Innovating entrepreneurship in health care

How health care executives perceive innovation and retain legitimacy

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Introduction

This chapter focuses on the executive's role in innovating health care. We make a distinction between two types of innovations: entrepreneurial innovations and institutional innovations. The first type aims to find new ways to enlarge market-share, size, and competitive position of organizations. The latter aims to find new ways to connect 'old' and 'new' logics (ways of thinking and working) in health care in order to make a long-standing contribution to a new type of health care system. We study how health care executives view and enact both types of innovations.

Both types of innovations are related to on-going changes in health-care systems in which a new market logic, new policies and new technologies force executives to rationalize health care delivery, compete with others and upgrade and up-scale organizations. According to Osborne and Brown (2005) such change implies a break with the past and will require new innovative structures and techniques and new management skills. It requires entrepreneurial innovations - on the organizational level. At the same time, executives cannot escape accepted professional and organizational logics, based on professional ethics and administrative aims like budgetary control and risk exclusion. Consequently, health care executives run the risk of being squeezed between politically driven reform policies on the one hand and resistance to change from e.g. professional staff, needed to implement change, on the other hand (Goodwin 2006). Neither direct government control, nor new businesslike organizational forms seem to provide executives durable legitimacy anymore. Thus, not only entrepreneurial innovations are required, aimed at new products and business models, but also institutional innovations, in order to find ground for new ways of thinking and working in health care and to retain legitimacy. Central questions are: *how do executives deal with opposing value systems? Do executives find innovative ways to combine innovations and legitimacy?*

The next few sections set the scene. After a brief explanation of the changes in health care (in The Netherlands) and the consequences for the position of executives, we will elaborate on the role of health care executives as 'institutionally active agents' and on the difference between entrepreneurial and institutional innovations in health care. Next, we will explore

executive strategies empirically by studying the outcomes of an extensive survey research, conducted in 2000 and repeated in 2005. At the end of the chapter we draw conclusions.

Retaining legitimacy in times of change

In the Netherlands health care traditionally is a public/private/professional affair. Health care professionals work for private organizations with a public task, predominantly funded by public means (Helderman et al. 2005). During decades the central government took direct responsibility for the development of the sector by means of elaborate planning, budgeting and tariff control of independent health professionals. Not-for-profit health care providers and insurers (sick funds) acted as quasigovernmental organizations, implementing governmental policy and regulations (Helderman 2007, Van der Scheer 2007). Successful management of these organizations required public administration competencies. The Dutch health care sector, however, is a public sector in transformation. Like in other countries, technical and political ends, like cost-containment and improved efficiency, have gained importance, in addition to traditional 'institutional' ends, reflecting professional values governing the provision of necessary and appropriate care, safety, accessibility, et cetera (Osborne and Gaebler 1992, Pollitt 2002, Kirby 2006). In the beginning of the nineties the Dutch government stated three policy goals for the health care sector. It had to be innovative, cost-efficient and demand-driven (Van der Grinten & Kasdorp 1999, WRR 2004). Existing political planning, budgeting and price control instruments were no longer considered to be adequate for realizing these aims. Markets were seen as new instruments to realize policy goals and government started to create market conditions in the health care sector (Putters 2001, Helderman et al. 2005, Helderman 2007). The intention was to limit the role of government and to control conditions for an optimal functioning of markets in the field of health care (Dijstelbloem et al. 2004).

This reorientation towards markets in the health care sector is a long term endeavor. Initial steps were made twenty years ago and today the Dutch health care sector is driven by a mix of market forces and governmental planning, budgeting and price control (Dijstelbloem et al. 2004, Van der Scheer 2007). It is not clear whether this mix will evolve towards more market elements, as this strongly depends on the color of governmental coalitions. This creates substantial uncertainty about the ultimate importance of markets in Dutch health care. At the

same time market conditions are becoming incorporated in the way the sector functions and develops. New logics of appropriate actions are disseminated through government guidelines, legislation, and practices of inspection and audit regimes (Noordegraaf et al. 2005, Van der Scheer 2007). Entrepreneurial risk is created for providers and insurers. Established market positions are breaking down. Price competition brings growing attention for cost management and productivity. Private payments are added to the traditional public funding of health services, et cetera (Schut et al. 2005, Varkevisser et al. 2008). As a consequence, executives of health care organizations are facing a situation in which their management routines, the rules of the game that belong to the public administration management tradition, rapidly become obsolete in substantial parts of their work (Pollitt & Bouckaert 2000, Grit & Meurs 2005, Goodwin 2006, Kirby 2006, Noordegraaf 2007). The emerging market conditions require other, more business-like knowledge and competencies of executives in health care (Valle 1999, Van der Scheer 2007, Noordegraaf & Van der Meulen 2008). In order to retain legitimacy it makes sense for executives to adapt to the new logic and incorporate the new entrepreneurial way to go about things and engage entrepreneurial innovations (Clarke & Newman 1997).

The strategy of adaptation may be perceived as legitimate from one perspective but abject from another perspective; it may be wise considering external claims and expectations, but wrong considering what traditionally is believed to be morally just in health care. Legitimacy is not only a matter of complying to law and state agencies (regulative legitimacy), but is also about what is perceived as morally just (normative legitimacy) and about respecting accepted, taken-for-granted, scripts (cognitive legitimacy), especially in such an institutionalized field as health care (see Scott & Meyer 1991, Ruef & Scott 1998, Scott et al. 2000, Scott 2001). What may contribute to the external legitimacy of executives and organizations (from the point of view of politicians, policymakers, insurers, etc), may be at the expense of internal legitimacy (from professionals and clients). According to this institutionalist point of view, legitimacy and institutionalization are virtually synonymous (Suchmann 1995). Organizations are likely to resist innovations that are inconsistent with performing known tasks. Some even belief revolutionary changes in public sector organizations are impossible to implement because of the many constraints (interdependencies, strong traditions, tied relationships, involved interest groups) that govern the activities of public agents (Terry 1996, Mouwen 2006). Putters (2001) calls this the ‘institutional trap’, referring to the pressure on executives

of health care organizations to conform to the demands of the health care field. How to innovate in such a field?

The executive role in an institutionalized sector

According to Terry (2003) the very function of public managers, such as health care executives, is to be responsive to the demands of political elites, the courts, interest groups, and the citizenry and at the same time preserve the integrity of public organization. The word integrity refers to the reasons for existence of the organization; it's desired social function, and its collective institutional goals that legitimizes it's actions. It refers to "the completeness, wholeness, soundness, and persistence of cognitive, normative and regulative structures that provide meaning and stability to social behavior" (Terry 2003:27, see also Scott2001). In line with Selznick (1984), Terry (2003) argues that serving the public good is a task which is about preserving the organization's distinctive values, roles and competences. According to this point of view executives themselves should also be selective in adapting to external demands and should resist pressures and demands that weaken the organization's integrity because of erosion of its regulatory, normative and cognitive systems. This does not mean health care executives should have an antagonism toward change, on the contrary, controlled adaptation to changing circumstances is obviously an ongoing necessity. The thing is that change and innovation in such vital fields as health care should be guided by respect for existing belief systems and traditions and by loyalty to its values and unifying principles (the very reasons for their existence). What is more, innovative courses of action are required to preserve organizational integrity (see Friedrich 1961 in Terry 2003).

External events that threaten the organization's integrity may justify a radical break with the organization's established conduct, but it will also put executives for the difficult task to respect and simultaneously distance themselves from institutional pressures and to act strategically. It asks of executives to challenge and change the very same institutions that constrain them. This controversy is often referred to as the 'paradox of embedded agency', requiring of actors to alter institutional logics without disembedding from the institutional world (see a.o. Scott & Meijer 1991, Suddaby & Greenwood 2005, Battilana 2006, Leca and Naccache 2006, Slyke 2006). It suggests executives can become 'institutionally active agents' and find new logics of legitimization that *bend*, rather than *break* with, traditional

bases of legitimacy (also Terry 1996; Newman 2005, Battilana 2006). Answers to how this can be done are sought in the enabling circumstances under which change is possible (see Koppenjan & Klijn 2004, Dorado 2005), in the enabling role of individuals' social position or the institutional awareness of individuals (see Battilana 2006). Others believe we should focus on exploring meanings actors attribute to their roles, on exploring their beliefs, preferences and how they take on particular forms of identity (Newman 2005, Suddaby & Greenwood 2005, Leca & Naccache 2006, Rhodes 2007). In this chapter we follow the latter strategy, for we want to find out how the new entrepreneurial way of thinking has affected the perceptions and actions of health care executives and what sort of innovation strategies are undertaken. As mentioned in the introduction we distinguish two sorts of innovations: entrepreneurial innovations and institutional innovations.

Entrepreneurial and institutional innovations

'Institutional innovations' are very different from 'entrepreneurial innovations' that - in response to external events - focuses on new products, business models and a new 'entrepreneurial' language (see also the definition of private sector innovation from the OECD and Eurostat 2005). Although product innovation is often seen as radical innovation, representing true discontinuity with the past (Osborne and Brown 2005), the institutional impact - a real change in thinking and working in organizations - may be minor. As Exton (2008) found studying entrepreneurship in the UK National Health Service, the new entrepreneurial strategy and language may remain 'loosely coupled' to mainstream organizational practices due to the interplay of power relations and 'old' institutions. Institutional innovations, instead, are connecting old and new logics in health care: developing new values and meanings, and engaging in new relations and partnerships (e.g. Scott et al. 2000). Each type of innovation serves its own goals and is accompanied by its own beliefs, languages, and practices, thus affecting *executive identities* as well as *organizational practices*, *executive perceptions* and *actions*.

Where entrepreneurial innovations focus on instruments and measurements, institutional innovations focus on people and values. The first form seeks the objective: the facts function as proof for organizational effectiveness, which is used to enhance and prove output legitimacy. Plans are concrete, feasible, and have a clear beginning and end. Aim is to ensure

organizational continuity by strengthening the competitive position of the organization (see for further elaboration Drucker 1985, Terry 1990, Osborne and Brown 2005, Van der Scheer 2007, Exton 2008). In this *business model* new services (products) are developed in order to attract more patients (customers). Executives are encouraged to reinvent themselves in more entrepreneurial and business-like managers. To take on images of competitive behavior as requiring hard, macho or 'cowboy' styles of working (Clarke & Newman 1997), to become risk takers and produce radical changes like 'real' entrepreneurs do (Terry 2003). Executives who advocate entrepreneurial innovations should do well to learn from their private sector counterparts, to enlarge their knowledge about finances, rationing mechanisms and other private sector technologies and practices. Moreover, in a more market driven context with a rising emphasis on matters of efficiency and accountability, a call for yet another 'type' of managers can be heard. Managers from 'outside' health care, who are supposed to run health care organizations more as 'normal' businesses (Grit & Meurs 2005).

The second form of innovating seeks the subjective or the social: change is an outcome of social interaction between multiple parties (see e.g. Denis et al. 1996, Ruef & Scott 1998, Scott et al. 2000, Kirkpatrick & Ackroyd 2003). Institutional innovation seeks recognition and support for new ways of thinking and working. Aim is to preserve the institution's distinctive values, roles and competences by re-shaping social orders without losing legitimacy. Therefore, health care executives have to consider patients' and professionals' interests, as well as private and public interests. In addition to measurable results and rules, professional values and client wishes need to be respected. For health care remains a matter of 'people processing', which depends on human contacts and trust. Quality is influenced by whether clients feel at home, and whether they are listened to, which are important ways to build and enhance input legitimacy. It requires of executives to cultivate and maintain a variety of supportive relationships, both internal and external, and a continuous effort to maintain a favorable public image (Terry 2003). This calls for managers who not only manage *downward*, controlling organizational operations, nor *outward*, achieving measurable results, but who also manage *upward*, and actively seek support from internal and external interest groups (Moore 1995). The corresponding leadership role is that of an intermediate in-between multiple parties and interests. A role which requires a good insight in and feeling with the specific field of action, as one develops through longstanding experience.

Both types of innovations are summarized in table 1, as well as the expected consequences on *executives' competences*, *organizational characteristics*, *executives' perceptions and actions*.

Table 1. Entrepreneurial innovations versus Institutional innovations

	Entrepreneurial innovations	**Institutional innovations**
Aim	Organizational continuity by strengthening the competitive position of the organization (market-share)	Preserve the institution's distinctive values, roles and competences by re-shaping social orders
Action	Investments in product development, organizational growth, new organizational structures, and the adoption of a new entrepreneurial role, language and business-knowledge.	Conscious reinterpretation of policy terms and seeking public support for it, an intermediary role for senior staff members who are strongly embedded in the organizational field of action, relations with different stake-holders.
Indicators	*Executive competences*: business experience and knowledge. *Organizational characteristics*: new products, new organizational structures / business models, organizational growth / mergers. *Executive perceptions and actions*: adoption of new entrepreneurial roles and language for senior staff	*Executive competences*: longstanding experience in health-care. *Organizational characteristics*: adjustments are made, but no radical break with existing ways of working. *Executive perceptions and actions:* adoption of an intermediary role for senior staff members, adaptation to the specific institutional field, new relations/partnerships, maintaining a favorable public image.
Effects	Output-legitimacy	Input-legitimacy

In the next section we explore the impact of emerging market conditions in health care on *executives' competences*, *organizational characteristics*, and *executives' perceptions and actions* empirically.

The empirical research

Empirical data comes from a large scale survey that was sent to all (around 800) members of the Dutch association of Health Care Executives (NVZD), in 2000 as well as in 2005.

Between 2000 and 2005, competition became a core issue in health care policy and major legislative changes were implemented, changing the Dutch health care system. Purchaser and provider splits were formalized, health care insurers became decisive, and a new cost-driven financing system was established (Den Exter et al. 2004, Helderman et al. 2005, Van der Scheer 2007). For this study we wanted to explore how executive competences, organizational characteristic and executive actions and perceptions have changed during the years 2000-2005. Do executives follow policies and opt for entrepreneurial innovations, or do they find innovative ways to combine entrepreneurship and other health care logics, and opt for institutional innovations?

The survey

The survey we used was basically a self-assessment tool. The survey provides insight in meanings executives attribute to their role and actions. Executives were asked about their personal backgrounds, their organizations, their perceptions and actions. The 2000 and 2005 surveys were largely identical, although some questions were altered or added. The most important changes were caused by contextual changes. In 2005, for example we asked respondents about (perceived) impacts of policy-induced innovations. This is especially relevant for understanding the strategies executives pursue. The larger part of the questions were closed questions. Answer categories were derived from interviews with executives of different types of organizations. In 2005 answer categories were again checked in interviews with executives of different types of organizations.

Table 2. shows the survey-data used to study executive competences, organizational characteristics and executive perceptions and actions.

Table 2. Questionnaire: relevant data

Type of data	**Data**	**Operational measures**

Executive competence	• Education • Management education • (Management) experience	• University/vocational schooling • Management programs/training • Management/executive positions, inside/outside health care, in what types of organizations
Organizational characteristics	• Size of organisation • Structure • Product development	• Budget, staff, number of professionals • Organizational structures, management structures • New services, commercial activities
Executive perceptions and actions	• Role • Interpretation of policy terms • Relationships	• Role importance and role strength • Entrepreneurship, effectiveness, required changes, accountability • Internal/external contacts, meetings, participation in public debate

In order to provide insight in sector specific forces that 'drive' executive behavior we studied both general trends in health care management, and differences between (sub)sectors. When a question was newly added in 2005, only cross-sectional outcomes are studied.

Respondents

Respondents are all Dutch health care executives, with so-called 'end responsibility'. They are members of the strategic apexes of different types of health care organizations, such as hospitals, organizations for mentally ill, organizations for handicapped people, organizations for elderly care and home care. The survey was send to all members of the Dutch association of Health Care Executives (NVZD), which can be considered a representative sample. In 2000 the overall response rate was 46%, in 2005 the overall response rate was 42% (i.e. 17% of all Dutch health care executives). Table 3 shows the response rate per sector for the 2005 survey. For the 2000 survey a division per (sub)sector was not available.

Table 3. Response 2005

Type of organization (sub)sector	**Population N**	**Sample n (members NVZD)**	**Response i.r.t population N**	**Response i.r.t. sample n**
Hospital	312	200	22 %	35 %
Organization for mentally ill	204	122	30 %	51 %
Organization for	305	134	19 %	43 %

handicapped				
Organizations for elderly care and home care	1030	271	9 %	35 %
Total	1851	743	17 %	42 %

Methods

To answer our questions we explored correlations between the 2000 and 2005 outcomes and between (sub)sector-outcomes and the mean. To find associations, chi-square was used for nominal variables, Spearman's rho for ordinal variables, and Pearson's correlation coefficient for interval and ratio variables. The values of Pearson's correlations and Spearman's rho were tested against '0' by means of a t-test approximation. The differences between independent groups were tested by the chi-square test in cases of nominal variables. In cases of ordinal, interval, and ratio variables a one-way ANOVA was used. When there were three or more independent groups and, subsequently, in cases of significant differences, post hoc tests for multiple comparisons were carried out using Bonferroni intervals. With t-tests, unequal variances were assumed. In all cases, only significant outcomes ($p \leq .05$) are mentioned. When relevant, outcomes are illustrated with tables.

Results

Executives competence

With respect to *education*, outcomes show that respondents (both in 2000 and 2005) are largely educated alike. 2005 respondents do *not* have increasingly more economic or business administration backgrounds, nor are they less likely to have been educated as medical doctors or nurses. Many respondents have combined studies: economics, medicine, nursing or sociology, as well as management and business administration. The latter also through many additional courses and trainings. The only difference is that:

- in 2005 more executives are educated in (other) social sciences (than economics) than in 2000.

In 2005 we also asked respondents what sort of additional training they had followed. Outcomes show much attention is paid to matters of finances and business administration.

With respect to *work-experience* respondents in 2005 appear to be more experienced health care managers than the respondents of 2000. Table 4 and 5 show: they have been working as a manager for a longer period of time; they have had more management positions (with and with-out end-responsibility); they have had more managerial positions in health care organizations; they have worked more often in different types of health care organizations.

Table 4. Work-experience, in years and number of (management) positions.

	2000	**2005**
Years since first managerial position	***19,3***	***21,2***
Number of management positions	***3,3***	***4,4***
Number of end-responsible positions	***1,9***	***2,2***
Positions in health care	***2,3***	***3,2***
Positions outside health care	1,0	1,3

Table 5. Work-experience, in different types of health care organizations (percentage).

	2000	**2005**
Work-experience in just one health care organization	15 %	12 %
Work-experience in one type of health care organizations	37 %	31 %
Work-experience in different types of health care organizations	***48 %***	***57 %***

Besides these general trends, some sector-specific trends can be found related to initial education and work-experience.

- In hospitals and organizations for mentally ill, executives are more likely to have a medical (or psychological) background than in other organizations;
- Executives of hospitals and organizations for mentally ill are less experienced managers than the mean (in years and number of management positions);
- Executives of organizations for elderly care and home care are more experienced managers than the mean.

The latter outcomes are likely to be related. Executives with professional backgrounds only become managers after having worked as a professional for many years.

A major change between 2000 and 2005 is a 9 % rise of executives who have work-experience in *different types* of health care organizations. Apparently, opposed to the call for more business-like managers from 'outside' health care, more executives come from 'other' types of health care organizations. Mobility between health-care sectors has increased. We can also conclude that becoming a health care executive is preceded by an extensive process of socialization and education in health care and much experience in health care management. Managing a health care organization seems to require a *specialization* in health care management.

Organizational characteristics

Between 2000 and 2005 health care organizations have changed in multiple ways. With respect to *size* outcomes show:

- organizations have become larger, in terms of budgets, numbers of employees, numbers of professionals, and numbers of locations.

With respect to *structures* outcomes show:

- organizations are more often organized in divisions and clusters, with units that are organized around client groups, medical specializations or geographical areas.

Management structures have also been adapted:

- most organizations have changed from a board of 'directors', with a clear-cut jurisdiction, to a CEO structure, with an executive board with a broad jurisdiction and a broad set of responsibilities.

In this model a supervisory board supervises policy and actions of the executive board that is formally and factually responsible for the functioning of the organization (a two-tier structure). In many cases there is a first-responsible executive.

With respect to *product development* outcomes show:

- Organizations increasingly invest in extension of services and commercial activities.

Executives of organizations for elderly care and home care show a more than average interest in commercial activities and extension of services. Executives of organizations for handicapped show a less than average interest in commercial activities.

With respect to size, structures and product development the same trends can be found in all sectors, but some differences between sectors have decreased. All organizations have grown in size, but, due to mergers, organizations for elderly care and home care have grown the most. Differences regarding structure remain varied. Hospitals, for example, are more often organized around medical specializations; organizations for the mentally ill are more often organized around client groups; organizations for the handicapped and for elderly care and home care are more often geographically organized. To conclude, during the years 2000 – 2005 health care organizations have become bigger and more complex. Executives of all types of health care organizations had to deal with organizational scaling-up and restructuring. Further, all organizations tend to invest in extension of services and commercial activities, but organizations for handicapped the least, and organizations for elderly care and home care the most.

Executive perceptions

Two questions were related to the executives' *role perception*. They were asked: (1) to rank the importance of different roles on a scale from 1 – 5: strategist, figurehead, entrepreneur, process-manager, intermediate, and administrator; (2) to rank how well they put the different roles into effect on a scale from 1 – 5. The outcomes are presented in table 6.

Table 6. Role: importance and performance (scale 1 – 5)

Roles	**Role importance**		**Role performance**	
	2000	**2005**	**2000**	**2005**
Figurehead	4,2	4,2	4,0	4,1
Strategist	4,7	4,6	4,4	4,4
Administrator	3,1	3,2	3,0	3,2
Process-manager	3,0	3,1	2,8	2,9
Intermediate	***3,3***	***4,2***	***3,4***	***4,1***
Entrepreneur	4,3	4,3	4,0	3,9

The outcomes show executives in 2000 and 2005 value the *strategist* role the most, followed by the entrepreneurial role; the *intermediary* role has gained importance between 2000 and 2005; executives are the least satisfied with how they perform the *entrepreneurial* role.

The same trends can be found in all sectors. Hospital executives, however, are the least satisfied with the way they perform.

We posed several questions with respect to the way executives interpret *policy terms,* such as *entrepreneurship, required change, effectiveness, accountability*. All questions were only posed in the 2005 survey, so only cross-sectional correlations could be analyzed.
With respect to *entrepreneurship* we asked respondents how they realized or practiced entrepreneurship. Answers show entrepreneurship can mean many things. Table 7. shows the outcomes per sector on a 1 – 5 scale.

Table 7. The meaning of entrepreneurship

	Hosp.	**Ment.ill**	**Hand. Org.**	**Elderly & Home care**	**Mean**
Creative use of resources	3,8	3,6	3,7	***3,9***	***3,8***
Optimizing work processes	***3,8***	3,6	3,5	3,4	***3,5***
Initiating commercial activities	3,0	2,6	***2,3***	***3,2***	***2,8***
Stimulating professional innovations	***4,1***	3,8	***3,7***	3,8	***3,9***
Realizing cooperation in order to meet regional demands	***3,7***	4,1	3,8	4,1	***4,0***
Entering new markets	***3,1***	3,2	3,2	***3,8***	***3,4***

It appears executives of organizations for elderly care and home care interpret entrepreneurship more *economically* than the others do. For them entrepreneurship is not just an attitude or a way to improve performances, but also a 'market strategy'. In elderly care and home care, entrepreneurship is more about 'entering new markets', 'introduction of commercial activities', as well as about 'creative use of resources'. Executives of hospitals interpret entrepreneurship more *professionally* in terms of 'stimulating professionals to innovate' and 'optimizing work-processes'.

We also asked how important the following *changes* are for their organizations: a more business-like attitude which focuses on results, a more professional attitude with more attention for the professional development of employees, a more entrepreneurial attitude with more attention for realizing innovations, more attention for quality of care, more attention for

broader public issues with respect to health care, or a better price/quality ratio (answers could be given on a 1 – 3 scale); The outcomes show that, generally spoken:

- executives feel a more business-like, entrepreneurial attitude is the most important, together with more attention for price/quality ratios.

Priorities, however, differ per sector. Hospital executives focus more on quality of care; executives of organizations for elderly care and home care focus more on broader public issues concerning health care and less on professional attitude; executives of organizations for the handicapped believe more attention is necessary for professional development of employees.

With respect to *executive effectiveness*, we asked respondents what decisive criteria for success are: to be able to deal with tensions and dilemmas, to realize changes, to achieve good financial results, to formulate a binding vision, to stimulate employees, to adapt to the situation (only one answer was possible).
Respondents of different types of organizations appear almost unisonous in their answers:

- executives believe 'realization of changes' is the most important criteria for success followed by formulating a 'binding vision'.

With respect to *accountability*, we asked respondents where they feel most accountable for and would prefer to be judged upon: complying to political commissions, optimizing logistics, financial results, competitive position, quality of care, public responsibilities (max. 2 answers could be given).
Again respondents of different types of organizations mostly agree:

- they feel most accountable for 'quality of care', followed by 'financial results' and 'public ends'.

Combining the outcomes regarding executive perceptions, we can draw several preliminary conclusions. First of all, executives strongly focus on entrepreneurship. Executives believe a more entrepreneurial attitude should be stimulated throughout the organization in order to realize change, and that they themselves should act more as 'entrepreneurs'. Yet entrepreneurship appears difficult to put into practice, especially in hospitals. Both the meaning of entrepreneurship and the opportunities to put entrepreneurship into practice,

differ per organizational field. Second, executives believe realizing change is an important criteria for success. The change they feel most necessary for their organization is a more entrepreneurial attitude. It suggests the entrepreneurial role is virtually synonymous to the role of change-agent. Yet, thirdly, executives themselves are not mostly concerned with change or competitive position, but with quality of care and financial results. That is what they feel they should really be held accountable for. Fourth, the intermediate role – acting in-between different parties inside and outside the organization - has gained importance to executives. In addition, realizing a binding vision is believed to be important to succeed. Apparently, executives believe they need to have a binding function for people inside and outside the organization.

Executive actions

In order to gain more insight in what relationships executives maintain we asked respondents: what stake-holders and sort of meetings they attend to, and in what ways they participate in public debates.

With respect to *internal contacts*, outcomes show:

- internal managerial contacts with other executives, managers, and supervisory board have increased between 2000 and 2005.

With respect to *external contacts*, outcomes show a growing external orientation between 2000 and 2005. Respondents maintain a broad network of external contacts, but:

- time spent on field contacts (with insurers, interest groups, et cetera) increased;
- time spent on governmental contacts (with politicians and civil servants) also increased.

A rise in field contacts and governmental contacts can be found in all sectors. Yet, executives of hospitals spend more time with insurers and – together with executives of organizations for the mentally ill –less time with politicians and civil servants than the others do, while executives of organizations for elderly care and home care and of organizations for the handicapped invest a lot in politicians and civil servants. Executives of hospitals spend more time with professionals than others do, but less time with clients and employees.

Executives might seek support for their position in the *public debate*, e.g. through: participation in political parties, direct contacts with politicians and civil servants,

participation in the board or a committee of sector organizations, by mobilizing colleague executives, and by using the media (more than one answer was possible). This question was newly added to the 2005 survey. The outcomes show:

- executives mainly participate in public debates through direct contact with politicians and civil servants and mobilization of like-minded colleagues.

With respect to participation in public debates, hospital executives are the least active. Executives of organizations for elderly care and home care are the most active in public debates about health care.

Executives have to deal with multiple internal and external stakeholders with diverse interests and expectations. Outcomes suggest external parties have gained importance. Much time is spent on managing relations and participation in diverse networks. It also appears public opinion is no longer a factor that can be neglected, though a comparison with the 2000 data is not possible on this matter. Nevertheless, outcomes do show executives spent more time on governmental contacts than before and actively try to influence politicians and the public, suggesting the work of health care executives has become increasingly *'political'*.

Conclusions

In this chapter we wanted to explore how the new entrepreneurial way of thinking has affected the perceptions and actions of health care executives and what sort of strategies are undertaken to combine innovations and legitimacy. We distinguished two sort of innovations: entrepreneurial innovations and institutional innovations. The latter type of innovations is especially interesting because long-lasting changes in health care call for innovations that connect old and new logics and that can provide legitimacy to new ways of organizing and operating. This means executives will have to *bend* rather than *break* existing institutional frames, by building on existing values and belief systems. We also looked for changes in executives' competences.

We conclude executives engage in both entrepreneurial and institutional innovations, and that in practice both innovation strategies mingle. Changes in size, structure and products indicate that between 2000 and 2005 many entrepreneurial activities took place, but also that

executives adapt strategies to the specific field of action (subsector). Local and sector-specific circumstances, habits, and traditions influence executives' perceptions and actions considerably. For instance, when asked what executives mean with entrepreneurship executives of different types of organizations answer differently. Executives in elderly care and home care interpret entrepreneurship the most *economically*, executives of hospitals more *professionally:* in terms of 'stimulating professionals to innovate' and 'optimizing work-processes'. It shows how executives reinterpret an abstract policy term like entrepreneurship, by seeing it from prevailing institutional logics, and by matching it to local settings. In that sense, the intentional and radical nature of innovation strategies must not be exaggerated. Even 'real' entrepreneurial innovations are institutionally biased – they flow from and are softened by existing institutional surroundings. Besides a pre-occupation with change and entrepreneurial activities, executives put considerable effort in realizing support for new ways of thinking and working from a variety of internal and external parties, and in maintaining a favorable public image. Executives aspire an entrepreneurial role, and feel that to realize change a more business-like, entrepreneurial attitude is necessary throughout the organization. At the same time executives aspire more and more an intermediary role, that binds internal and external parties. This double loyalty also shows in the way they are educated and trained. Executives combine longstanding experience in health-care management with new business-knowledge. Becoming a health care executive is preceded by an extensive process of socialization and education in health care and ample experience in managing health care organizations. They are *specialized* managers. Nevertheless, executives continuously seek to extend their knowledge, especially on matters of finances and business management. Not only executives' background, but also their loyalties appear to be strongly related to their institutional roots. Despite all efforts to realize a more entrepreneurial way of thinking and working, most respondents' main priority is quality of care.

Further, we conclude the strategic space to operate and realize changes is more limited in organizations with high complex work-processes and self-employed professionals. Executives of organizations for elderly care and home care appear to be the most entrepreneurially minded and institutionally active and executives of hospitals the least. The latter are the least satisfied about the way they perform. They have more attention for professional affairs and less for external/political affairs and public issues/debates. It seems strong professional logics can not only prevent existing institutional frames to break, but also

to bend. In elderly care and home care entrepreneurial changes are more easily realized, but a break with traditions too, including the risk of long-term loose of legitimacy. We conclude, therefore, that thoughtful innovating in an institutionalized field as health care requires the necessary 'diplomacy', which is so typical for steering networks, or 'management by negotiations', as Rhodes (2007: 1248) calls it. In daily practices this means executives have to act as liaisons: balancing between new and old stakeholders, between politically driven ambitions like entrepreneurship, on the one hand, and prevailing institutional logics, full of local and sector specific habits and traditions, on the other hand. Innovating in health care requires support from and dealing with professionals, as well as politicians, the media and the 'public' in general. As a result, the work of health care executives has 'politicized' too. Executives have to deal with many perspectives, parties, interests and issues, and are held accountable for many things they do not directly control.

In a situation in which old legitimacy grounds are falling apart while new ones are not yet clear, a strategy seems to be required of *'and … and'*. Executives need to respect both established and new ways of thinking and working. They need to conform to new, output-oriented, 'rules of the game', but simultaneously need to be careful not to lose other grounds of legitimacy. In order not to frustrate necessary innovations nor to harm legitimacy, the most appropriate strategy for executives may not be to act as an 'innovation hero' or 'champion' themselves, but as an 'innovation sponsor'. He motivates people for innovation, brings parties together, seeks support for innovations, but is also selective in adapting to external demands. The rise of entrepreneurship in health care is no clear-cut phenomenon. Entrepreneurship itself should be innovated.

Literature

Battilana, J. (2006) 'Agency and institutions: The enabling role of individuals' social position'. *Organization,* 13/5: 653-676.

Clarke, J., and J. Newman (1997) *The managerial state: Power, politics and ideology in the remaking of social welfare*. London: Routledge.

Den Exter, A., Hermans, H., Dosljak, M. and R. Busse (2004) *Health care systems in transition: Netherlands*. Copenhagen: WHO .

Denis, J. Langley, A. and L. Cazele (1996) 'Leadership and Strategic Change under Ambuiguity', *Organization Studies*, 17/4:677-699.

Dijstelbloem, H., Meurs, P.L. and E.K. Schrijvers (2004) *Maatschappelijke dienstverlening, een onderzoek naar vijf sectoren.* Amsterdan: Amsterdam University Press [Dutch].

Dorado, S. (2005) 'Institutional Entrepreneurship, Partaking, and Convening', *Organization Studies,* 16/3:383-413.

Drucker, P. (1985) *Innovation and Entrepreneurship*: practice and principles, New York: Harper & Row.

Exton, R. (2008) 'The entrepreneur: a new breed of health service leader?', *Journal of Health Organization and Management,* 22/3:208-222.

Goodwin, N. (2006) *Leadership in health care: a European perspective*. London: Routledge.

Grit, K. and P. Meurs (2005) *Verschuivende verantwoordelijkheden: Dilemma's van zorgbestuurders*, Assen: Koninklijke Van Gorcum [Dutch].

Helderman, J-K. (2007) *Bringing the market back in? Institutional complementarity and hierarchy in Dutch housing and health-care*. Thesis. Erasmus University Rotterdam.

Helderman, J-K., Schut, E., Van der Grinten, T. and W. Van de Ven, (2005) 'Market-oriented health care reforms and policy learning in the Netherlands', *Journal of Health Politics, Policy and Law,* 30/1-2: 189-209.

Kirby, E. (2006) 'The impact of competition on the importance of conforming to social norms: Strategies for managed care organizations', *Journal of Health Organization and Management,* 20/2 115-129.

Kirkpatrick, I. and S. Ackroyd (2003) 'Transforming the professional archetype?', *Public Management Review*. 5/4:511-531.

Koppenjan, J. and .H. Klijn (2004) Managing uncertainties in networks: a network approach to problem solving and decision making. London: Routledge.

Leca, B., and P. Naccache (2006) 'A critical realist approach to institutional entrepreneurship', *Organization,* 13: 627-651.

Moore, M. (1995) *Creating Public Value. Strategic Management in Government*. Cambridge, Massachusetts, London: Harvard University Press

Mouwen, K. (2006) Strategieontwikkeling en hybriditeit. In: Brandson, T., Van de Donk, W., and P. Kenis (red.), *Meervoudig bestuur*. Den Haag: Lemma. [Dutch].

Newman, J. (2005) 'Bending bureaucracy: Leadership and multi-level governance' in *The values of bureaucracy.* Du Gay, P. (eds), 191-209, Oxford: Oxford University Press.

Noordegraaf, M. (2007) 'From pure to hybrid professionalism: Present-day professionalism in ambiguous public domains', *Administration & Society*, 39/6: 761-785.
Noordegraaf, M., Meurs, P. and A. Stoopendaal (2005) Pushed Organizational Pulls. *Public Management Review*, 7/1: 25-43.
Noordegraaf M. and M. Van der Meulen (2008) 'Professional Power Play: Organizing Management in Health Care', *Public Administration*, 86/3:1-15.
OECD and Eurostat (2005) Guidelines for Collecting and Interpreting Innovation Data, Oslo Manual, 3rd dn.
Osborne, D. and T. Gaebler (1992) *Reinventing Government*. Reading: Addison-Wesley.
Osborne, S.P. and K. Brown (2005) *Managing change and innovation in public service organizations*. London: Routledge.
Pollitt, C. (2002) 'The new public management in international perspective; An analysis of impacts and effects' in *New Public Management: Current trends and future prospects.* MacLaughlin, K., S. Osborne and E. Ferlie (eds), London: Routledge.
Pollitt, C. and G. Bouckaert (2004) *Public Management Reform, a Comparative Analysis.* Oxford: Oxford University Press.
Putters, K. (2001) *Geboeid ondernemen: een studie naar het management in de Nederlandse ziekenhuiszorg*, Assem: Koninklijke Van Gorcum [Dutch].
Rhodes, R. (2007) 'Understanding governance: Ten years on'. *Organization Studies*, 28/8: 1243-1264
Ruef, M. and W.R. Scott (1998) 'A Multidimensial Model of Organization Legitimacy: Hospital Survival in Changing Institutional Environments', *Administrative Science Quarterly*, 43/4:877-904.
Schut, F.T. and W.P.M.M. Van de Ven (2005). Rationing and competition in the Dutch health-care system. *Health Economics*, 14:59-74
Scott, W. (2001) *Institutions and organizations. Second edition.* Thousand Oaks, London, New Delhi: Sage Publications
Scott, W.R. and J.W. Meyer (1991) 'The organization of societal sectors' in *The new institutionalism in organizational analysis*. Powel. W.W. and P.J. DiMaggio (eds.), 108-140, Chicago: University of Chicago Press.
Scott, W., Ruef, M., Mendel, P. and C. Carona (2000) *Institutional change and health care organizations: From professional dominance to managed care*. Chicago: University Press of Chicago.

Selznick, P. (1984) *Leadership in Administration: a sociological interpretation*, Berkeley: University of California Press.
Suchmann, M.C. (1995) 'Managing Legitimacy: Strategic and Institutional Approaches', *The Academy of Management Review*, 20/3:571-610.
Suddaby, R. and R. Greenwood (2005) 'Rhetorical strategies of legitimacy', *Administrative Science Quaterly*, 50: 35-67.
Terry, L. (1990) 'Leadership in the administrative state. The concept of administrative conservatorship', *Administration & Society*, 21/4: 395-412.
Terry, L. (1996) *Leadership of public bureaucracies: the administrator as conservator*. Thousand Oaks: Sage publications.
Van der Grinten, T. and J. Kasdorp (1999) *25 jaar sturing in de gezondheidszorg: van verstatelijking naar ondernemerschap*. Den Haag: SCP [Dutch].
Van Kersbergen, , K. and F. Van Waarden (2001) *Shifts in Governance: Problems of Legitimacy and Accountability.* Den Haag: NWO.
Van der Scheer, W. (2007) 'Is the new health-care executive an entrepreneur?', *Public Management Review,* 9/1: 49-65.
Van Slyke (2006) 'Agents or Stewards: Using Theory to Understand the Government-Nonprofit Social Service Contracting Relationship', *JPART* ,17:157-187.
Varkevisser, M., Capps, C.S. and F.T. Schut (2008). Defining hospital markets for antitrust enforcement: new approaches and their applicability tot The Netherlands. *Health Economics Policy and Law*, 3/23:7-29.
WRR (2004) *Bewijzen van goede dienstverlening*, Rapporten aan de regering nr. 70, Wetenschappelijke Raad voor het Regeringsbeleid (WRR), Amsterdam: Amsterdam University Press [Dutch].