to design a study of quality development in Swedish health care. Two parallel paths of quality development can be traced in Swedish health care; professional knowledge, which is dominated by an institutional logic of quality in medical care and profound knowledge, which is dominated by an institutional logic of managerial control. Between these two concepts of knowledge, entrepreneurial actors can alternate and a challenge in Swedish health care is to federate the two paths. The study is aimed to seize the patterns of entrepreneurial actors’ movements and the translation of ideas. The design of the study works on the supposition that entrepreneurial actors in different ways have an impact on the prerequisites for quality development. Based on an institutional perspective in combination with theories of translation, actors’ movements can be illustrated by a time-geographic model. The empirical investigation will be provided with a data triangulation of official/unofficial documents, archival records and interviews. The tentative findings are presumed to identify actors’ constraints and potentials when it comes to quality entrepreneurship in health care.

Keywords: Public Administration, Institutions, Entrepreneurial actors

First draft – please do not quote!
Introduction

This paper should be read as a first outline to a case study design. This case study design is aimed to become a second article of an ongoing research of quality development in Swedish health care. The first article reviews the emerging of quality register in Swedish health care as an effect of institutional arrangements and analyzes the intersection of diverse factors in different institutional settings and logics. In contrast, the next article is aimed to focus on the actors within these institutional frames.

This case study design begins with indentifying the phenomenon of the two paths of quality development and entrepreneurial actors in health care. From the description of the phenomenon, research questions and propositions will be generated. Then, the case unit of translation of quality ideas and knowledge transfer is introduced. A brief overview of previous research is presented before the tentative theoretical approaches of an institutional perspective are described and as well analytical strategy and technique. Thereafter, a plan for data collection and quality assessment are defined. Finally, the design is summarized.

The study’s purpose and propositions

Quality issues have always been of great importance in health care, because of the striving to reduce uncertainty. As early examples of individual actors’ endeavor to gain quality in health care could Florence Nightingale and Ignaz Semmelweis be mentioned. Florence Nightingale (Chung, 2010) as the founder of modern nursing developed an organized way of learning from experience. Her empirical findings have improved methods of treatment that would lead to medical progress and a new thinking when it comes to nursing education. Ignaz Semmeweis (Nuland, 2005) is most known as an early avant-gard of antiseptic procedures. His empirical observations and discovery of cadaverous poisoning and efforts to reduce childbed fever conflicted the established scientific and medical opinion of his time. Although he did not gain any honor himself of his findings of the germ theory, but they were later confirmed by Pasteur and Lister.

As pioneers in there respectively area they have affected human health profoundly. In a modern sense they both could be looked upon as entrepreneurs in health care quality. But the interesting questions are how we can understand how and why they were prosperous in their respectively historical context.

To begin with, questions about quality in health care cannot be understood as an isolated phenomenon. They should be put into a bigger context. The health care system has traditionally been characterized by the medical profession, which stand as a guarantee for quality in healthcare. In public funded health care good quality is a common issue not only for physicians but also for local managers and patients – it is co-created by policy makers, management and the medical professions. Thus, quality in health care also becomes a political issue.

During the 1990s (Örnerheim, 2011) the quality concept in Swedish health care developed in two separate paths. Management ideas opened the way for quality improvement in structure and process. In contrast to the professional path, the profound path was not significant for the health care sector in general. When medical quality refers to the core of health care activities, organizational quality is aimed at the emergence of systems with the aim to follow up quality in the entire health care, although, the two paths have not yet crossed. One reason is that the two paths of professional knowledge and profound knowledge (Örnerheim, 2011) are ruled by different institutional logics, i.e. two diverse systems of norms. The distinction between these two quality concepts are important since actors can be active in both systems or mainly be concerned of one quality concept. Interests and ideas can also be moved across the two concepts over time.
The puzzle is that now demands are rising in Swedish health care of public transparency, with a view to facilitate patient choice and to improve quality of choices. A challenge is to make the translation of different quality systems feasible. The proposition in this paper is that the puzzle is handled by entrepreneurs, which make information comprehensible and manageable to initiate new ways of thinking, starting new projects and taking risks over time. Thus, the purpose is to design a study of entrepreneurship in order to understand how different actors justify their activities and emphasize their beneficial properties in bridging the gap between the two knowledge paths. But first a description of the case and its context is needed.

Introducing the case unit

Sweden has since late 19th century a decentralized healthcare system and has a long tradition of regional democratic health care. But the national level has always tended a great interest in the development of the health care system as a policymaker and through the legislative power. The healthcare system is divided into 17 counties and four regions. The National Health Care Act (1982:763) is a frame law and regulates the county councils responsibility for health care.

The medical organization can vary between different councils, but the health care is dominated by the physicians and medical ethics as the moral code (Calltorp et al, 2006). Among physicians there is a well known hierarchy depending on specialties. Ironically, in the hierarchism, the most political urgent specialties have a remarkable low status. Health care processes are ruled by a strong medical profession and lack of resources are often considered as a threat to the medical quality and freedom. Parallel to the medical hierarchy, there is an administrative hierarchy, which is connected to responsibility and power and a different moral code. It extends over both the administrative as well as the medical domain, and management, cost containment and quality of care are the guiding star.

In Sweden there are a lot of examples of rules for standards and regulations in the health care area as in many other areas. But when it comes to health care the medical profession has been expected to secure the quality (Garpenby, 1996). One condition to make improvements is the professional's incentives for self-monitoring where interventions are followed up and lead to changes. Other specialties, politicians or administrative staff can question a situation that can lead to documentation in order to control and ensure quality. The medical profession is also shaped by external influences. Research as a driving force is also important since it is a prerequisite for advancement.

Since the administrative and medical organizations are ruled by different systems of norms and at the same time are closely tied together a fundamental question is how ideas and knowledge are transferred between these two systems. Thus, this design has the ambition to form a case of translation of quality ideas and knowledge transfer. In order to make it understandable a theoretical approach is required. But before that, some preceding research will be delineated.

Previous research

Earlier studies of quality in Swedish health care go back to the mid 1990s. Then, a couple of studies with a special focus on issues related to quality registers were published. These studies mainly concerned the relationship between the medical professions and the state (Garpenby & Carlsson, 1994; Garpenby, 1996, Garpenby, 1999). Theoretically these studies focus on concepts of policy network, resource dependency, domains and mainly with an actor focused perspective.

An example of a study with an institutional perspective (Erlingsdóttir, 1999) that focus on quality assurance within the Swedish health care shows that the institutionalization of the quality assurance idea has been both a free process and a controlled process and that they are ongoing
processes. The accreditation idea has literally been copied, but also authorities and organizations from time to time have been able to interpret the idea in different ways.

In the last years some discourse analysis with focus on quality registers and Total Quality Management (TQM) have been made (for example Bejorot, 2008; Bejerot & Hasselbaldh, 2008), which claims that the control over the medical work shifts from the medical core to a complicated network of procedures, systems and standards were the medical profession is only one part of many.

In contrast to these studies, this study aims to apply an institutional perspective in combination with a theory of translation and a focus on actors. It will also consider both of the two quality concepts.

**Theoretical perspective, analytic strategy and technique**

The analytic strategy in the case study will rely upon theoretical propositions. Health care is often characterized as a complex system. The system contains institutional arrangement of rules, regulations, constraints, professionals, norms and ethics. An institutional perspective on health care shows that over time, great ambitions have tried to govern health care but from different logics (Scott 2000). In this study institutional logics are seen as practices and symbolic constructions which constitute organizing principles which can be elaborated by organizations and individuals.

The institutional environment provides meaning and stability to the health care sector through cultural belief systems, normative frameworks and regulatory systems (North, 1993); i.e. the institutions constitute the gamepad. Another reason for institutions to be interesting is that they create power configurations that are hard to change; i.e. they create and capsulize interests. March and Olsen (1984) also claims that institutions not only affect what is considered rational to do but also enact what is appropriate to do in a certain situation. That is why individuals act different in diverse situations. Institutional logics constitute the organizing principles and are according to Scott (2000) the cognitive maps by which actors navigate.

Institutional actors could be either organizations or individuals and they can be carriers and creators of institutional logics (Scott 2000). In this case study focus will be on individuals. In the institutional environment, actors participate by possessing institutionally defined identities, capacities, rights and responsibilities. But they also take part in the material-resource environment and take advantage of it as consumers or suppliers. In these environments, actors features as entrepreneurs by new thinking within existing frames or by changing the system of regulations. The entrepreneurship is thereby connected to environmental institutions and resources. Within these frames ideas are translated by entrepreneurial actors in different contexts.

According to Røvik (2008) there are three types of translation motives. First, translation can be a rational and conscious act. Second, translation can happen in a context of contrarious interests, which affect the translation in a certain direction. Third, translation can be motivated by unspoken considerations to achieve symbolic or prestigious impressions. But not all translations have a motive; there is also a possibility that ideas are translated unwarily without any motives.

In order to capture patterns, Røvik (2008) argues that the rules of translations deal with possibilities and restrictions and these have to be identified. First, the possibilities are about to what extent the translator can reinterpret and reshape an idea. Second, the restrictions are about to what degree the translator is limited and if an idea is possible to translate or not.

Pattern matching as analytic technique will be used in the case study to explain to what dependent and independent variables are related. To illustrate how entrepreneurial actors can be active in both quality systems or mainly be concerned of one quality concept a time-geographic model developed by Hägerstrand (SOU 1970:14) is applied. In this way it can be visualized how and when in time interests and ideas are moved between the two quality concepts (Figure 1). If the space
is considered as a compressed surface and if the y-axe is picturing time we can make an image of actors' movements in time and space.

![Figure 1: The basic time-geographic model](image)

The actors’ movements are described by the trajectory (T) and the professional knowledge path are described by \( K_1 \) and the profound knowledge path by \( K_2 \). An isolated occurrence will in this model be illustrated as a point but do have a state of both time and space. The paths are as earlier mentioned, ruled by different institutional logics which are the cognitive maps by which the entrepreneurial actors navigate. Based on institutional theory this study is aimed to seize movements of entrepreneurial actors, their ideas and the translation of these in time and space. Here arise several questions that have to be answered through empirical investigations. What happens when an actor enters a new system of norms? Which are the motives to make translations? How do actors round inertial factors? Is the medical profession political? If that is the case, in what way is the profession political? And which are the possibilities and restrictions that creates a pattern of how ideas are translated between the two systems of norms? To answer these questions data gathering is required and need to be organized. To capture entrepreneurial actors’ movements and translations of ideas between the two quality concepts based on different institutional logics the principle of multiple sources of evidence will be applied, which will be described in the next section.

Data collection and quality assessment

Using multiple sources of evidence develop converging lines of inquiry, which construct validity. The process of triangulation will corroborate the other sources and augment the conviction of the findings.

In order to increase the quality of the study the evidence of the case study will come from three sources in a data triangulation. The first two sources are official/unofficial documents and archival records from the county councils, the Swedish Government and other national authorities such as the National Board of Health and Welfare (NBHW) and Swedish Association of Local Authorities (SALAR). A selection of documents and archival records that are relevant for the study will be made according to the purpose of the paper. The reason to study these documents is to identify the reformation of institutional arrangement and the reactions which they aroused.

For the purpose of getting further insights into the development of quality in health care interviews will be made with key actors, with a special interest in quality issues in health care at both
the regional and national level. The choice of interviewees will be in some way explorative. First, a couple of key-persons will be selected on the premise that they work in strategic parts in different health care arenas. Then, the respondents in their turn hopefully will suggest other persons with knowledge in the area (Kvale & Brinkmann, 2009). The main theme during the interviews will be the development of the two quality paths. Each interviewee will have the opportunity to tell his or her own story about the process. The interview will be recorded and transcribed. Also, the respondents will be able to review a draft of the interview as a way to construct validity. In order to increase the reliability a database will be created as a principle of organizing and documenting the interviews, documents and archival records.

Linking data to propositions will be made through the institutional theoretical guideline. The data provided from these three different sources will make it possible to analyze movements of individual actors and the translation of ideas in an institutional context. Thus, the study is a case of translation of quality ideas and knowledge transfer. In the study different kinds of observations are put together, which form a pattern of the movements of entrepreneurial actors and ideas. The point with this method is to improve knowledge on how ideas are translated and transferred.

The conclusions will be drawn by the empirical examination of the two paths of knowledge. The ambition of the study is to show that entrepreneurial actors in different ways have impact on the prerequisites for quality development.

**Completion**

The aim with the paper was to make an outline to a case study design. The study’s purpose is to examine entrepreneurship in order to understand how different actors justify their activities and emphasize their beneficial properties in bridging the gap between the two knowledge paths ruled by different institutional logics. The institutional perspective gives the opportunity to constitute organizing principles which can be elaborated by organizations and individuals and are also the cognitive maps by which actors navigate. In combination with a theory of translation, patterns could be captured by identifying possibilities and restrictions of translation. The actors’ movements can also be visualized in a time-space model. The data gathering will be organized in data triangulation of official/unofficial documents, archival records and interviews. The paper/article is expected to enhance existing knowledge about quality development in health care and identify new knowledge about actors’ constraints and potentials when it comes to quality entrepreneurship in health care. This could also be useful information for policy makers when it comes manage quality development.
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