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Institutional Logics and the View on Consultants in Healthcare

– An exploratory study of how enactments of logics alter Polish healthcare providers' views on management consultants

Abstract

This study explores how different constellations of institutional logics are enacted by healthcare providers in the Polish healthcare system and how these affect the view that providers have on management consultants. It introduces a framework that links research concerning institutional logics, which has been a central theme in new institutional theory, to the client's view on consultants in an organizational field which has seldom used consultancy services before. The results show that multiple institutional logics are enacted by different types of providers in Poland and that these enactments also lead to different perceptions of management consultants. Public providers in Poland to a larger extent enact logics of the state and the professional logic of doctors, which leads to greater skepticism towards consultants. Private providers, on the other hand, enact a market logic, which leads to a more positive perception of consultants. The findings reveal however, that providers generally view consultants in an ambivalent way.

Keywords: institutional logics, healthcare providers, management consultants, Poland

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1 Introduction

1.1 Problem Definition

Management consulting represents an important and growing industry. In the last decade, there has been a growing demand for consulting services in the healthcare sector in Europe (Poór et al. 2009). There are however geographical variations for management consultants in general and also cross-country differences for the demand of management consultants in specific industries. In some countries, the healthcare sector now comprises up to 16% of the national management consulting market turnover. In other countries, e.g. Poland, this phenomenon is still in its infancy (Poór et al. 2012).

Given many years of research, there is now extensive literature on the development of management consulting as a business activity in most developed and emerging economies. In *The Oxford Handbook of Management Consulting* (2012), Kipping and Wright provide a good literature overview of this development. Yet, the main focus in this research is related to the supply side of the development, i.e. how many consultants are there in certain countries and what services are they providing? What roles do they play? Less attention has been directed to the demand side of the development, i.e. what do the clients want from the client-consultant relationship? Moreover, and perhaps more interestingly, how can we better understand the prerequisites for consultants in certain geographical and industrial settings?

To understand this question it is natural to consider institutional or cultural-variety explanations. One of the phenomena that can explain alterations in how consultants are perceived is the theory that describes the effect of institutional logics on the behaviour of organisations (Thornton & Ocasio 1999). Logics can affect client behaviour and therefore influence the way management consultants are perceived in different contexts. The institutional and cultural "receptivity" to management consulting expansion is not only interesting to study for a specific country, but also for a specific industry. Cross-country differences for the expansion of management consulting in general have started to gain academic attention from scholars; among others, Kipping and Wright (2012) and Faust (2002) have studied the role of consultants in business at a general level in different countries.

Less attention has been attributed to in-depth studies of the view on consultants in specific countries and specific industries. From our academic review, we have noticed a particular gap in the contemporary understanding of how the institutional context influences the view and potential role of consultants in the healthcare sector. Among others, O'Shea & Madigan (1997) have noted that the healthcare sector, through adaptation of management practices that have historically been more connected to other areas of business, has been characterized by a growing demand for services provided by management consultants. In order to better understand the conditions and the future potential for management consultants in this market, we want to explore how consultants are perceived by clients and what external factors influence these perceptions.

1.2 Purpose and Expected Contribution

The purpose of this study is to explore how the view on management consultants in the healthcare sector is shaped by the multiple institutional logics that influence it. By providing a framework for describing this phenomenon, the study contributes to the contemporary scholarship about the view on consultants as well as current institutional theory. Previous literature on institutional theory has conceptualized the link between the institutional context and organisational behaviour and action, but has only recently recognized the surrounding environment and the national context as having an effect on consultancy and the relationship between clients and consultants (Kipping & Clark 2012). However, research on consultants is still mostly focused on the role of consultants and their contribution to business life, rather than on exploring how clients view consultancy and how clients are influenced by the institutional setting. By addressing this gap, this thesis aims to contribute to the discourse of management studies by accentuating the influence that the institutional context has on the view on consultants.

1.3 Research Question

This study aims to answer the following question:

How do institutional logics influence the view and perception of management consultants in the Polish healthcare field?

The question raises two sub-questions:

- ***Which institutional logics do healthcare providers within in the Polish healthcare field enact?***

- ***What is the view and perception of management consultants among healthcare providers?***

1.4 Definitions

Consultants are in this study defined as management consultants, i.e. external parties that are contracted by healthcare providers to work with strategic and operational management.

Providers are defined as hospitals and outpatient clinics that provide healthcare services to patients, or, if applicable, firms that manage a number of such hospitals and clinics. For a lengthier assessment surrounding how providers are categorized, see section *3.3.2*.

Voivoideships, powiats and **gminas** are administrative units of local authorities. *Voivoideships* are equivalent to districts, *powiats* to counties and *gminas* to municipalities.

Złoty (PLN) is the currency used in Poland. In May 2015, 1 PLN was approximately €0,247.

1.5 Disposition

Following the definition of the research problem and main research question in the introduction (*chapter 1*), we continue (*chapter 2*) with reviewing the literature on two main research areas: the

role of and view on management consultants and institutional theory. The chapter concludes in describing the research gap and introducing the theoretical framework of the study.

Following this, we discuss (*chapter 3*) the methodological approaches applied and introduce the research design and method of data analysis. Subsequently, we present (*chapter 4*) the findings of the study and provide an empirical overview of the research question and its sub-questions. It is presented with accordance to the theoretical framework and follows the methodology presented in chapter 3. Following this, *chapter 5* analyses the findings in the light of the research question and the theoretical framework. The following part (*chapter 6*) discusses the results and links them to previous research, before answering the research question and presenting the theoretical contribution and practical implication of the results (*chapter 7*). Finally, we discuss the limitations of the study and raise questions for future researchers to explore (*chapter 8*). The structure of the thesis is presented in the "thesis roadmap", see *figure 1*.

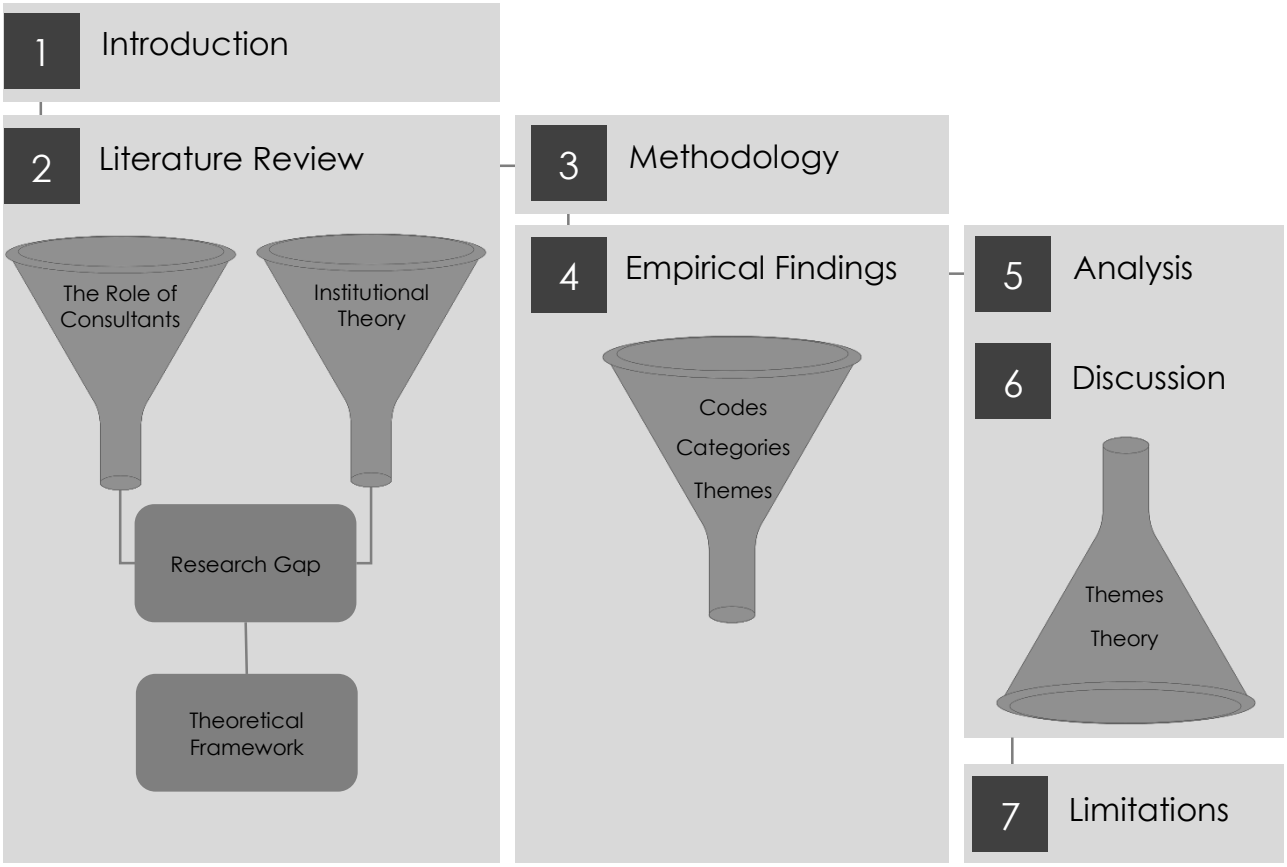


Figure 1 Thesis roadmap

2 Literature Review

The research question set in this study inflicts the understanding of the link between the institutional context and the view on consultants in healthcare. As a result, this thesis integrates research focused on management consultants and their role in business on the one hand, and institutional theory, which seeks to explain how the institutional context influences behaviour on an organisational and individual level, on the other. This literature review focuses first on how management consultants are depicted in literature and discusses relevant previous research and its limitations. Secondly, it describes the characteristics of new institutional theory and explores the institutional logics perspective. Thirdly, it highlights earlier research of institutional logics and their effect on organisational behaviour in the healthcare sector. Lastly, it discusses the identified research gap and summarizes relevant theoretical concepts used in the theoretical framework of the study. For an overview of this chapter, see *figure 2* below.

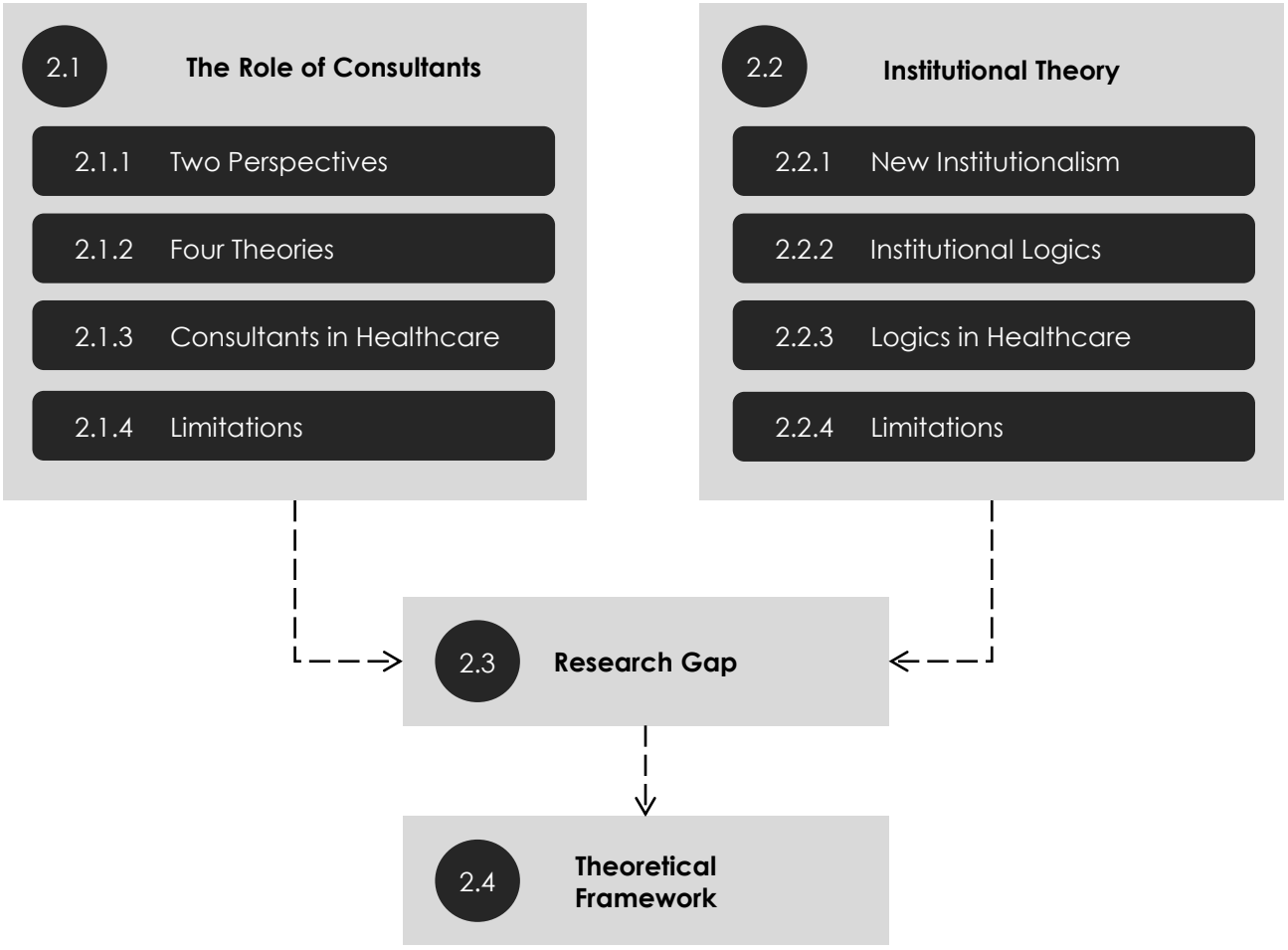


Figure 2 Structure of the literature review

2.1 The Role of Management Consultants

Only since the beginning of the 1990s has management consultancy gained wide interest from management researchers. One of the reasons for this may very well be that management consultancy constituted a relatively small service sector before the rise of 'the big 4' (Deloitte, PwC, EY and KPMG) in the 1980s. In a handful of studies on the subject at that time, management consultants were seen as transmitters of management techniques and methods for organisational change. Following the rapid development of the consultancy industry in the early 1990s, management consultants became a popular field for researchers who created a vast bulk of the literature that expanded the discourse (Armbrüster 2006).

2.1.1 The Functionalist and Critical Perspectives on Consultants

Armbrüster (2006) provides a holistic review of this consulting literature by distinguishing between two salient perspectives on management consultants that has dominated the field since the 1990s: ***the functionalist perspective*** and the ***critical perspective***.

Advocators for *the functionalist perspective* recognize the management consultant's important role as a carrier and transmitter of management knowledge. They argue that management consulting firms, with their global representation, familiarity with different sectors and, what follows, their ability to obtain knowledge about analytical procedures from multiple different sources in different fields, lead them to providing services that cannot be matched by the abilities of conventional organisations (Starbuck 1992; Moore & Birkinshaw 1998; Morris & Empson 1998; Sarvary 1999; Werr et al. 1997; Werr 1999; Werr 2002; Armbrüster & Kipping 2002).

Authors taking a *critical stance against management consulting* argue, however, that the view on management consultants as experts and carriers of knowledge is too narrow (Clark & Fincham 2002) and point out that many of the management concepts developed and offered by consultants turn out to be fads rather than institutionalized management techniques. Many claim that consultants have an economic interest in fashion setting of such management concepts (Abrahamson 1996; Kieser 2002; Ernst & Kieser 2002). Some authors have also raised the use of "consultancy speak", i.e. the use of established terms for rationalizing a broad assortment of services (Benders et al. 1998), or the practice of legitimizing approaches by referring to rationality and pragmatism myths (Berglund & Werr 2000).

Both the critical and the functionalist literature sees management consultants as agents of change; they are hired in order to change something that is perceived as bad or insufficient to the better. The final result of this change may nonetheless be contended – functionalist authors are keener to recognize that the consultants' contribution may indeed be valuable for the purchasing organisation, while some critics claim to see through a charade of status symbolism and opportunism. Yet others offer alternative interpretations of what consultants do. Furusten (2009), for one, argues that consultants may be seen as agents of stability rather than change. He sees consultants as improvisers in a business setting, which has not clearly stated their definite role. By improvising internally and simultaneously acting as standardizers against the client organisation they contribute to and give a sense of stability for the client organisation.

2.1.2 Four Theoretical Views on Consultancy

Among the management consulting literature that has been written since the 1990s, one can also distinguish four different theoretical stances that differ in their view on how the relationship between the client and the consultants is perceived, valued and managed (Armbrüster (2006). These theoretical perspectives have different assumptions about the characteristics of the factors that affect organisations and individuals and drive them to economic action. The theories of ***transaction cost economics*** and ***theory of embeddedness*** focus on factors that are internal to the relationship, and see these as the main attributes that affects it. In turn, the theories of ***sociological neoinstitutionalism*** and ***signalling theory*** both recognize that mechanisms that are external to the immediate client-consultant relationship impact economic action.

Models based on the theory of *transaction cost economics* recognize cost as the main driver of economic action. Opportunistic behaviour and rationality, limited by the boundaries of available information and capabilities, become the main focus of clients and therefore the services that provide cheaper and better solutions than those performed in-house become the targets for purchase. Transaction-cost theorists were among the first to emphasize the functional and beneficial role that consultants fill for their clients. One of the first to provide a concrete list of potential functions of management consultants was Turner (1982). He used eight task categories that range in scale from providing only some information to the client to permanently improving organisational effectiveness. Bessant & Rush (1995) developed another popular systematization of consultants' roles by listing consultant activity through recognizing technology, skills and human resources, financial support, business and innovation strategy, new technology and implementation as the main fields in which clients require consultancy.

Embeddedness theorists recognize the weight of transaction cost economics in economic action, but add the dimension of networking and social ties to the calculation. Indeed, some empirical findings have suggested that competition between management consultants rarely occur on price or cost (Dawes et al 1992; File et al 1994; Clark 1995; Page 1998), but rather social ties and networks between contractors and sub-contractors. (Brown & Duguid 1996; 1998)

The theory of *sociological neoinstitutionalism* is based on the argument that *beliefs* in the efficiency of a solution or approach, rather than its actual aftermath, determines and influences economic action. The most important factor of organizing is therefore the *legitimacy* of a certain approach to the organisational environment, rather than the technical efficiency of it. Innovations and organisational practices that cannot be evaluated objectively are therefore focused on action that is seen as efficient by managers and organisations themselves or by the external environment. As a consequence, management ideas and practices that are considered efficient – but which are not necessarily so – become institutionalized in the sense that other organisations adopt them in order to gain legitimacy. This adaptation of management ideas is often referred to as *isomorphism.* The theory of isomorphic distribution of management practices was e.g. presented in an extensive study of McKinsey interventions in the 1980s (Powell & DiMaggio 1983), which was based on the observation that advice given by the renowned consulting firm led to adaptation of the same management ideas by other firms.

Whereas sociological neoinstitutionalists argue for the impact of legitimacy-seeking behaviour on economic action, *economic signalling theory* takes into account the knowledgeability and experience of the clients and argues that clients invest in services that signal features important for them, such as status, reliability and quality (Spence 1973, 1974; 1976). Such signal features can e.g. be expressed through educational background and experience. To exemplify, a consultant with documented experience and a Doctor's degree from Harvard would have a more bearing opinion than a junior consultant with a Bachelor degree from Stockholm School of Economics (regardless of actual knowledge). In this sense, although it emphasizes different determinant factors, signalling theory shares two commonalities with sociological neoinstitutionalism. Firstly, they both recognize factors that are external to the factual exchange relationship as the ones that determine economic action (Armbrüster 2006). Secondly, they both see quality of the service as independent from the reputation of the service provider.

The four theories exemplify four different views on management consultants, their role in business, and their contribution to business as well as on the prerequisites for hiring them (see *table 1*). Whereas economic considerations and cost are the main explanatory powers behind economic action in transaction cost theory and signalling theory, sociological neoinstitutionalism and embeddedness theory also recognize social mechanisms as drivers of behaviour. The theories provide explanations that vary from focusing on factors that are attributable to the exchange relationship between the client and the consultants (as is the case with transaction cost economics and embeddedness theory) to factors that should be considered external to said relationship (as is the case with signal factors and legitimacy-seeking).

	Focus on factors external to immediate exchange relationship	**Focus on factors internal to immediate exchange relationship**
Focus on cost considerations	Signalling theory	Transaction cost economics
Focus on sociological mechanisms	Sociological neo-institutionalism	Theory of embeddedness

Table 1 Four different views on management consultants, adapted from Armbrüster (2006)

2.1.3 Consultants in Healthcare

Despite the fact that managerialist ideas have started to dominate over the last decade in the healthcare sector, surprisingly little research has been done on the subject of how consultants are perceived by medical institutions.

Out of the few studies conducted in this area, Badrick & Preston (2002) explore how consultants have contributed to the implementation of TQM in Australian healthcare. Their study shows that there seems to be a difference between public and private actors in terms of use of external management consultants in implementation activities. Firstly, private actors are keener to engage in long-term relationships with consultants, as opposed to public actors, who mostly seek advice for

short-term projects. Secondly, private actors perceived the value of hiring consultants as higher than their public counterparts did.

2.1.4 Limitations in Existing Research about the Role of Consultants

None of the theories on management consultants sufficiently describe the effect that the institutional environment has on the relationship between client and consultant. By recognizing the impact of external factors on this relationship, instead of a mere consideration of cost or networking abilities, sociological neoinstitutionalism and signalling theory however open for such interpretations. Still, in the myriad of studies performed on management consulting in the 1990s, few actually explored the differences in factors that lie beyond the immediate client-consultant relationship and its effect on consultancy. Some researchers, however, have deciphered the contextual differences by recognizing that national business systems bare different characteristics, depending on history, cultural legacy and the large breadth of practices that the broadly defined system of capitalism allows and accounts for. For one, Powell & DiMaggio, expanded the idea of isomorphism set by renowned consultants, and recognized (1991) the cultural and normative elements of societies and how these affect isomorphic relationships between institutions. By doing so, they laid the foundations for their concept of new institutional theory, which in turn led to a diffusion of studies whose aim was to link the institutional context to organisational and individual behaviour.

2.2 Institutional Theory

This section reviews literature concerning new institutional theory and introduces the concept of institutional logics.

2.2.1 New Institutionalism

According to Scott (2008), institutional theory is "*a widely accepted posture that emphasizes myths, isomorphism and legitimacy"*. In that sense, it deals with the process of transforming schemes, rules, norms, routines and ditto structures into *authoritative guidelines for social behaviour* (Scott 2004). These guidelines are substantialized by *institutions*, i.e. social structures that are characterized by stability and resilience (Scott 1995).

Much in line with Powell & DiMaggio (1991), Scott argues, that stability and resilience of institutions is dependent upon cultured-cognitive, normative and regulatory elements, which he names as the three pillars that build up a *common meaning system*, which in turn incorporates a web of organisations that interact with each other on a frequent basis. This network of organisations he names as the ***organisational field.*** The organisational field can e.g. consist of companies that operate within the same value chain.

2.2.2 Institutional Logics

The term ***institutional logics*** was coined by and developed by Friedland & Alford (1985; 1991), and later revised by other authors (e.g. Haveman & Rao 1997, Thornton & Ocasio 1999; 2004 and Scott 2000). Whereas rooted in the same concern about how cultural and societal aspects shape organisational structures, Friedland & Alford (1991) recognized institutional logics as the defining

factor in shaping content and meaning of institutions. Authors propagating this approach to institutional analysis (Friedland & Alford 1991, Thornton & Ocasio 2004), as opposed to new institutionalists such as Powell & DiMaggio and Scott, shift the focus from isomorphism within the society and organisational fields to the different institutional logics' effects on organisations and individuals in a broader spectrum of contexts, such as the market. Thus, they seek to explain the link between institutions and the action and behaviour of individuals and organisations.

In 1985, Friedland & Alford argued for three main institutional orders, i.e. capitalism, state bureaucracy and political democracy, contending for how individuals engage in politics through the different practices and beliefs that they yield. In their paper from 1991, they argue that each of the institutional orders that they deem relevant for the Western society (adding family and religion to the three named above) has a central logic that guides its ideology and organizing practices and provides both motive and identity for organisations and individuals. These central logics constrain the means and ends of behaviour among social actors, as well as they – somewhat paradoxically – provide a basis for change. The authors argue that change, transformation and agency in the society is an effect of discrepancies between the institutional logics that in turn give the organisations, and individuals acting within it, the cultural resources needed it.

Envisioned by Friedland & Alford in 1991 and empirically developed by Thornton & Ocasio (1999), the ***interinstitutional systems model*** is a tool for institutional analysis. Presented in a matrix, the x axis contain the institutional orders that represent the symbolism and practices of a certain area of life and acts as a frame of reference for individual and organisational decision making and behaviour. These systems of governance are materialized in the aforementioned institutional orders of the capitalistic market, the bureaucratic state, the Christian religions and the nuclear family (Friedland & Alford 1991), but can also relate to the institutional order of profession, community or even the specific corporation (Thornton & Ocasio 2004). The y-axis represents the categories – or building blocks – that each of the orders are composed of. They describe the set of organisational behaviour and practices that the orders are characterized by, and explain the organizing principles. Thornton & Ocasio recognize the root metaphors, sources of legitimacy, identity, norms, and authority and the basis of attention as the most relevant, albeit they emphasize that the types need to be tailored to the specific profession and corporation analysed (Thornton & Ocasio 2004). An overview of the typology is presented in *table 2*.

Categories	Family	Community	Religion	State	Market	Profession	Corporation
Root Metaphor	Family as firm	Common boundary	Temple as bank	Redistributor	Transaction	Relational network	Hierarchy
Sources of Legitimacy	Loyalty	Unity	Faith	Democracy	Share price	Expertise	Market position
Sources of Authority	Patriarchal	Commitment	Priest	Bureaucracy	Shareholder activity	Association	Management
Sources of Identity	Reputation	Emotional connection	Association with deities	Class	Faceless	Reputation	Roles
Basis of Norms	Household	Group	Congregation	Citizenship	Self-interest	Association	Employment
Basis of Attention	Status in household	Investment	Relation	Status of interest group	Status in market	Status in profession	Status in hierarchy
Basis of Strategy	Increase honour of family	Increase status & honour of members	Increase symbolism	Increase community good	Increase efficiency profit	Increase personal reputation	Increase size & diversification
Informal Control	Family politics	Visibility of action	Worship	Backroom politics	Industry analysts	Celebrity professionals	Organisation culture

Table 2 Typology of institutional logics, adapted from Thornton & Ocasio (2004)

Thornton & Ocasio (1999) see institutional logics as the link between individual agency and cognition and societies' institutional patterns and rules. As the authors argue, however, although approaches to institutional logics emphasize different things, they all recognize that individual and organisational behaviour is rooted in a social and institutional context that outlines said behaviour and inhibits a possibility for change.

Based upon the findings of Thornton & Ocasio (1999), researchers have continued to develop the understanding of the effect that institutional logics have on behaviour by applying it to different organisational fields and studying the co-existence and dependability of different logics within industries.

Washington (2004), Reay & Hinings (2005) and Greenwood (2011), in particular, recognize that organisational fields and industries often are subject to multiple, sometimes conflicting, institutional logics. Most previous studies have focused on the dominance of single logics in terms of their effect on the structure of organisational and individual behaviour (e.g. Reay & Hinings 2005), but as Greenwood (2011) and Lounsbury (2007) note, relatively little is known about how multiple logics affect organisational response.

Some researchers have explored how value systems, or logics, may change over time. Caronna (2004) e.g. argues for a historical stance when she recognizes the changes in institutional logics in US healthcare, and how the political climate and the competing logics of profit and non-profit organisations have changed the healthcare field over the last decades. However, the context of the geographical setting is generally less explored by researchers. While some had previously shown an interest for geographical communities, i.e. countries and regions, (e.g., Guthrie et al. 2008, Lounsbury 2007, Marquis & Lounsbury 2007, Marquis & Lounsbury 2007, Romanelli and Khessina 2005), Greenwood (2011), explore the link between the geographical setting and the pressure of community logic on organisational behaviour. Their study showed – perhaps unsurprisingly – that organisations that are regionally concentrated, visible (which mostly attributes to their size) and considered significant in their regions are the ones affected the most by the logic of the region. Thus, they become the carriers of the logic. Their study is particularly interesting for this thesis, as they both explore the effect of several different non-market logics on organisations, but also place their study in a geographical context. The study was set in Spain, which, the authors argue, is burdened by historically competing logics of the state; one centralised and one regionally enforced.

2.2.3 Institutional Logics in Healthcare

The healthcare industry, many researchers agree (Scott 2000, Caronna 2004, Caronna 2013, van den Broek et al 2014, Reay & Hinnings 2009), is an industry that is characterized by a complex structure with different actors and stakeholders pursuing different goals and inhibiting many different values. Scott (2000) recognized four different actors that build up the organisational field of healthcare: 1) organisations with governing authority, e.g. public agencies, corporate systems and professional associations; 2) purchasers, i.e. patients; 3) providers, i.e. hospitals, clinics and medical professionalists; and 4) intermediaries or payers, i.e. insurance companies and health funds.

Goodrick & Reay (2011) use a historical perspective whilst analysing how changes in multiple institutional logics affect the professional work of pharmacists. Dissimilarly to Caronna, however, they recognize the problem of defining institutional logics that are applicable at the level of professional work, rather than at the societal level (as done by e.g. Thornton & Ocasio 2004). In order to solve this problem, the authors take on a segmentation approach, which draws from the fact that professional work is performed differently across different geographical locations, and even between professionals working in the same organisation. Thus, they argue, professional work can be segmented by the influence of different institutional logics. In their study, they recognize the ideal types of market, professional, state and corporate logic and define these extremes by tangible characteristics. In a world dominated by professional logic, organisations would e.g. be completely controlled by the profession. In an ideal market logic world, organisations would operate in an unregulated, free competition and consumer preferences would be the sole determinant of success (Freidson 2001). A state logic utopia would incline that the government takes direct responsibility over professional work. Lastly, if corporate logic would dominate, work would be encoded in routines and subject to managerial control, steered by corporate hierarchy (Thornton 2004).

The authors found no completely dominant logic; rather, all of the logics were present in the studied organisations to some extent, and affected organisational practices. In line with this, van den Broek et al. (2014) studied the effect conflicting multiple institutional logics may have on an

implementation of an innovative practice in healthcare in the Netherlands. The authors found that when a practice aimed at empowering nurses in Dutch hospitals was introduced, there existed two – to some extent – conflicting logics of profession among nurses and business among managers and directors. They were scrutinized by the different aims of the professional groups, as the nurses were more inclined to strive for a greater quality of care, whereas management aimed to increase the efficiency of the ward.

Other researchers have also suggested that as ideas that are perhaps usually more connected to business management are being increasingly recognized even in public healthcare institutions (Kipping & Wright 2012), a conflict of logics is bound to increasingly affect the healthcare system. As hospitals and clinics undergo "managerialisation", they become subject to corporate routines and practices (Caronna 2004).

2.2.4 Limitations in Existing Research About Institutional Theory

Albeit researchers have begun to explore the link between institutional logics, their multiplicity and characteristics, and organisational action (e.g. Reay & Hinings 2005, Greenwood 2011), few (see Greenwood 2011 for an exception) have explored this link in a specific organisational field and in a specific national context. Many studies, and among them those conducted in the healthcare sector (e.g. Scott 2001, Caronna 2004), concentrate on the US market. As Greenwood (2011) accurately observes, however, the logics prevalent in organisational fields are intertwined with the history of the region and its economic and political preconditions, which may be deeply rooted in the system. What is true in one healthcare system may not necessarily be true in others.

2.3 Addressing the Research Gap

Research, concerning the role and view of consultants in business and the effect of institutional logics respectively, give important insights about the possible role that consultants can have and how the view and behaviour of different actors can be influenced by the institutional context. Both research fields have however their limitations. In order to begin to fill these research gaps, this study aims to explore how the view and perception of external consultants in healthcare is shaped by identifiable institutional logics in the Polish healthcare system.

By setting this study in Poland, a young democracy with a specific history and significant growth rates, the authors of this study recognize the influence that national conditions may have on the prevalence of certain logics in the healthcare system. By doing so, this study contributes by exploring how the enactment of institutional logics may differ across contexts, and aims to expand current knowledge about how logics may shape organisational actors' views and behaviours in different ways depending on the characteristics of the field.

2.4 Theoretical Framework

By drawing on insights from the literature on management consultants and the literature on institutional theory, this study provides an integrated analytical framework that will allow us to explore the link between context and the potential view on consultants and address the limitations in both these research streams.

Our study of the view on consultants in the healthcare field in Poland is defined by the realms of sociological neoinstitutionalism (see *table 1*). Sociological neoinstitutionalism recognizes that factors that are external to the direct relationship between the client and the consultants can influence the characteristics of the relationship. Thus, this study acknowledges the link between central logics of institutions and individual and organisational behaviour, in accordance with e.g., Powell & DiMaggio (1991), Scott (2000), Thornton (2004) and Caronna (2004), as well as the prevalence of multiple institutional logics in healthcare organisations, as previously shown by Caronna (2004), Reay & Hinings (2005) and van den Broek et al (2014). Furthermore, this study draws from the contribution of Greenwood (2011) who indicated the effect of the national context on the composition of different logics in the organisational field.

Different typologies of institutional logics have been previously identified by e.g. Friedland & Alford (1991), Thornton & Ocasio (1999), Reay & Hinings (2005) and Greenwood (2011). The typology of Thornton & Ocasio (1999) is the most theoretical of these. Further developed by Thornton & Ocasio (2004) and Thornton et al. (2012) (as presented in *section 2.2*) it presents seven different central logics in institutions that the authors deem as effectual on today's Western society. The authors of this *interinstitutional model* (Thornton & Ocasio) have however noted that the model and its typologies need to be considered as metatheoretical, abstract reflections of logics that can differ between different contexts. In subsequent studies, researchers have recognized the phenomenon of co-existence and conflict of different logics (Caronna 2004, Thornton, Jones & Kury 2015, van den Broek et al 2014 among others), which seems to confirm that the concrete composition of different logics within different systems is far more complex than the typologies would suggest. We therefore choose to not develop utopian definitions of any of the logics, as opposed to e.g. Goodrick & Reay (2011).

Similarly, researchers that have been concerned with the phenomenon of management consultancy have seen fit to view consultancy in a myriad of different ways, and the classifications of the roles that consultants play in business are many. All in all, however, the discussion concludes that management consultancy has both its criticisers and its advocates. Some see consultants in a positive light; e.g. as experts or carriers of important knowledge, or negatively, as e.g. opportunists and carriers of fads (Armbrüster 2006). Albeit recognizing what previous researchers have established, the theoretical framework of this study, see *figure 3*, focuses utmost at two central phenomena:

1) The fact that institutional logics exist in some setting or another within a certain institutional context and that they affect organisational behaviour

2) That management consultants may be viewed in a positive or negative way

By applying this framework on the healthcare field in Poland, we seek to understand how the composition of institutional logics affects the view on management consultants among healthcare providers.

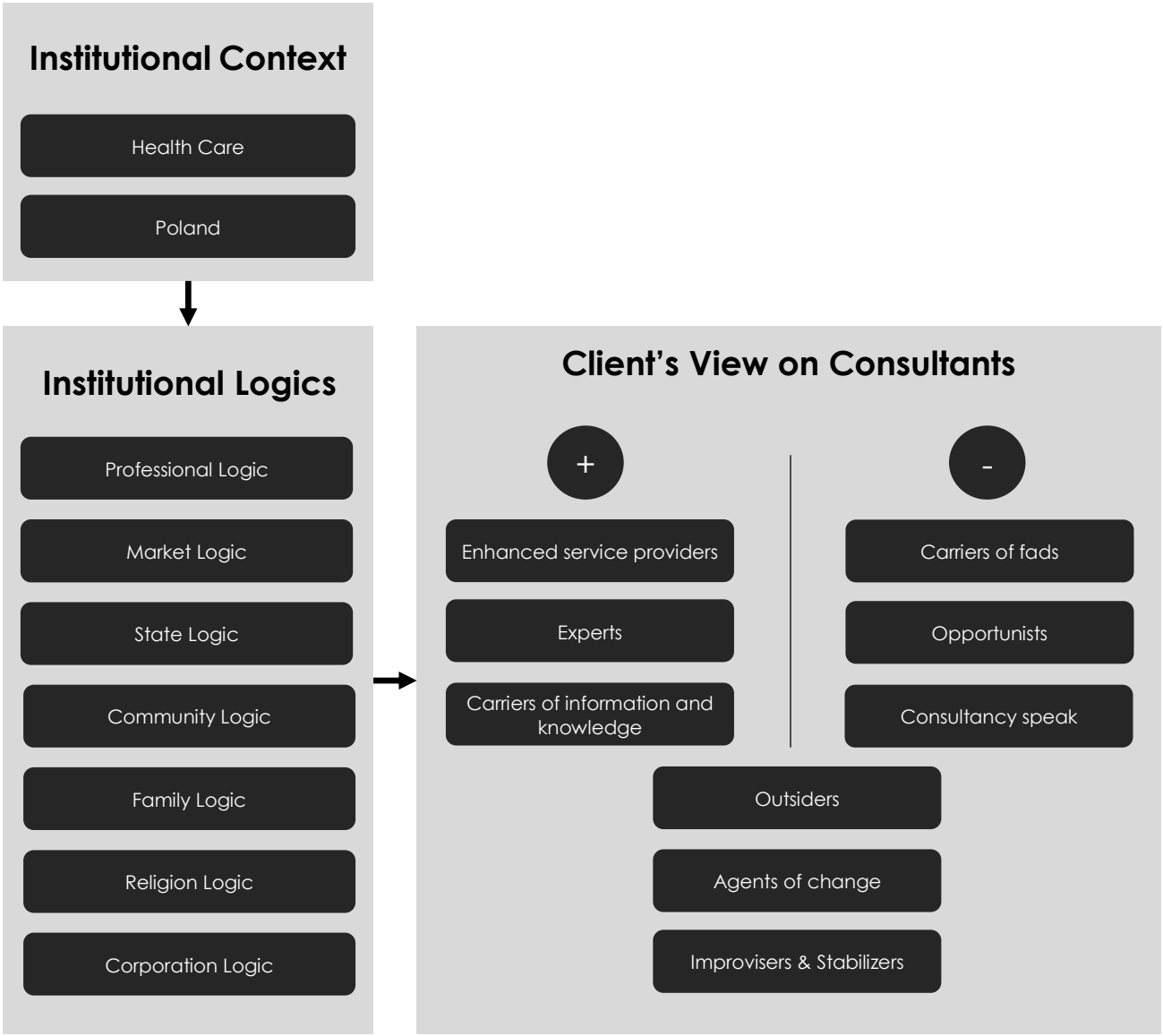


Figure 3 Theoretical framework of this study

3 Methodology

This section describes the methodology used to conduct this study. It begins by outlining the sociological paradigm that lies at the heart of it and continues by explaining the exploratory study approach. We then discuss the research method and outline data collection, and analysis. This chapter ends with a discussion of the study's validity and reliability.

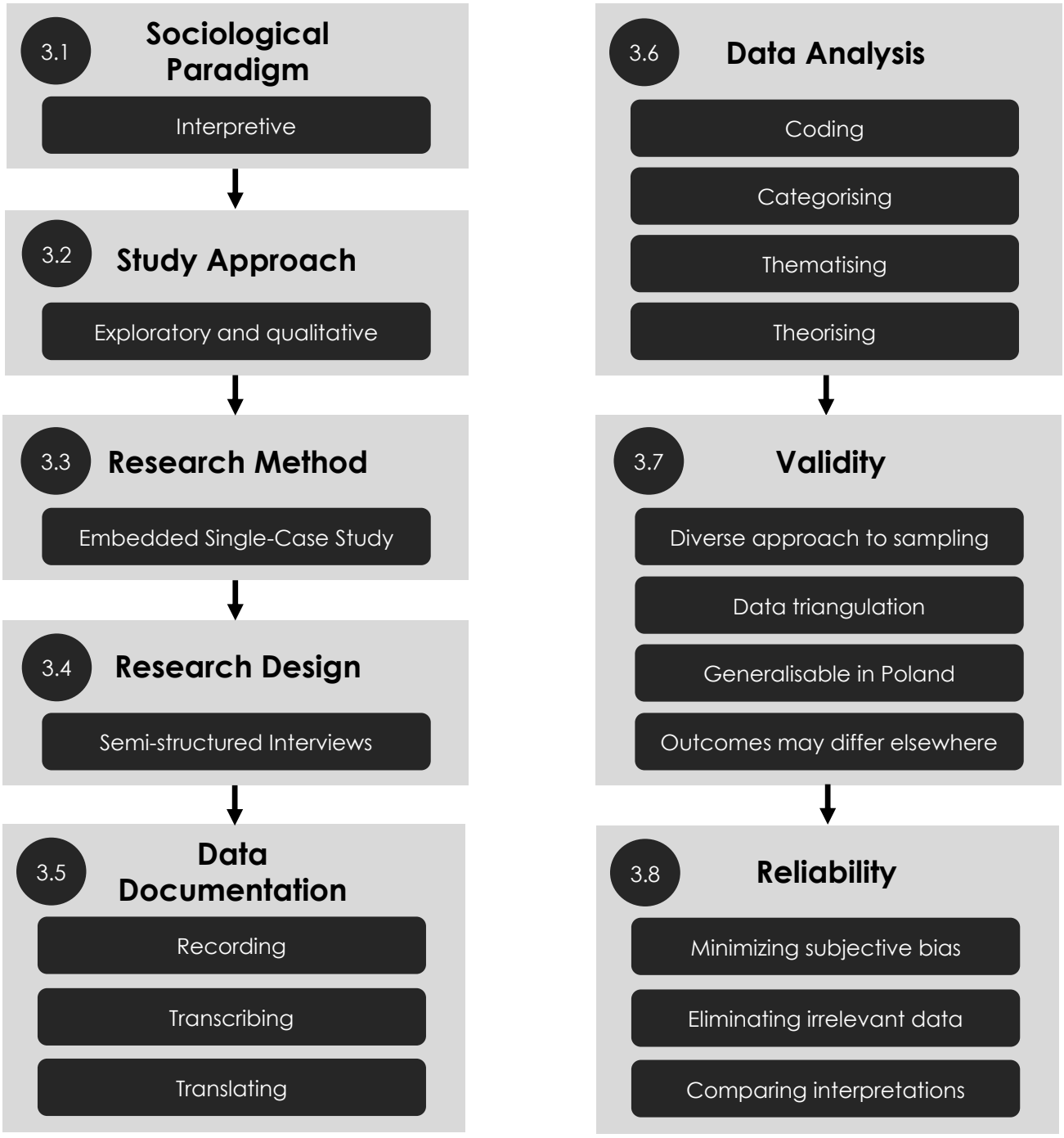


Figure 4 Rhetorical structure of chosen methodology

3.1 Sociological Paradigm

All researchers, consciously or not, follow a research paradigm, which in turn has consequences for the use of theories, questions and methods (Burrell & Morgan, 1979). According to Burrell & Morgan, see *figure 5*, there are four main research paradigms for the analysis of social theory: (a) radical humanist, (b) radical structuralist, (c) interpretive and (d) functionalist. These are based on different assumptions about reality. Paradigms that are objective by nature see, foremost, reality as independent from human explanations of it, whereas subjective paradigms see reality as socially constructed. The sociology of radical change assumes that conflicts are natural and even necessary elements of societies and organisations, in contradiction with the sociology of regulation, which sees organisations and societies as moving towards stability and order.

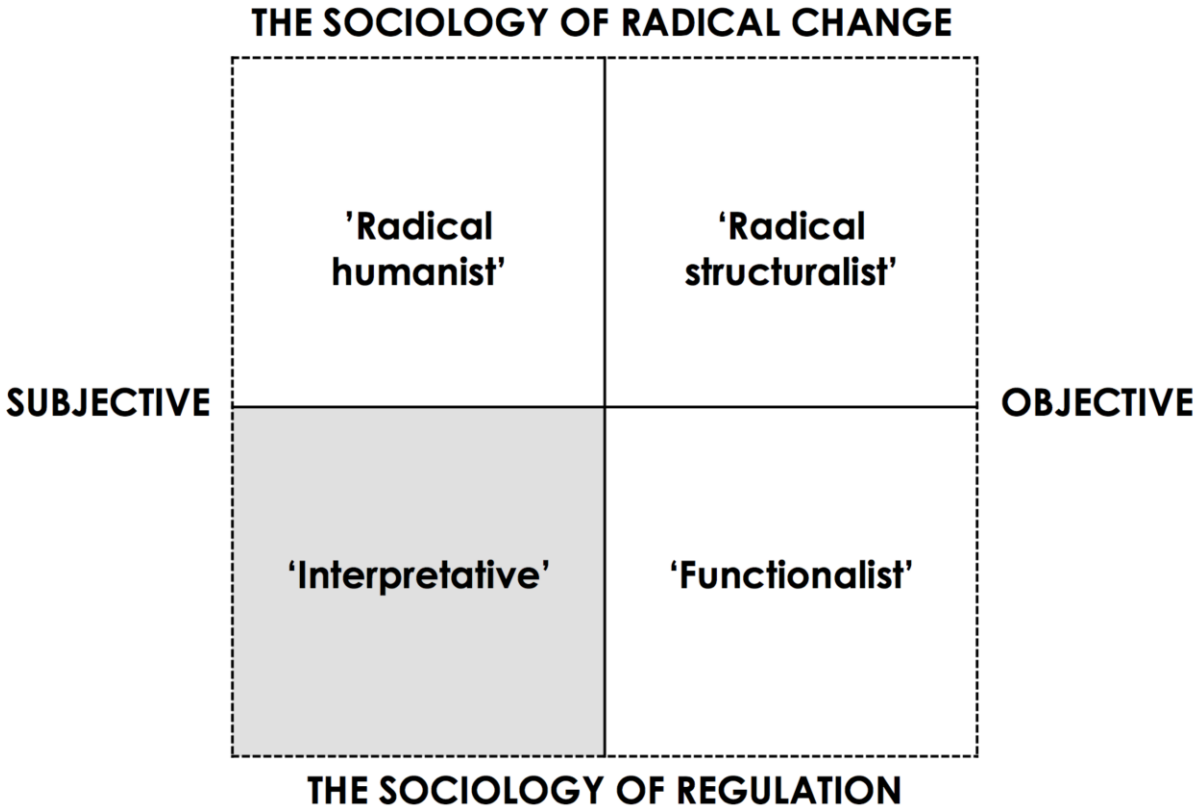


Figure 5 Four paradigms for the analysis of social theory (Burrell & Morgan, 1979)

The authors of this study have chosen to follow what Burrell & Morgan define as the ***interpretive paradigm*** – i.e. "*seeking explanation within the realm of individual consciousness and subjectivity, within the frame of reference of the participant as opposed to the observer of action*" (Burrell & Morgan, 1979). The reason for this is that, in conformity with Angen (2000) and others who perceive knowledge as perspectival, the authors take an interpretive stance and acknowledge findings to be incomplete and open to reinterpretation. By following this paradigm, this study seeks to understand motives and intentions behind actions.

3.2 Study Approach

The research gap, which was identified in *section 2.3*, shows that previous research has been insufficient in describing the link between institutional logics affecting behaviour and the perception of external consultants. Therefore, we have found a causal or descriptive approach as inappropriate for this study. Causal designs (as described e.g. by Shrejesh 2014, Bryman 2012) often involve concrete theoretical standpoints and hypothesis testing. Although some previous researchers have managed to explore the link between institutional logics and behaviour in healthcare, no theorisations have been made on their effect on the client's view on management consultants. This makes the formation of any hypothetical stances highly questionable. Descriptive designs, in turn, often make use of quantitative data collection through surveys and pre-determined questionnaires (Shrejesh 2014). In the case of this study, quantitative measures would be inappropriate because of their preconceived limitation of scope. As a result, they may have difficulties in capturing the breadth of the relatively unexamined phenomenon, which this study aims to explore.

We have therefore settled to rely upon an ***exploratory, qualitative approach***. This methodology is seen by a large number of authors as appropriate for studying phenomena that have not been fully understood and examined before (e.g. Edmondson & McManus 2007 p 1155, Shrejesh 2014, p 31 f., Bryman 2012). Shrejesh (2014) notes that qualitative research gains flexibility to adapt to different situations and can therefore capture phenomena that may be out of reach for descriptive and causal studies. The same author also points out the value of obtaining visceral feedback from respondents through qualitative methods, thus making the results less data-centric and open for richer interpretations. At the same time, explorative studies are not aimed at producing a definite end result. They lack, therefore, the preciseness of quantitative research approaches, which can be statistically analysed. On the other hand, explorative studies are appropriate for framing a phenomenon and provide an understanding that could act as a basis for future quantitative research.

3.3 Research Method

In order to achieve the best possible methodological fit towards the overarching research purpose (Edmondson & McManus 2007), this study is built on a **case-based method** of research. The well-known authority in the field of case study research, Robert Yin, defines the term 'case study' as *"an empirical enquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident"* (Yin 2014: 14). Case studies as a relevant method in qualitative and exploratory studies have been lifted by researchers on both a general level (Yin 2014) and for health science studies, as it enables both flexibility and accuracy. It has been argued that qualitative case studies have the advantage of facilitating examination of certain phenomena within a specific context, while taking advantage of data from multiple different sources (Baxter & Jack 2008).

Yin (2014) argues that case studies are the most appropriate method of research, when the study (a) aims to answer questions of 'how' and 'why', (b) when the behaviour of actors involved in the study cannot be manipulated by the researcher, (c) when there are contextual conditions that have bearing on the studied phenomenon and lastly (d) when there are unclear boundaries between said context and phenomenon. Given the exploratory approach of the study and the fact that previous research on

the subject is scarce, the question of 'how' is the most important for us to answer (a). This, in turn, means that the main aim of the study is to understand how the studied actors view consultants (b). Also, the institutional context that may affect the perception of consultants, expressed through the various institutional logics, is the main focus of this paper (c). Finally, the boundaries between the context and the view on consultants are not clearly defined (d).

3.3.1 Case Study Design

Methodology literature recognizes several types of case studies (Yin 2014, Baxter & Jack 2008, Bryman 2012), depending on the targeted outcome of the study, albeit the most pertinent typology divides case studies in *single-* and *multiple-case studies*. Although the method of using multiple cases has been lifted as more robust and reliable (Baxter & Jack 2008), we deemed a single-case study to have a better methodological fit to the research question.

As the objective of this study is to explore how the view on external consultants is shaped by the institutional logics prevalent in the Polish healthcare system, we are *"interested in capturing the circumstances and conditions of an everyday situation […] because of the lessons it might provide about the social processes related to some theoretical interest"*, which is what Yin (2014: 52) defines as the common case and a rationale for choosing a single-case study. Thus, we define Poland as a single case. Initially, we considered studying multiple countries and comparing them to increase the robustness and reliability of the study. However, as Yin (2014) states, there is a risk that the conduct of a multiple-case study requires extensive resources and time beyond the means of independent research investigators (Yin 2014). We acknowledged this and concluded that, given the limited time resources that constrain this master thesis, it would be more valuable to study a single case and do an in-depth analysis of Poland, rather than scratch the surface of multiple healthcare systems in different countries. This conclusion is confirmed by Eisenhardt & Graebner's (2007: 30) findings: "*single cases can enable the creation of more complicated theories than multiple cases, because single-case researchers can fit their theory exactly to the many details of a particular case*".

Within the single-case design, Yin (2014) distinguishes between *holistic* and *embedded* designs. Both are considered single-case designs, but holistic designs have a single unit of analysis, whereas embedded designs have multiple units of analysis. The holistic design is beneficial when *"no logical subunits can be identified or when the relevant theory underlying the case study is itself of holistic nature"* (Yin 2014: 55). However, this design also poses some problems. Firstly, there is a risk that the entire case study is conducted at a too abstract level. Secondly, the whole nature of the case study may shift, without the researcher knowing, during the course of study. One way to increase the sensitivity to such an unanticipated shift is to have several sub-units of analysis. Hence, an embedded design can function as a useful method for focusing a case study inquiry. Furthermore, an embedded design can increase the chances for extensive analysis, enriching the insights from a single case (Yin 2014: 55). Thus, in order to avoid an unduly abstract level, reduce the risk for an unanticipated shift of the whole nature of the case study, and finally to enhance the insights from our study, we decided to do an ***embedded single-case study***. Thus, although we consider Poland to be a single case, we have multiple subunits of analysis in order to explore the phenomenon in the best possible way.

3.3.2 Empirical Setting of the Case

This section introduces the Polish healthcare system, which sets the boundaries of the study. To start with, the overall structure and the main stakeholders will be presented, according to the stakeholder model in healthcare, developed by Scott (2001). The second part focuses on the financing system. The final part introduces how decision-making and responsibilities are divided between the actors in the system.

3.3.2.1 Structure

In brief, the Polish healthcare system is comprised of five main stakeholders (adopted from Scott 2000): *tax-paying employees, policy-setting politicians, healthcare-service payers, healthcare-service providers* and, of course, *patients*.

All Polish ***tax-paying employees*** pay a social insurance, which is comprised of 7.75% of the income tax and 1.25% of the income, to the Social Insurance Institution (ZUS), which then allocates to money the National Health Fund (NFZ). The NFZ then allocates the resources to its regional branches that in turn allocates funds to the different service providers based on providers' needs (i.e. the number of patients and types of services provided).

The ***politicians*** play a large role in the system by setting policies and national strategies. The Ministry of Health is the main health policymaker and is responsible for the national health policy, investments, research and education.

The National Health Fund (NFZ) is the main financer of healthcare, as well as the contractor of most healthcare services. As mentioned above, the NFZ finances healthcare services from collected insurance fees. It also covers the costs of medical services provided to Polish citizens within the EU. The fund is forbidden to engage in profit-generating activity and cannot own any healthcare service provider.

Healthcare providers are public and non-public healthcare units, as well as individual and group medical practices.

> ***Non-public providers*** (NZOZ and private practices) are organisations contracted by the NFZ to provide health care services. The NZOZ is not a legal form and does not have legal capacity, but can be owned by a company or a foundation, which is responsible for its obligations. Several private companies own a number of private outpatient clinics and hospitals, thus dominating the market for privately own healthcare. Non-public providers also dominate the primary and ambulatory care market in Poland. Providers which are owned by private companies will be henceforth addressed as ***private providers***.
>
> ***Public providers*** can be established by local authorities (voivoideships, powiats and gminas), as well as by state universities, and are contracted by the NFZ. They can take the form of autonomous health care units (SPZOZ), research institutes and budgetary units, whereas the latter have no legal personality and are financially dependent on budgetary allocation.

Patients in Polish healthcare do not have to pay any fees when going to the doctor. For almost all working Polish citizens, there is an obligatory universal health insurance and there is no possibility of opting out. However, many Poles are additionally covered by private medical subscriptions paid for by their employers. Yet others choose to pay for private healthcare via out-of-pocket payments. (Sagan et al. 2011)

3.3.2.2 Financing Systems

Polish healthcare is financed through *the government financing system*, *the social insurance system* (both public) and *the private financing system*. See *figure 6* for a financial flowchart of the five main payers.

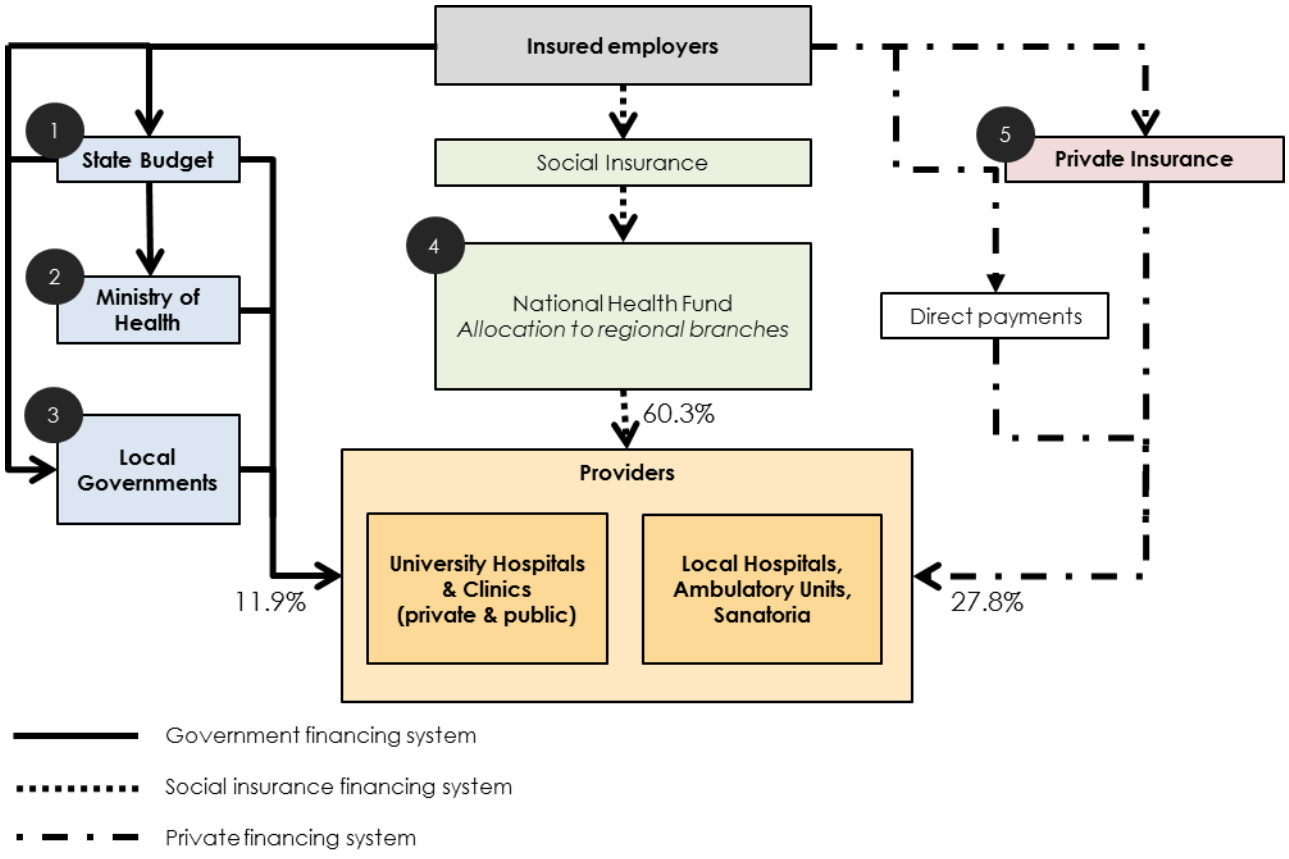


Figure 6 General Financial Flowchart with the five main payers, adopted from European Observatory (2015)

3.3.2.3 Government Financing

11.9% of the total expenditure on healthcare is financed by the state budget, either by the government directly (in rare cases), the Ministry of Health (for emergency services and special equipment) or through the local government. The vast majority of government funding for health care is accounted for by local authorities, which run public hospitals in their respective regions, whereas stately controlled funding has rapidly decreased over the past decade. (Sagan et al. 2015)

3.3.2.4 Social Insurance Financing

83.5% of the public expenditure is funded by the social insurance financing system. Every working Polish citizen pays social insurance to the Social Insurance Institution (ZUS), which then allocates the 7.75% of the income tax and 1.25% of the income to the NFZ. The NFZ then allocates the resources to its regional branches, which subsequently act as the main financers of healthcare services provided by the contracted public and non-public providers. (Sagan et al. 2015)

3.3.2.5 Private Financing

Nearly 28% of the total health expenditure in Poland is financed from private sources. The vast balk of this sum is paid by out-of-pocket, or direct payments, from patients (nearly 70%), however this figure has been steadily falling (with over 20% since 2004). Most of these payments account for purchases of medicinal products. The remaining expenditure is covered by voluntary health insurances, a market that has seen rapid development since the early 2000s. (Sagan et al. 2015)

3.3.2.6 Decision-Making and Responsibilities

Most healthcare providers are owned by the local governments, which are divided into three levels of administration. As owners, these have supervisory as well as limited managerial responsibilities. Those hospitals that are not owned by public actors are owned by private firms and corporations. In the case of clinics and hospitals owned by private companies, the managerial situation is quite different. Albeit most of them are dependent upon their contract with NFZ, many of them receive financing from private sources. Thus, many private owners have the mandate to take operational and managerial decisions that can alter the structure and the volume of the providers' services (Sagan et al. 2015).

3.3.3 Subunit Sampling

The sampling of interviewees for this study was limited to three categories (see *table 3*). The first category is comprised of healthcare providers. These were selected from different geographical locations and also categorized by type of ownership (public vs. non-public). The second category is management consultants with experience from working with healthcare providers. The third category consists of external industry experts that academically study the Polish healthcare market. The rationale behind these categories is that providers act as the primary source of empirical data for which institutional logics healthcare providers within in the Polish healthcare field enact and how healthcare providers perceive management consultants. The second and the third category can then provide a deeper understanding of the phenomenon. By using multiple reference points, we can triangulate the empirical data to check interpretations, reveal alternative meanings and form a better understanding of the situation**.** ***Triangulation*** is an established method (e.g. Duneier 1999: 345–347) for making the findings as robust as possible.

	Category type	Sub-categories
Category 1	Healthcare providers	a) Public b) Private
Category 2	Management consultants	-
Category 3	Industry experts	

Table 3 Case categories used in the study

3.4. Data Collection

This study is based on data from 20 interviews conducted with 21 different individuals. 7 of these are management consultants, 6 are industry experts, and 16 of them had professional experience of 10 different healthcare providers in Poland. Out of these providers, 5 are publicly owned and 5 privately owned. Please note that one interviewee can belong to several categories (e.g. healthcare provider and management consultant). The interviews were conducted between March 27th and May 13th 2015. The interviewees were situated in Warsaw, Poznań, Kraków and Wrocław. 11 of the interviews were conducted face-to-face on different locations in Warsaw and Poznań. The rest of the interviews were conducted via telephone. 15 of the interviews were conducted in Polish, whereas the rest were conducted in English. The average length of the interviews was 40 minutes. The following sections outline the design and setting of the interviews and describe the process and criteria for selecting relevant interviewees.

3.4.1 Research Design

Qualitative research, according to Shrejesh (2014), can be performed using three main research techniques; (a) *depth interviews*, (b) *focus groups*, (c) *projective techniques*. Unlike (b) and (c), interviews are usually performed individually and consist of a conversation between interviewer and interviewee. Individual depth interviews can differ in their structure, from almost completely unstructured to standardised. The first give the interviewee the freedom to steer the conversation in a self-imposed direction, whereas the latter are based on a scenario predetermined by the interviewer, often concerning a concrete subject and theoretical hypothesis (Shrejesh 2014).

Among others, Saunders et al. (2009) and Edmondson & McManus (2007), praise ***semi-structured interviews*** as an especially relevant technique for conducting explorative studies. They have noted the value with allowing a certain amount of flexibility for both interviewer and interviewee. The first has the chance to steer the conversation into the right direction, while also being able to adapt further questions to the received responses. The interviewee has the flexibility to supply information that might add another dimension to the discussed topic. However, if the interviewee is given too much

flexibility, the discussion may result in unanticipated outcomes, that are not in line with the researchers' topics (Shrejesh 2014).

In order to deflect unwanted bias and to keep the conversation on track, the interviewers had a set of ten main questions that were asked during all of the interviews, while opening for a broader discussion within these main themes. These questions are presented in *Appendix 10.1*.

3.4.2 Selection of Interviewees

In the case of healthcare providers, the criteria for selection of interviewees were based on the position, responsibilities and the potential experience with work together with external consultants of the interviewee. In order to provide a holistic view on providers, both managers and professional doctors were subjects to interviews. Where opportunity was given, two or more members of the same organisation were interviewed.

In addition to representatives of healthcare providers, management consultants working in Poland were also asked to give their opinions on how their clients view them, and how providers' behaviour is affected by the different logics in the healthcare system. The main criterion for selection for these interviewees was their prior experience of clients in the healthcare field. The interviews were conducted both at small consulting firms, niched towards the healthcare market, as well as big, international consulting corporations that provide general consulting services.

Interviewees classified as industry experts were chosen based on their area of academic research. The area of general medicine and health economics were deemed as most relevant for this study.

3.4.3 Presentation of Interviewers

The two interviewers, nota bene also the authors of this study, have similar academic background and have studied management on a Master's level at Stockholm School of Economics. Both of the interviewers are fluent in English, whereas one of them is also fluent in Polish, which was the main language in which most of the interviews were conducted.

3.5 Data Documentation

All of the interviews were recorded in audio form. Additional notes were taken during the interview in order to preserve the impressions of the conversation. The recordings were later played in their entirety and transcribed in detail in the language they were recorded in. In those cases it was necessary, the transcriptions were translated to English. Each interview was discussed and summarized in bullet points by the two interviewers, in order eliminate bias resulting of misinterpretations. The recordings were used only for the purposes of this study and have been deleted since.

3.6 Data Analysis

Exploratory studies that are based on semi-structured interviews often generate a substantial amount of data. Some researchers have therefore suggested that the process of data collection often can overlap with data analysis (Edmondson & McManus 2007). In the case of studies that are concerned

with areas scarcely covered by previous research, this may prove to be difficult to conduct, and it may prove to be necessary to code and thematise the data into different categories. For one, Saldana (2009) argues for data coding being an "*exploratory problem-solving technique (…) that links data to an idea".*

Saldana (2009) also offers an extensive overlook of different approaches to what he labels as *first cycle* and *second cycle coding*. First cycle coding is concerned with how raw data is sorted into a systematic order, thus creating subcategories and categories of codes that inhibit similar characteristics in one or more dimensions. Second cycle coding concerns in turn how code categories are put in systematic themes. Based on this, he presents a *streamlined codes-to-theory model* that involves the processes of coding data to categories and thematising the categories, which later leads to the formulation of theory (*see figure 7*).

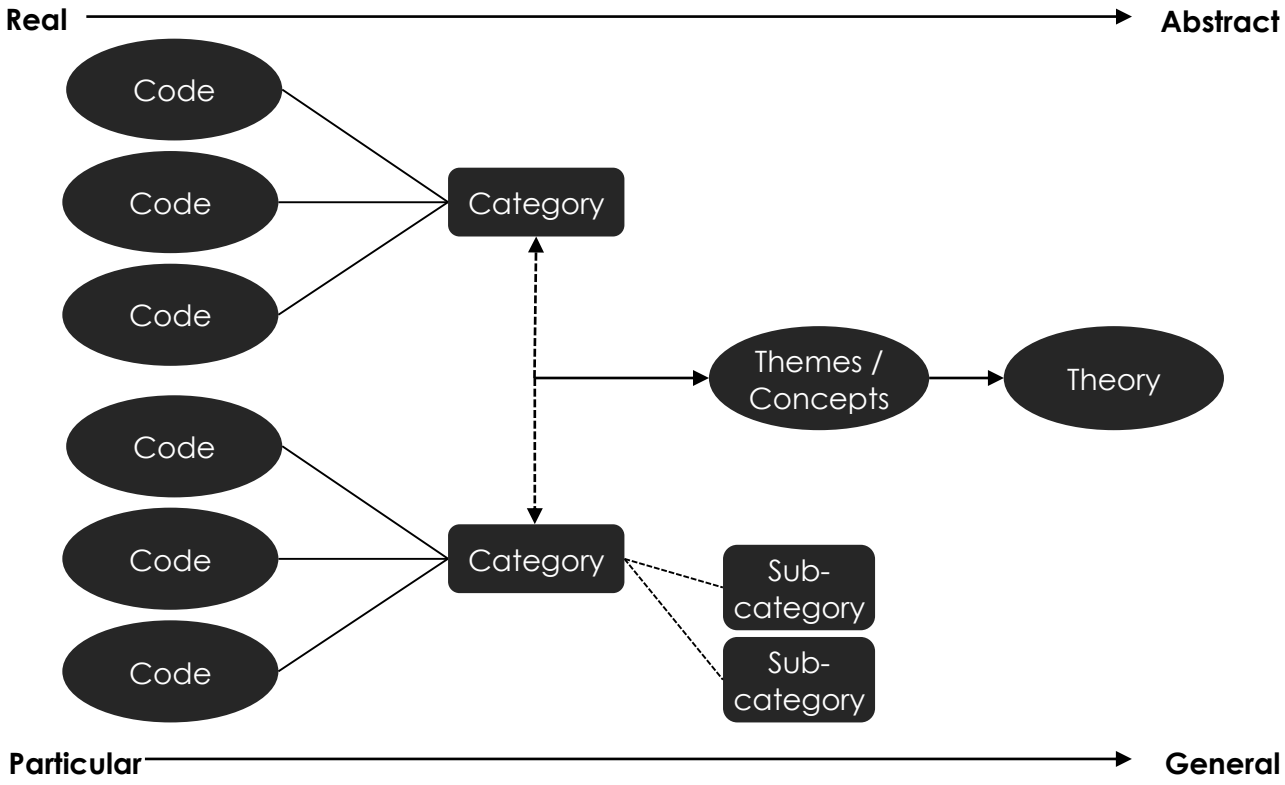


Figure 7 A streamlined codes-to-theory model, adapted from Saldana (2009)

The authors of this study used an inductive approach in order to code data. Thus, data from the interviews were coded based on raw data, rather than directly categorized by theory. Only after code generation, the codes were categorized by categories presented in the theoretical framework (i.e. the different institutional logics and the different categories of how consultants are perceived) using an abductive approach. Lastly, the categories of data were put into the two themes of institutional logics on one hand and the perception of consultants on the other through a deductive approach. An example of the data coding process is presented in *table 4*.

Code	Subcategory	Category	Theme	Theory
"The management of public hospitals is mostly senior doctors."	Doctors as a profession	Professional logic	Institutional logics enacted by public providers	The professional logic of doctors leads to scepticism towards management consultants.
"Many managers in the public sector think they know best and that no outsider should tell them what to do."	Consultants as outsiders in a negative sense	Negative view on consultants	The view on consultants by public providers	

Table 4 An example of the data coding process

3.7 Validity

One of the main criticisms towards exploratory research, and case study research design in particular, is the validity of the findings. Validity is defined as the degree to which the study actually reflects the reality and is often categorized in *internal validity* and *generalizability* (or external validity) (Yin 2014, Silverman 2010).

Internal validity to a large extent concerns the choice of the cases and the representativeness of the data collected through interviews (Yin 2014). As mentioned in section 3.3.2 about the sampling of cases, there is a vast range of techniques that seek to raise the internal validity of case studies. By selecting cases in different geographical and organisational settings, and likewise by selecting interviewees with different professional and academic backgrounds we have aimed to raise the representability of the outcomes through a diverse approach to sampling, and data triangulation.

The external validity, or generalizability, of the study in turn concerns how the outcomes of the findings can be applied on other cases, or even the whole population (Yin 2014). We recognize that the findings of this study may only be applicable to the general view on consultants among healthcare providers in Poland, and recognize that the outcomes may differ in other geographical regions, as e.g. Greenwood (2011) has proposed. For a more detailed discussion on what this may bring for future researchers, see *section 7.1*.

3.8 Reliability

The reliability of case studies has been frequently discussed in methodology research (see e.g. Bryman 2012) and Yin 2014). The reliability of research is often understood as the degree of how the findings of a study can be reproduced and interpreted by other researchers (Yin 2014). Among others, Silverman (2010) points out that research based on case study designs can contain subjective biases when it comes to interpreting data. This bias can be based on the researchers' preconceived notion of reality and inherent assumption about how the phenomenon is represented in reality (Flyvbjerg 2012). However, these biases can be minimized if the data is put under scrutiny and analysed from different perspectives (Bazeley & Jackson 2013). Data coding and thematising methods have also been cited as methods for restricting biases towards subjectivity in exploratory research (Saldana 2009).

By using an inductive data coding technique and encompassing a large portion of data in the first cycle of coding, the authors of this study have sought to eliminate the risk of bias. We were also careful to eliminate codes, categories and themes that may be seen as irrelevant for the specific research question which is the focal point of the study, by discussing the data thoroughly after each interview. The fact that one of the researchers comes from Poland whereas the other does not, which beds for potentially different interpretations of the outcomes, also works in favour of the study's objectivity.

Furthermore, we have aimed to raise the reliability of this study, by discussing the methodology choices with our supervisor, Anna Essén. Through an iterative process, we received feedback on our interviewing methods and analytical tools.

Nonetheless, the authors acknowledge that certain bias may be unavoidable but also agree with e.g. Flyvbjerg (2012), that the nature of case studies plays an important role in the conceptualisations of phenomena, which have not been explicitly scrutinized by previous researchers. By describing these phenomena, case study research creates a fundament for future research, which may prove or disapprove findings through e.g. quantitative hypothesis testing (Flyvbjerg 2012, Bryman 2012).

4 Empirical Findings

This section presents the empirical findings, which are based on data collected from the 20 interviews. The chapter is centred on the two themes of this study; the institutional logics that exist and affect behaviour in Polish healthcare and the view and perceptions of management consultants among healthcare providers in Poland. It consists of two sections. The first explores the multiple institutional logics that coexist in the field and explores how - and by whom - they are enacted. The second section explores data concerning the link between these logics and the view on consultants among different providers. Each of the sections features a presentation of data, which is based on the process of data coding and thematising presented in *section 3.6.* For an overview of the structure in this chapter, see *figure 8*.

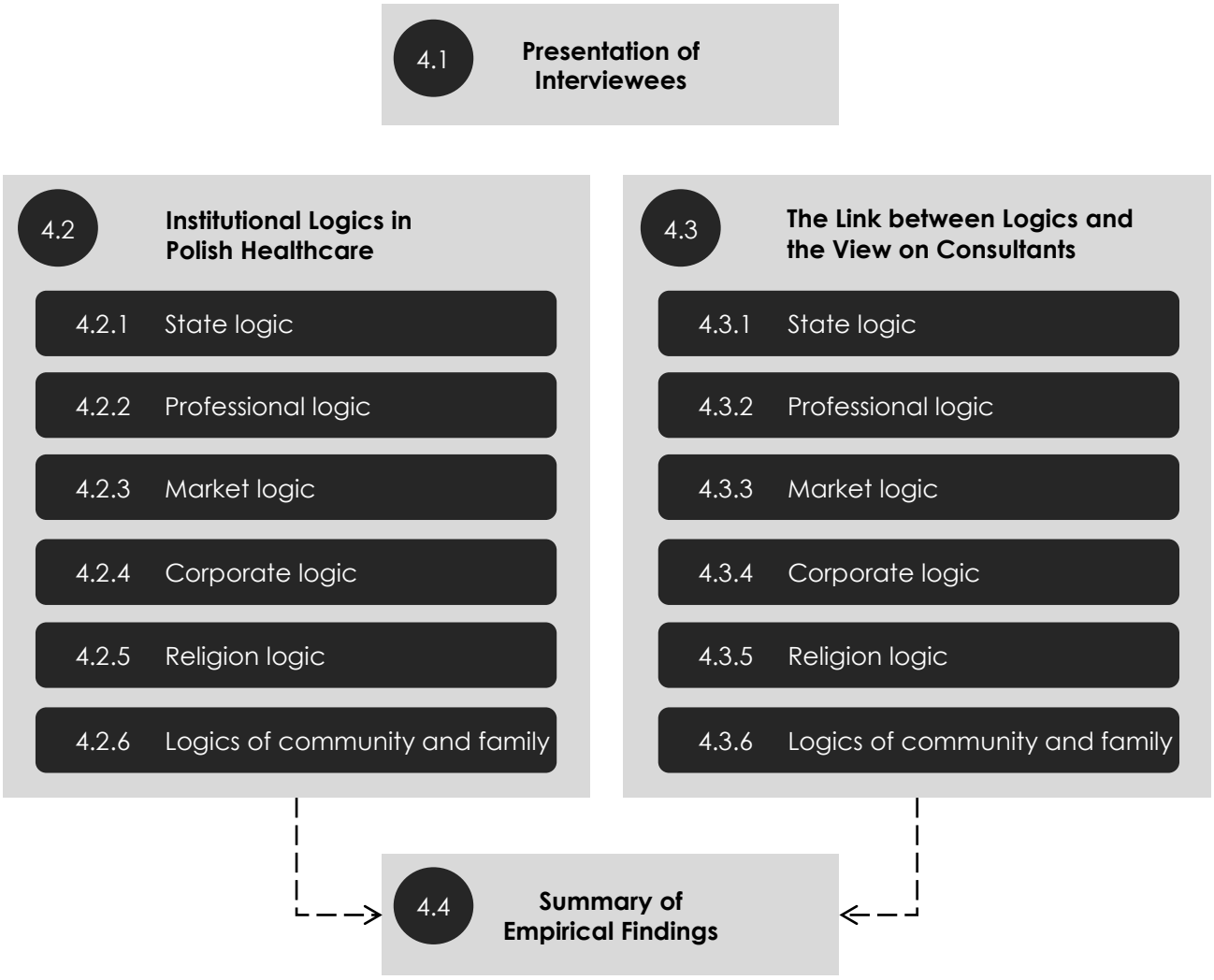


Figure 8 Structure of empirical findings

4.1 Presentation of Interviewees

The 21 interviewees that participated in this study had in many cases professional experience from the Polish healthcare system. Twelve of these had a medical background and had practiced as doctors before either advancing to management or becoming consultants. Nine of them still practiced as doctors within different fields, such as cardiology, anaesthesiology and general medicine.

Seven of the interviewees had experience with working both within the private as well as the public sector, whereas five of them had worked or are working in the public sector only.

Some of the interviewees are currently, or have in the past been, working as consultants within the healthcare sector, whereas others have had experience with the work that consultants do in the field. Yet others did not have any significant experience with consultancy, but were nevertheless asked to give an opinion on how they, as individuals working for a healthcare provider, perceive consultancy and in what way they would consider them helpful or not. The interviewees are presented in *table 5*. For a more detailed presentation, see *Appendix 10.2*.

Category	**# Frequency**
Private healthcare provider management	4
Public healthcare provider management	3
Professional experience of private healthcare providers	8
Professional experience of public healthcare providers	8
Professional experience of consulting in healthcare	7
Industry experts of Polish healthcare	6
Total number of interviewees	**n = 21 ***

* = Some interviewees are in more than one category

Table 5 Presentation of interviewees and their professional experience

In the presentation of the empirical findings, the interviewees have been given an arbitrary two-letter combination in order to not disclose the interviewees' real identity, as some of the interviewees expressed their desire to remain anonymous.

4.2 Institutional Logics in Polish Healthcare

This section presents data that concerns the first sub question of this study, i.e.:

- ***Which institutional logics do healthcare providers within in the Polish healthcare field enact?***

The data has been categorized into each of the logics presented in the theoretical framework in *section 2.4*.

4.2.1 State Logic

According to interviewees, the state logic within Polish healthcare is mostly expressed through a widespread bureaucracy within the public sector. Some of them noted that exaggerated bureaucratic procedures are an effect of the fund allocation mechanism which is governed by the state and enacted by the NFZ, which in turn leads to financial deficiency at many public hospitals.

> *"Public providers don't have the money. The state allocation mechanism creates bureaucracy and inefficiency in the system", expressed TC, a doctor with professional experience from both public and private providers.*

BO, a chief of ward at one of the larger public hospitals in Warsaw points out that the allocation mechanism is quite rigorist:

> *"We are solely dependent on the money we get from the NFZ. Of course, some of the doctors additionally make money by working for their own, small private outpatient clinics. But here, we cannot really do anything. The only thing we can spend money on is patient care. Nothing else will be accepted."*

Many of the interviewees who had experience of work within the public sector also pointed out that that politics – often enacted in the back office – play a large role in both the appointment of management at public hospitals, but also on how the public sector operates.

> *"It's all politics. The public sector is steered by the Ministry and NFZ.* [The ones that work for public providers] *hate them both, but at the same time is dependent on them. The local governments have supervision over the public hospitals, and the head of ward is of course responsible to these politicians. I believe there is a lot of backroom politics going on (...) it's better to appoint someone that is loyal to your political agenda, so one can say that it is a politisation trend going on in public hospitals"*, said GS, who has over 20 years of experience of working as a dermatologist.

This political influence is according to most interviewees characterized as a negative influence on the public healthcare field, because of lack of medical expertise among politicians.

> *"[...] Public hospitals are influenced by politicians, who are not experts in medical facilities' operational management."*, QN points out.

Many noted that this influence affects the organisational goals of hospitals, who instead of concentrating on the efficiency of their organisation, aim to increase availability to their patients.

> *"*The *public providers are not interested in efficiency, but rather in increasing availability, no matter the cost", AT expressed.*

Others noted that the public healthcare field, with its inefficiencies, is a difficult topic to bring up in the political discourse.

> *"The political influence is (…) problematic. The public's points of view differ – people want to pay less for public health care, they also demand all services [to be] included or complain about insufficient funds for treatment (…) The healthcare system is not the topic most willingly discussed by politicians, since it is not popular among Polish citizens. The system is not efficient, it has to be stated out loud, but only the political parties in opposition are willing to bring up the topic, [but only] in order to attack the ruling party.",* expressed EG, who works at the Polish Insurance Institute, but has a large experience of working with different healthcare providers.

The influence of the state seems to be much less prevalent among private providers, since they are neither managed nor supervised by the state. Still, state allocation funds are the most important source of revenue for many private clinics.

> "*Without the money from the NFZ, the private clinics wouldn't survive. If we want to reform Polish healthcare, there has to be a viable alternative to the state payer system. Most private payments are either out-of-pocket payments or medical subscriptions paid by the employers.*", EG explains.

4.2.2 Professional Logic

The professional logic influences the healthcare field in several different ways. In many aspects, the professional logic of doctors and medical staff is important for explaining the behaviour and goals that drive them. The results show that this logic influences the public healthcare sector to a large extent.

Whereas most interviewees acknowledged that among private providers, the management does not necessarily always have an academic background in medicine, but rather possess business-oriented degrees. Among public healthcare providers, on the other hand, the management is comprised primarily of doctors:

> *"The management at public hospitals are mostly senior doctors, but they still have to manage everything else, including budgets and the whole administration (…) even when they become managers, they still remain doctors."*, said QT.

Despite the difference between private and public providers with regards the composition of the management team, several interviewees underscored that the medical staff, no matter where they work, are driven by giving the best treatment to their patients:

> *"There is no difference. I have worked in both [private and public healthcare], why would I behave differently? The only thing is that at [the private provider], they are onto you to be more friendly, more professional to the patient."*, NN claimed.

However, there seems to be limited conflicts between the different professional groups, regardless of the type of provider.

> *"Conflicts rarely occur between managers and doctors in the private sector. In the public sector, conflicts arise more between doctors and different specialisations. The conflict between the anaesthesiologist and the surgeon is a classic example.",* said BO.

KB, a Swedish doctor, who has several years of experience of research in Poland, agrees:

> *"Among my Polish medical colleagues, I think it is their profession that drives them to a large extent."*

However, some interviewees, especially consultants that have experience of working with projects for both public and private providers, pointed out differences in attitude towards innovation and new technological solutions. Others also commented on the difference in the doctor's approach toward the patient.

> *"In public hospitals, dominated by doctors, people are more conservative when it comes to for example e-health solutions. The doctor is the expert, and the patient should listen."*, QT pointed out.

4.2.3 Market Logic

The market logic within the Polish healthcare field seems to influence mainly private healthcare providers. Whereas public providers rely on state allocation funds solely, and are oriented towards increasing availability of care, private healthcare providers, at least at the management level, are more concerned with market forces. For example, one of the board members in a private hospital stresses the importance of efficiency and profit within the organisation as a necessity to provide good healthcare services:

> *"The 'grey' sphere, which focuses on the administrative and economic side of the business, is a foundation allowing the 'white' sphere (medical side) to fulfil its main mission, namely to provide healthcare service and treat patients, which generates the profit for the company. That is why those both sides are equally important for the success of the organisation as a whole.",* BM noted.

Similarly, a Polish management consultant with over 30 years of experience as a cardiologist states:

> *"You cannot separate money from medical outcomes. If you provide good services, then you earn money. Cardiology is a good example. Cardiology services are on a very high level in Poland. The service provided by private providers in this field is one of the highest standards in Europe now. The majority of these providers are private and profit-oriented.",* AT told us.

BC, development director at a private hospital, says:

> *"Our main goal is profitability. Without profitability, we cannot cure people."*

The importance of efficiency is also emphasized by QT, member of the management board at one of the major private healthcare providers:

> *"We want to be the best on the market. Efficiency is also very important for us (...) and we're interested in solutions that could raise efficiency in handling patients."*

BM, board member of a company owning two private clinics, states:

> *"There is a difference between public and private institutions, and it may influence the way the service is conducted – meaning that private institutions have a more business-focused approach, although not in all cases"*

NL, however, downplayed the importance of efficiency among private providers and claims that the current main focus is profit and growth:

> *"The private healthcare sector in Poland is focused on growth because there is a lot of room for it. Nobody really thinks about cost reductions or service efficiency, rather profit and growth. I mean, it's all hands on deck. We need to increase our market share"*

Finally, in order reach the financial goals, the market position is of vital importance to a private hospital chain:

> *"We are far more advanced in the market than many others and we strive for maintaining and developing our market position.", QT concluded.*

4.2.4 Corporation Logic

The corporation logic exhibits its influence on the Polish healthcare field in two ways. The first of these is the specific corporate culture that exists among the different private healthcare providers in the country. The second is linked to the organisational structure of public providers, which is described as very hierarchical and autocratic. While not being a direct expression of corporate logic per se, it expresses a logic that can be linked to the characteristics of the corporation – or rather the organisation – itself.

The hierarchical structure among public providers, giving the head of ward full responsibilities for the hospital was a distinguishable theme across most interviews.

> *"It is a very hierarchical system. The head of ward is God. He decides absolutely everything."*, AT noted.

> *"There is a financial regime and the chief of ward is the dictator. It is very hierarchical."*, TC agrees.

KB notes that this hierarchical, top-down approach can have a negative influence on public providers' organisation:

> *"The structure at the hospitals is extremely hierarchical. If you become a professor, then you can basically do what you want. Nurses cannot oppose doctors whatsoever. A junior doctor cannot oppose a specialist. A specialist cannot oppose a physician and a physician*

> *cannot oppose a professor. I don't think it really benefits the work output. It's good to know who leads and decides, but one must also dare to say things."*

Private healthcare providers in turn seem to emphasize a different culture, especially noting that a culture of openness and humility should be communicated to the patient:

> *"We want to emphasize to our patients that we offer the best possible care. They are our clients, and every doctor should understand that we do this for the patient's good. It's our goal.",* QT states.

> *"I think that our doctors talk more to the patient. People come to us, because we have a policy that doctors should give the best possible service",* he adds.

4.2.5 Religion Logic

When asked about the influence of the logic of religion and Polish healthcare, interviewees were clearly divided. Some expressed that this connection is very clear, but that it mostly affects the medical practice of doctors.

> *"As you probably know, Poland is a pretty religious country. This actually affects the healthcare a lot. No one is allowed to die! It has hit me very hard that, sometimes, it seems as if there is no limit for how long one tries to keep patients alive. For me, it is actually quite unethical to keep the patients alive in that way."*, said BK.

AT very much agrees with her:

> *"In my view, the influence of the* [Catholic] *church is overwhelming. For example you have in vitro or euthanasia. There was a discussion if the pharmacists can refuse a patient to give contraceptives because of his or her moral standpoint. It is absolutely crazy.*

When it comes to organisational practices, however, he notes that the influence is unclear:

> *"No, I don't think it has anything to do with how the system is organised, or how the hospitals are managed. It's more of an influence on each individual."*

Others, such as NN, agreed that the moral values and the view on life do affect the medical practice of doctors, but disagreed that this is an effect of the Catholic religion:

> *"No, I don't agree with that religion has an effect on healthcare. It is more of the Slavic nature – our cultural heritage – that drives us to take care of people. We are just more sentimental in nature (...)."*

Some, including SM did not see the connection at all.

> *"No, there is no connection. My religious views have nothing at all to with how I treat patients! What a strange question."*

4.2.6 The Logics of Community and Family

Whereas many interviewees noted the importance of communities and the importance of the nuclear family in the Polish culture, few expressed that these influence Polish healthcare.

DT noted however, that there are professional associations that play a role within Polish healthcare:

> *"Many doctors, especially in the private sector, are part of doctor communities. One such professional association is Porozumienie Zielonogórskie. It is an organisation that has been very active in media lately, because of the introduction of the new oncology program by the Ministry of Health. It ended with a very heated debate over the programs' appropriateness. But this should be seen as more of a political association than anything else."*

GS in turn expressed:

> *"Yes, there are associations. But average doctors are not really engaged in that. If they are, I think these associations are more driven by the professional logic of doctors – the medical aspects are in the centre of attention."*

She also continued, in regard to the importance of the nuclear family in the Polish society:

> *"The nuclear family is a very important thing for the moral stances that most Poles have. But it is more connected to the Church, I think. In healthcare, I have a really hard time seeing any influence on either practices or routines."*

4.3 The Link between Logics and the View on Consultants

This section explores how the multiple institutional logics that are enacted in the Polish healthcare field affect the view that providers and other actors in healthcare have on management consultants. The findings presented in this section concern both the second sub-question of this study, as well as the main research question of the thesis. The second sub-question of this study is:

- ***What is the view and perception of management consultants among healthcare providers?***

The main research question is:

How do institutional logics influence the view and perception of management consultants in the Polish healthcare field?

4.3.1 State Logic

Interviewees suggested that bureaucracy, which in many cases plagues the public sector, also has an effect on the work of consultants. A problem, pointed out by EG, is that while public providers as well as governmental institutions use consultants, inefficiencies in the system make the relationship between client and consultants strained:

> *"Any public entity can hire consultants for a given project, given that it is well justified and that they are chosen through public procurement. […] Of course, the parties of the*

> *procurement are often being sued so it takes time to complete the whole process and start with the project (…). This negatively affects the outcome."*

QN, a board member of a healthcare consultancy firm in Poznań, pointed out that while public providers use his company's consulting services, they are mostly consulted for short-term projects, as there is not really an interest to perform any long-term projects by public clients:

> *"Yes, we do cooperate with public providers (…) A big difference between private and public providers is that the cooperation with a private client is regular (…) and more focused on building long-term relationships, while for the public entities we usually provide one commissioned service, and this is the end of the cooperation".*

Others have noted that consultants are usually hired by the Ministry of Health in order to perform audit projects on national and international levels:

> *"Most of our clients are pretty high up in the political hierarchy. It happens that the Ministry wants to do a benchmarking project with other national health systems for example.",* BN explained.

Most interviewees agreed upon the fact that the state fund allocation mechanism poses a financial restraint on the use of consulting services by public providers. BO, for example, opened for a greater use of consultants, if the hospitals were allowed to spend state money on such services:

> *"The state allocation mechanism leads to underfinancing of the public system. I would hire consultants to more things, but the NFZ only pays for the actual care and medical equipment, not for consulting services."*

Many point out that because of the involvement of politics, consultants are not considered as a favourable option, and head of wards therefore decide against using them.

> *"It is not unusual for political representatives from the local government to say to the chief medical doctor: "We have appointed you and you have to manage yourself. You don't need consultants… Or aren't you good enough? Of course it makes the doctors afraid as well.",* AT notes.
>
> *"They are afraid to spend resources for something that is not seen as particularly needed for them",* he adds.

Some interviewees expressed, that the consultants in public healthcare sometimes are used not in order to contribute to the development of the hospital, but rather as a political tool:

> *"Sometimes, clients want us to do an audit of their hospital just to show how bad the previous management was (…). They see us like useful idiots… You know like the Soviets did with some of their citizens.",* said BL, who is the founder of a smaller healthcare consulting firm operating in Warsaw.

He continued, by expressing that public clients often are not too keen on accepting any radical changes:

> *Some clients just want to keep the record showing that there were some steps taken to find out what can be changed, but not willing to introduce change in real terms. We show our solutions, indicating where the changes may be introduced – and at this point the will for cooperation starts to fade on the client's side. The client fears what the results of our research will be, since it may lead to a change in status quo."*

4.3.2 Professional Logic

The findings suggest a distinguishable link between the different professions that comprise management at public and private providers, and the view they have on consultants. Most agree that, in general, private provider management is more open to external consultancy than the public sector is. Many claim this to be an effect of the organisational structure, which sets doctors in management positions in public hospitals.

QT sees this influence negatively:

> *"Public hospitals want to stay in status quo, they don't want to develop and they don't want advice, because they are the doctors, they think they are the experts in healthcare"*

AT, who has done projects for public providers, agrees:

> *"Public providers (...) they perceive themselves as their good managers of their business. They don't think that they need any help"*

> *"Many managers in the public sector think that they know best and that no outsider should tell them what to do",* expressed TC.

BL also alludes to the fact that head of wards are afraid to be seen as incompetent managers, and see the hiring of external consultants as a failure and immediate threat to their medical legitimacy:

> *"They are the doctors, you know. If they ask for help, they think that people are going to think bad of them."*

BN, who works at one of the larger, international consulting firms notes that there is much to do in regard to the awareness of what consultants actually do among the medical profession:

> *"There is a low awareness about consultants and their job."*

Private providers, most interviewees agree, are more open to external consultancy, simply because they are, to a larger extent, managed by managers and not doctors:

> *"If you have a background in consulting, and many at our hospital do, you have a better understanding of what consultants can do. Not everything can be solved internally. Then*

> *again, consultants are not the solution to everything.",* says NL, who currently works at one of the larger private healthcare providers in Poland.

4.3.3 Market Logic

The interviewees have expressed that market logic to a large extent affects private providers at the management level. Although this market-oriented approach seems to have an impact on the organisational structure and strategy, which differs greatly from the public sector, the effect this has on the view on consultant is ambivalent, as the providers seem to have both positive and negative experience and perception of consultants.

First of all, however, most interviewees pointed out that the private healthcare sector in Poland uses external management consultants to a much larger extent than the public sector does.

> *"Yes, we quite frequently work with external consultants (...) on all kinds of projects, really"*, states QT, board member at one of the largest private providers in Poland.

> *"They help us with strategic issues, we also have these guys that have been working with us for years. We don't use the same firm all the time, it depends"*, adds BD, development director at the same company.

> *"We cooperate with consultants when it comes to learning sessions with the personnel and the board. We also have strategic sessions once in a while in order to get someone from outside to help us with our strategic goals",* claimed BM, a board member at a private hospital in Warsaw.

One of the reasons for why consultant are used more extensively is, apart from the lack of financial restraints which burdens the public sector, the more market-oriented approach of the management. Consultants are seen as actors that can provide expertise, knowledge and information that is difficult to collect within the company.

> *"There are people that actually have a very broad experience and knowledge when it comes to strategic consulting. These people can actually go into a company and make a difference by improving its operational core."*, said NL.

> *"I personally think that hiring consultants makes sense. They are better in monitoring the market, and can even spot trends that are currently going on"*, added TC.

BD, however, points out that, in her experience, the results of project conducted with external consultants can be disappointing. Among private providers, there seems to be consensus that large international consulting firms often act in an opportunistic way and provide results that are very general:

> *"Consultants mostly have knowledge and information that is very general, they rarely offer expertise that we didn't possess internally… they just put in nice words (...) Our field requires specific knowledge, not general formulas which everybody knows about."*

> *"You want to hire someone that has worked with many projects within your field and broken their teeth on them. Unfortunately there are projects which consultants call a "generic ride" which result in management saying "fuck, we organised a student school for half a million zlotys"*, NL continued.

QT agreed:

> *"International consultants are too expensive, and the pay-off is too low to be worth it"*

At the same time, BD points out that large consulting firms often have greater capability, and for that reason can guarantee a consistent quality. Still, smaller firms, which often lack large resources, are seen as more innovative than their larger counterparts.

> *"Big consulting firms are more controlled, and the quality is much more transparent. Smaller firms may have bigger knowledge and may improvise more, but there's no guarantee"*, BD said.

> *"Smaller firms are more revolutionary, and these guys can actually make a change. If something is really innovative - we raise our eyebrows. General formulas, which most firms give, are not given much thought"*, she added.

4.3.4 Corporation Logic

The link between the corporation logics present in the healthcare field and providers' view on consultants is equivocal. In the public sector, which is subject to a largely hierarchic organisational structure, the view on consultants is characterized by more scepticism than in the private sector. One of the reasons for this is the different corporate culture in these types of organisations:

> *"In the private sector, the culture is much more open, and client-oriented, which opens for the use of consultants, especially when these can help the company to reach out to their staff and their clients."*, noted CL, a professor at an economics university with experience in private healthcare.

The culture in the public sector, much because of the hierarchical strategy, accelerates the effects of the professional logic of the heads of wards, who may be sceptical towards external consultants on behalf of professional and political reasons. As the heads of wards are the only ones that have the authority to consult external consultants, many potential projects fail to materialize.

> *"When we are doing projects for public providers, we only talk with the management. They are the ones that decide everything. Among private providers, we sometimes have projects that also involves the staff, or at least middle management."*, AT points out.

4.3.5 Religion Logic

Most of the interviewees agreed that while religion may affect medical practices and individual doctors' actions, they fail to see a link between this influence and the view actors within the healthcare field have on consultants.

> *"I have a very hard time to see that Catholic values would influence how consultants are viewed. It doesn't matter whether the manager is Catholic or atheist; his view on consultants is not influenced by this. It's more that private providers are keener to use* [consultants]. *It's not like they are more or less religious that the head of ward at a public hospital. It's a matter of the system, the organisation and the bureaucracy.",* GS explains.

4.3.6 The Logics of Community and Family

The findings have not suggested a clear link between the logics of community and family on the medical field in general, and neither on the view on consultants. When explicitly asked about the influence of family values on the view on consultants, none of the interviewees gave any clear or indicative answers. In regard to the political power that professional doctor associations have in Polish healthcare, they noted that these organisations comprise mostly of doctors, i.e. not management individuals, which in most cases are the ones that take the decision to use management consultants.

4.4 Summary of Empirical Findings

Interviewees agreed that multiple institutional logics influence the Polish healthcare field. These logics are enacted by different groups and individuals, and noticeable differences exist between public and private providers. The first are strongly influenced by the logics of their medical profession and by the logic of the state. The latter are more influenced by a logic that lies closer to the values of the capitalist market.

The findings suggest that there are links between the different logics and the view on consultants. The logic of the state and profession in general affects the view on consultants more negatively, and leads to a perception of consultants as an external threat to the medical practice, but also to the individuals that manage the public hospitals. The logic of the market in turn gives individuals a more distinct view and experience of consulting, leading to both negative and positive views on management consultants. The empirical findings are summarized in *table 6*.

LOGIC	Professional	Market	State	Corporation	Family	Religion	Community
Characte-ristics	Medical knowledge and experience as determinants of expertise	Profit and profitability as important goals	Bureaucracy, redistribution of funds, backroom politics	Strong hierarchy	Importance of nuclear family	Catholic moral values	Unclear
Enacted by	Medical staff, public provider management	Private provider management	Ministry of Health, local governments, to some extent public provider management	Public provider management	Society in general	Society in general	Unclear
Effects on organisation	Public provider management consisting of doctors	Concern with market factors, Managerial practices in hospitals Patient as a client	Appointment by politics, bureaucracy, adjustment to political agenda, inefficiency, limited capabilities	Top-down managerial approach, limited knowledge sharing	Unclear	Negative view on euthanasia, abortion and contraception	Unclear
Effect on the View on Consultants	Outsiders in a negative sense (external threat to medical quality), Carriers of information	Carriers of information and knowledge Opportunists Carriers of fads	External threat, too expensive an alternative	External threat (to position)	Unclear	Unclear	Unclear

Table 6 Summary of empirical findings

5 Analysis

This section addresses the empirical findings presented in *chapter 4* and analyses the link between the institutional logics found in the healthcare sector in Poland and the influence they have on providers' views on management consultants.

5.1 Multiple Institutional Logics in Polish Healthcare

Previous research has pointed out the fact that multiple institutional logics exist in organisational fields, and that the composition of these logics can differ between different institutional, and even organisational contexts. The empirical findings of this study have showed that, indeed, there are multiple institutional logics that influence Polish healthcare. The logics differ in their composition, and are enacted differently by different actors, which in turn leads to different views on management consultants and on their contribution to the Polish healthcare field. One of the more distinguishable themes that permeate the results is the division between public and private healthcare providers. One explanation for this is the substantially larger influence of state logic on the public sector.

5.2 Influence of State Logic

It is the state that writes and executes the law, and as the main payer, it has the greatest influence on how the public healthcare field is composed. Furthermore, it has managerial supervision over all

public healthcare providers, which are on one hand managed by local governments and on the other hand dependant on state allocation funds from the NFZ in order to survive. Interestingly enough, many have cited the NFZ and the state as being the antagonist of healthcare development. Many have noted that the public sector in Poland suffers from underfinancing which is an effect of this rigorist fund allocation mechanism. As it is based on the provision of care services, rather than on other metrics such as quality of care and organisational efficiency, it limits the incentives for conducting projects that are connected with management and operational efficiency. Indeed, projects that are not explicitly connected to actual care (such as e.g. the procurement of new medical equipment), may not be favourably evaluated by the NFZ, leading to less pleasant consequences for the provider. As a result, this allocation mechanism limits the amount of projects for which management consultants can be hired for within the public sector.

The findings suggest however, that public providers differ from their private counterparts not only in the frequency of using consultancy services, but also in their more sceptical approach towards management consultants. Whereas the lack of sufficient funds, as well as limitations of the decision-making scope regarding the spending of funds, can be seen as strong explanatory factors for explaining the frequency with which consultants are used in the public sector, they cannot be considered as the solely explanatory factors for public providers' larger scepticism towards these consultants.

An alternative explanation may be the large involvement of politics in the public sector. As all public hospitals are put under direct supervision of local governments, the political agenda of the state, to some extent at least, permeates the organisational practices of the public hospitals. Many interviewees have suggested that this creates a negative spiral, which leads to a managerial interest in preserving the status quo and dismissal of radical change. It is simply easier to advocate stability than change that may or may not lead to actual improvement. As a result, consultants are rather seen as an external threat to the status quo, which may undermine the credibility of management in the eyes of the political powers that appoint them.

5.3 The Influence of Professional Logic of Doctors

Another explanation is more connected to the professional logic of doctors, rather than the political agenda of the state. As the findings suggest, the composition of individuals in providers' management is vastly different between the public and private sector. Public providers are almost exclusively managed by a head of ward, which in most cases is a senior doctor with long-lasting medical experience, appointed on the merits of his professional carrier. The hierarchical structure of the public provider organisations gives the heads of ward the means to supervise the whole organisation, which, apart from medical supervision, also includes managerial, financial and administrative responsibilities. These responsibilities are of great importance for the provider, especially when taking into account that the organisational culture at public hospitals imposes a strict hierarchy for professional doctors, leaving many describing the head of ward as the autocratic leader of the hospital.

As a result of this, it is mostly medical, professional knowledge that is seen as the determinant of expertise. Management consultants are seen as outsiders with limited medical experience. In the eyes

of public provider managers, they can therefore hardly contribute to the development of the hospital, and may even pose an external threat to the professional reputation of the head of ward. This reputation is of great importance to public provider management because of two reasons. Firstly, an undermined reputation also undermines respect from fellow professionals and may cause a threat to the hierarchical organisational structure. Secondly, in the eyes of the doctors that compose public provider management, it poses a threat to the hospital itself, since employment of external consultants that are not regarded as medical experts may be seen as an initiative not directly linked with the provision of healthcare services, and therefore may not be funded by the NFZ.

5.4 The Influence of Market Logic and Professional Logic of Private Management

Whereas public providers are much inclined to enact the logics of the state and the medical profession, the situation in the private healthcare sector is different. A simple explanation would be that this is because the management of private providers – in most cases – consists of individuals with different academic and professional backgrounds. Another explanation may be that actors in the private sector are directly competing with other actors, and therefore are more often choosing change and innovation over the status quo.

Indeed, according to the participants of this study, market forces have a large impact on how private providers behave. They are more inclined to think about the profitability of their organisation as an important determinant for the quality of care and often have a corporate culture that recognizes the patient as a client and payer.

The findings suggest that external consultants are used far more frequently among private healthcare providers than in the public sector and that the view on consultants is in general more positive among private actors than among their public counterparts. This may be, as many interviewees have pointed out, because the private sector, in contrast to the public sector, has the financial means for hiring external expertise. As has been argued before, it is a plausible explanation for why consultants are hired to a larger extent by private providers. However, one should take into account that many private providers are as dependent on state reimbursement as public hospitals are. This shows that there are other factors that alter the view on consultants than mere financial strength.

The more favourable view on consultants is to a large extent also an effect of the more market-oriented professional composition of the management of private providers. They are keener to enact the profit-driven logic of the market, instead of the state and medical profession logic of their public counterparts. Thus, they are more inclined to recognize the value of external expertise that is not directly based on medical knowledge. Many of the representatives of private providers that we talked to, recognized that consultants carry knowledge and information that may be hard to possess internally.

The influence of what Friedland & Alford (1991) described as the logic of the capitalist market among private healthcare providers in Poland does not however explicitly lead to an overwhelmingly positive perception of management consultants among private provider management. All of the interviewees pointed out that they had as much positive, as negative experiences with management

consultants. Albeit it is true that private providers in general have a more positive view on consultancy, and use consultancy services more frequently, they also expressed that management consultants often act opportunistically, and that especially bigger, well renowned firms, sometimes contribute sub-par results. This shows a generally sceptical view on management consultants, which very well may be an explanation for the lower revenues of consulting firms across all business areas and organisational fields in Poland in comparison with other European countries. Also, it may not lie far from the truth to say that public providers scrutinize and critically evaluate these services to a larger extent than public providers do. The market logic that they enact puts more focus on efficiency and profitability, but also on innovation and competitiveness, which in turn leads to higher requirements on consultancy services.

5.5 The Influence of Other Logics

Some of the interviewees have suggested a large impact of the Catholic Church on the medical profession in Poland. Indeed, the link between religion and healthcare is perhaps as imminent as the historical battle between science and spirituality, and it is difficult to argue against our Western perception of the nuclear family as very influential on the moral and ethical stances that have prevailed in Western societies across history. The results have suggested however, that the recognition of the influence of the Catholic church on healthcare practices can be seen as equivocal; while some have mentioned a direct link between Christianity and specific medical practices (e.g. the strong stance against euthanasia, and abortion to some extent as well), others see the connection as an effect of cultural heritage. In either case, the empirical findings have not suggested that this influence, whether we acknowledge it or not, has any noticeable influence on the view that providers have on consultants. It is safe to assume that this influence, if it exists, is enacted by society as a whole. It is a part of the institutional context of Poland, and is therefore interesting for understanding the context in which healthcare in Poland operates, but has limited bearing on the specific research question that was raised in this study.

6 Discussion

6.1 Differences in Logics between Providers

The empirical findings of this study bring much credence to the discussion concerning the abstract form of the concept of institutional logics. As e.g. Thornton & Ocasio (1999) have pointed out, the typologies of logics may differ between different institutional contexts, and the constellations of logics that influence organisational behaviour may differ vastly depending on many different circumstances. In the case of the healthcare field in Poland, the results strongly suggest that there are large differences between the public and private sectors when it comes to what and how logics are enacted. This shows that these logical configurations – or institutional logics if you will – may depend on the characteristics of the organisation and its environment. In the Polish healthcare field, the constellation of logics that is enacted by public providers leads to a more sceptical view on management consultants. One of the reasons for this is the large influence of state logic on the public sector.

6.2 The Trends of Politisation and Professionalisation

In European healthcare systems, the involvement of the state and governmentally controlled organisations is much more pronounced, and in some countries nearly exclusive, when compared to e.g. the US healthcare system. It should therefore come as little surprise that the logic of the "bureaucratic state", as described by Friedland & Alford (1991), influences European healthcare systems to a greater extent than US research (see e.g. Scott 2000 and Caronna 2004) has suggested.

However, it is not sheer state involvement in the organising of public healthcare that puts consultants in a dim light for public providers. On the contrary – it is the government that hires management consultants to the biggest extent in the public sector. The key word here seems to be the involvement of politics in how the public sector is managed, how managers are appointed, and which agenda is set, both nationally and at the provider level. One of the interviewees went as far as describing this involvement as a "*politisation*" of public hospitals. This "politisation" leads to two consequences that explain why the view on consultants is lukewarm among public providers: 1) the fact that the political agenda often focuses on stability ahead of change and 2) the fact that consultants are seen as agents of change rather than stability, and may therefore pose a threat to it. Interestingly, this seems to contradict the idea that consultants are hired in order to preserve stability, as some researchers have suggested (see e.g. Furusten 2009 for an interesting argumentation concerning consultants as improvising agents of stability).

The trend of "politisation" is complemented by the equally strong trend of – what we fittingly choose to call – the "*professionalisation*" of public provider management. To a degree, they both seem to be a consequence of the organisational structure that prevails among public providers, but they can be seen as enactments of two different logics (even if they, undeniably, support each one another). The second of these trends can be seen as an enactment of the professional logic of doctors, which differs from other professional logics, such as e.g. the professional logic of business managers. The doctors seem to be driven by their profession to a larger extent and tend to emphasize medical knowledge and expertise. The "professionalization" trend is further strengthened by the hierarchical corporate logic that influences the public sector. The doctors are subject to a clear hierarchy, which is determined years of medical experience. This hierarchy limits the influence that other professions – and even junior doctors – can have on the organisation.

The "professionalization" of the management positions in public hospitals leads to very similar outcomes in the light of management's perception of external consultants. The distinguishable difference is that it questions the knowledgeability of consultants in a field in which it is the doctors that are the experts. It is fair to acknowledge that most who have been appointed as head of wards – including the ones that we have talked to – have a vast experience and have had admirable carriers as doctors. Many have developed programs that have revolutionized healthcare practices. In the light of this it may not be difficult to understand that they see themselves as experts in the medical field, and question solutions that management consultants may offer.

In previous research, mostly van den Broek et al (2014) explored the significant influence of professional logic on healthcare. The professional logic of the nurses in the study of Dutch hospitals showed a conflict of interest between the logic of the nurses and the business, or market, logic of the

top management. In Polish public healthcare, conflict between medical staff and management are not clearly defined, simply because management and staff is handled by the same profession. Furthermore, nothing suggested that the logic of the head of ward changed with the infusion of managerial duties; it seems that they have remained being doctors, only with a myriad of new responsibilities. When conflicts arise, findings suggest, it is between the different medical specializations; it happens that the anaesthesiologist is in conflict over a patient with the surgeon, and so on. Arguably, this is a natural conflict that occurs in most hospitals.

The picture that the empirical findings paint of Polish private healthcare providers and their organisational practices is similar to what other researchers have called a "managerialisation" of healthcare (see e.g. Kipping & Wright 2012 and Caronna 2004). It is notable, that the market orientation of their managers influences the view on consultants positively. First of all, they are considered a viable option, which is rarely the case within the public sector. Secondly, they are recognized as actors that can contribute to the provider's business and operations, even if most of the interviewees confided, that many projects involving consultants fail to meet their expectations.

Previous researchers have suggested that as "managerialist" ideas are being increasingly recognized even in public healthcare institutions (Kipping & Wright 2012), a conflict of logics is bound to increasingly affect the healthcare system. As hospitals and clinics undergo "managerialisation", they become subject to corporate routines and practices (Caronna 2004). However, the findings do not suggest that conflicts arise between the hospital staff and market-oriented management in the private sector, as one would suspect on account of previous research. Even more interestingly, none of the interviewees that had experience in both the public and private healthcare sectors stated that there exist any differences between the professional logic of doctors working in the two differently governed sectors.

6.3 The Ambivalent View on Consultants

The empirical findings suggest another interesting theme. There seems to be a general consensus among healthcare providers that management consultants from large consulting firms guarantee stability and transparent quality, but that they rarely contribute with ideas that are innovative and tailored-made for the provider. Smaller firms are on the other hand more inclined to revolutionize the business, but are very often too small to follow all projects through. This shows a division of the market between niche and general consultants.

The findings also bring another important consideration to the table: the fact that all interviewees expressed opinions that put consultants in both a negative and positive light. This ambivalent approach shows that the perception of consultants is not as black and white as either of the advocators for the two main views on consultancy have suggested (the reader may recall the discussion on the functionalist and critical view on consultants in *section 2.1.1*). The client's perception of the consultant is naturally an effect of previous experiences, but as this study shows, it may also be altered by different constellations of institutional logics that the client organisation operates in.

7 Conclusion

7.1. Addressing the Research Question

This study has aimed to answer the research question:

How do institutional logics influence the view and perception of management consultants in the Polish healthcare field?

In order to fully understand the underlying factors that affect the answer to this question, two sub questions have permeated the presentation of empirical findings and the analysis:

> ***- Which institutional logics do healthcare providers within in the Polish healthcare field enact?***
>
> ***- What is the view and perception of management consultants among healthcare providers?***

The results of this study suggest that there are multiple institutional logics at play within Polish healthcare. The composition of logics is different between private and public providers. This affects the organisational behaviour of healthcare actors in different ways. There are differences in organisational structures and practices between these two types of providers. The biggest difference is noted in the configuration of management, which in the public sector mostly consists of senior doctors. The organising of the public sector is marked by two interconnected trends. The first concerns the "*politisation*" of public hospitals, which enforces the influence of state logic. The second concerns the "*professionalisation*" of management, which is an enactment of the professional logic of doctors and is strengthened by a hierarchical corporate structure. Private providers are governed by individuals with different backgrounds that are generally more market-oriented, rather than internally focused, as is the case of public providers. This is reflected in the coherent "*managerialisation*" of organisational practices among private providers.

The different logics affect the providers' views on consultants. Whereas public providers are generally more sceptical about employing external consultancy services, and do so rarely, private providers are generally more open to management consultants, and also use these services regularly. One of the explanations found for this is the influence of state logic, which leads to bureaucratic procedures, and an underfinancing of the public healthcare system as an effect of an inefficient fund allocation mechanism. Another, as suggested by interviewees, is connected to the "professionalisation" and "politisation" trends among public provider management, which leads to public managers' expressing doubt over consultants' knowledge in the field. Some have also suggested that consultants are seen as an external threat to public managers' political position.

Albeit being more open towards consultants, private providers expressed a polarized view on consultancy, noting that projects sometimes fail to meet their requirements. This finding suggests that the general view on consultants, in practice, is a reflection of both the critical and functionalist views on consultancy, which have dominated the discourse in previous research. Albeit many recognize that consultants may act as carriers of important knowledge, information and expertise

which may not be available internally, a general view is that consultants sometimes act on opportunistic motives, are overpriced and even that they can become a tool for undermining political competition.

The outcomes of this study, constitute the completion of the theoretical framework presented in section 2.4 and are summarized in *figure 9*.

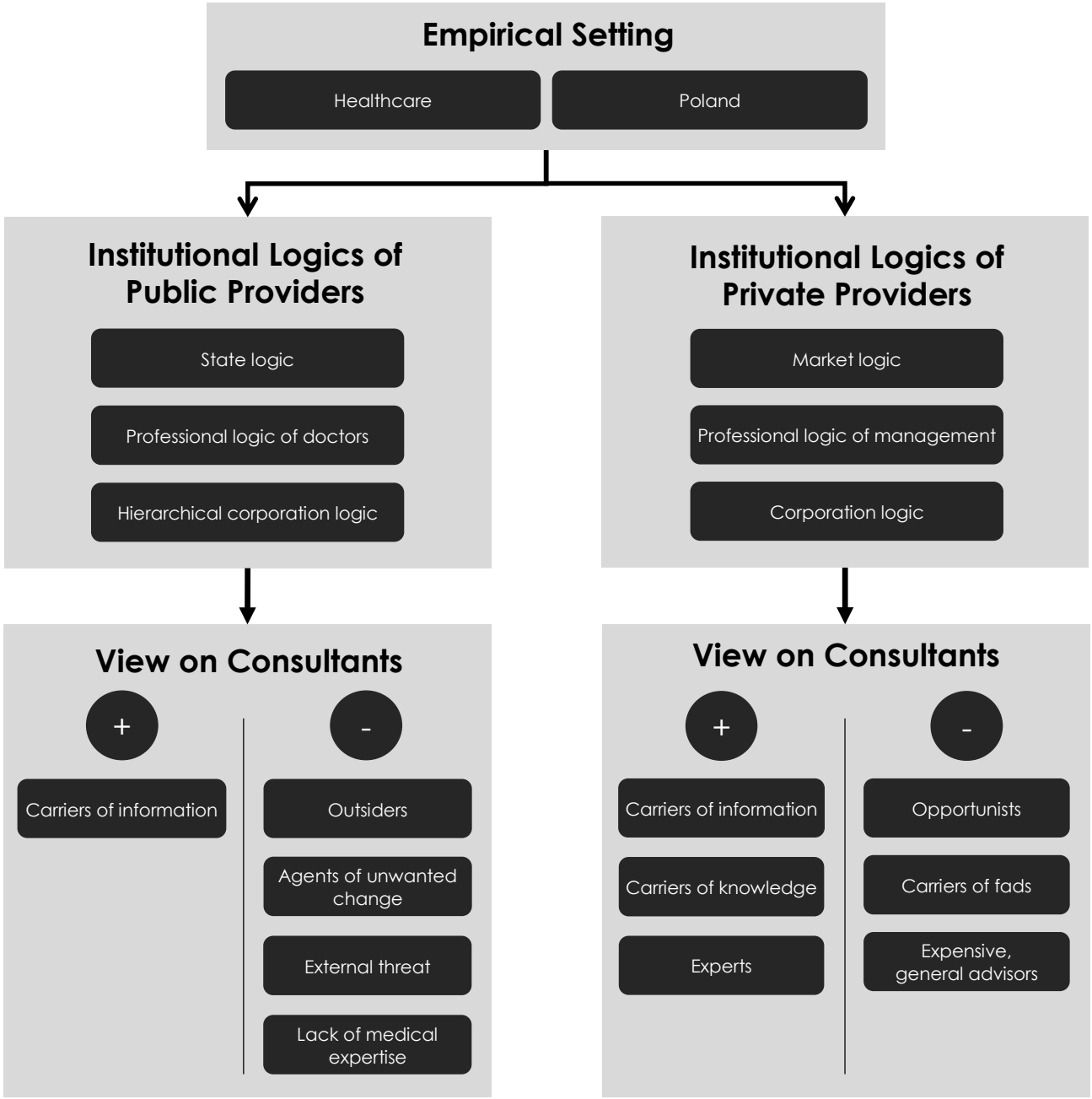


Figure 9 Outcomes of this study and completion of theoretical framework

7.2 Theoretical Contribution

This study has explored the effect of different institutional logics on the view and perceptions of consultants in the healthcare system. By doing so, the study recognizes two phenomena. Firstly, it

addresses the growing involvement of external management consultants in the healthcare system, a field that (for some exceptions see Axelsson 2000, La Penna 2009) is largely unexplored by other researchers. Secondly, it addresses the effect institutions with their central logics have on the view on consultants. This is yet another area which has been vaguely explored by other researchers; surprisingly enough, since much of new institutional theory, from which the concept of institutional logics derive, is based on results from a study of management consultants (Powell & DiMaggio 1983).

Foremost however, the authors of this study have developed an integrated framework, which links multiple institutional logics to the view that client organisations have on management consultants. The framework has, in this study, been used in a specific institutional setting and has disclosed that different constellations of logics affect the view on consultants in different ways. The framework is however not limited to this context. It is theoretically viable, that it can be applied to different industries as well as geographical contexts.

In many ways, the findings of this study bring credence to the discussion surrounding the abstract form of central logics of institutions. Previous researchers, among them Thornton & Ocasio (1999) have themselves pointed out that, albeit institutional logics do affect individual and organisational behaviour, their exact form and characteristics are metatheoretical guidelines, rather than concrete solutions. In spite of this, this study shows that albeit the composition of institutional logics varies between different contexts, the link between the logics as institutional patterns of practices and rules and the action of concrete actors, is empirically justifiable.

7.3 Practical Implications

The practical implications of the results presented in this study vary for different stakeholders. The most important of these stakeholders are (a) the management consultants, who are the selling entities in the client-consultant relationship described throughout the study, and who's image may alter this relationship, (b) the providers of healthcare services who act as purveyors of consultancy services, and who's views on consultants have been the subject for this paper, (c) the policymakers who decide the national health policy and in that way can alter organisational and financial structures in the healthcare system and finally – and perhaps most importantly – (d) the patients, who are the consumers of healthcare.

7.3.1 Practical Implications for Consultants

The findings have showed that the general view on management consultants within the healthcare sector is ambivalent. There is also much to do in order to improve the image of external consultants among public providers. The scepticism of public management towards external consultants is in many cases connected to on one hand a lack of knowledge about what consultants can offer and on the other the limited assortments of services that consultants can provide which are tailored for healthcare providers. This seems to be especially true for larger international firms. By understanding the connection between the institutional logics that providers enact and how they perceive the work of consultants, management consultants can seek to improve their supply of services and gain an insight in the practical needs of the provider clients.

7.3.2 Practical Implications for Providers

The results have showed that management consultants are not always evaluated on factual criteria. Public providers may need to reconsider how they are organised and seek to improve understanding for what other business fields can contribute to the medical field in which they operate in, especially as clearer organisational procedures and operational as well as financial efficiency has been cited as important areas for improvement for public providers. In these areas, management consultants may be able to provide solutions that medical professionals cannot develop themselves. The framework that this study provides may be used as an analytical tool – by both public as well as private providers – for understanding how logics influence the behaviour of the organisation and how this can influence the organisational outcome.

7.3.3 Practical Implications for Policymakers

The results of this study have shown inefficiencies resulting from bureaucratic procedures and underfinancing of the public sector in Polish healthcare. Many have expressed criticism towards the fund allocation mechanism, and pointed out that it diminishes incentives that aim to improve organisational efficiency.

As the involvement of the state is bound to be large in the public sector, the Polish policymakers have it in their power to address these issues. Some have pointed out that a revision of the fund allocation mechanism may induce a more innovative climate in the public healthcare sector. Such innovations, which management consultants can help to develop and implement, may prove to be vital for the future development of the whole healthcare field in Poland. The framework linking logics to the view on external consultants can be used for a better understanding of why external actors are less engaged in the development of the public sector than it can be, and create a blueprint for policymakers to stimulate the engagement of management consultants in public healthcare projects.

7.3.4 Practical Implications for Patients

Whereas not directly connected to the outcomes of this study, we acknowledge that a rise of efficiency in public hospitals is of great interest to the consumers of the healthcare services in Poland. Audits of the situation of Polish healthcare, such as the European Observatory (2014) have pointed out that the Polish population faces many medical challenges, such as obesity and high consumption rates of alcohol and tobacco. An efficient healthcare field, whether private or public, is a prerequisite for a successful handling of these challenges. In the light of this, it is important to understand what steers the routines and practices of healthcare organisations, and what factors steer or deter involvement of external actors in the improvement of these practices, since a better understanding of these by the other stakeholders discussed above, may also lead to an improved care for the patients.

8 Limitations

The limitations of this study are connected to the results' generalizability in other geographical settings, and to the fact that other institutional logics than those presented may be enacted in the healthcare field.

8.1 Generalizability

Researchers have previously argued for the impact of geographical context on the institutional logics within the healthcare field (Greenwood 2011). Since the results of this study are limited to the healthcare field in Poland, we cannot guarantee the generalizability of the findings of our study on other countries, industries or different types of healthcare systems. The organisation of the Polish healthcare field and the market for management consultancy in Poland differ from other countries in Europe, which suggests that the enactment and configuration of logics may be different in other countries. By choosing a diverse approach to sampling of sub-units and a broad selection of interviewees, the authors have however strived for gaining results than can be seen as representative within the realms of the Polish healthcare field.

8.2 The Effect of Other Logics

By choosing an inductive approach to data coding, we have opened for discovering results that may not be directly connected to the seven institutional logics, which previous researchers have seen as central to Western societies (Friedland & Alford 1991; Thornton & Ocasio 1999). However, the results that are disclosed in this study encompass only the most distinguishable categories of logics that were identified in the data. As has been discussed in *chapter 6*, the way logics are enacted in practice often differs from their theoretical portrayals. We can therefore not dismiss that enactments of other logics, perhaps not covered by previous researchers, bare an influence on the healthcare field, which in many ways differs from other organisational fields.

8.3 Suggestions for Future Research

In the light of the results and their implications, we can assume that the theoretical contribution that this study makes is a worthy subject for future, perhaps, quantitative studies. We rest assured that there are many aspects of the link between institutional logics and the client's views on consultants that remain uncovered. By introducing a framework that links these two phenomenon, we have only scratched the surface of what future research may contribute to the subject.

One suggestion for future researchers is to explore how the enactment of institutional logics affect the perception of consultants in other industries and countries. Such studies would contribute to a broader understanding of this phenomenon, and contribute to the generalizability of our results.

Finally, future researchers may explore the different configurations of logics and open for other explanations that can contribute to the understanding of how consultants are viewed in different institutional contexts.

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10 Appendix

10.1 Interview Structure

The interviews were structured around the following central questions:

1. Tell us about your experience within healthcare. Where have you worked?

2a. What is your view on consultants? Why?

2b. How do different providers view you as a consultant? Why?

2c. What is the view on consultants by different providers? Why?

3. In what way does state logic affect healthcare providers? In what sense? Which providers and why?

4. In what way does market logic affect providers? In what sense? Which providers and why?

5. In what way does professional logic affect providers? In what sense? Of which profession? Which providers and why?

6. In what way does corporation logic affect providers? In what sense? Which providers and why?

7. In what way does religion affect providers? In what sense? Which providers and why?

8. In what way does community logic affect providers? In what sense? Which providers and why? Which communities?

9. In what way does family logic affect providers? In what sense? Which providers and why?

10. In what way does any of the logics affect your view on consultants?

10.2 Presentation of Interviewees

These are the interviewees that participated in the study:

#	Interviewee (anonymous alias)	Field
1	BL	Medical consulting and public provider management
2	BM	Private provider management
3	EG	Polish Insurance Association
4	QN	Medical consulting
5	BN	International consulting
6	QT	Private provider management
7	QA	Private provider staff
8	TC	Private clinic staff and management, public provider staff
9	BO	Public provider management
10	BC	Private provider management
11	NL	Private hospital chain, consulting
12	BD	Industry research
13	KB	Industry research
14	NT	Academic research
15	NN	Public hospital staff, private hospital staff
16	DT	Academic research
17	AT	Medical consulting, private hospital staff, public hospital staff
18	ST	Private hospital staff
19	ND	Swedish hospital, Polish hospitals
20	CL	Academic research
21	BK	Academic research