

9 Innovating Entrepreneurship in Health Care: How Health Care Executives Perceive Innovation and Retain Legitimacy

Wilma van der Scheer, Mirko Noordegraaf and Pauline Meurs

Introduction

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

Both types of innovations are related to ongoing changes in health care systems, in which a new market logic, new policies and new technologies force executives to rationalize health care delivery, compete with others and upgrade and up-scale organizations. According to Osborne and Brown (2005), such changes imply a break with the past and require new innovative structures and techniques as well as new management skills. This requires entrepreneurial innovations at the organizational level. At the same time, executives cannot escape accepted professional and organizational logics based on professional ethics and administration, such as budgetary control and risk exclusion. Consequently, health care executives run the risk of being squeezed between politically driven reform policies on the one hand and resistance to change from, for example, professional staff on the other that are required to implement change (Goodwin, 2006). Neither direct government control nor new business-like organizational forms seem to

provide executives with durable legitimacy anymore. Thus, not only are entrepreneurial innovations that are aimed at new products and business models required, but also institutional innovations, in order to find ground for new ways of thinking and working in health care and in order to retain legitimacy. The central questions are: *How do executives deal with opposing value systems? Do executives find innovative ways to combine innovations and legitimacy?*

The next few sections set the scene. After a brief explanation of the changes in health care (in the Netherlands) and the consequences for the position of executives, the chapter elaborates on the role of health care executives as 'institutionally active agents' and on the difference between entrepreneurial and institutional innovations in health care. Next, executive strategies are empirically explored by studying the outcomes of an extensive research survey, conducted in 2000 and repeated in 2005. At the end of the chapter, some conclusions are drawn.

Retaining legitimacy in times of change

In the Netherlands health care traditionally is a public/private/professional affair. Health care professionals work for private organizations with a public task, predominantly funded by public means (Helderman et al., 2005). During decades the central government took direct responsibility for the development of the sector by means of elaborate planning, budgeting and tariff control of independent health professionals. Not-for-profit health care providers and insurers (sick funds) acted as quasi-governmental organizations, implementing governmental policy and regulations (Helderman, 2007; van der Scheer, 2007). Successful management of these organizations required public administration competencies. The Dutch health care sector, however, is a public sector in transformation. Like in other countries, technical and political ends, such as cost-containment and improved efficiency, have gained importance, in addition to traditional 'institutional' ends, reflecting professional values governing the provision of necessary and appropriate care, safety, accessibility and so on (Osborne and Gaebler, 1992; Pollitt, 2002; Kirby, 2006). At the beginning of the 1990s, the Dutch government stated three policy goals for the health care sector. It had to be innovative, cost-efficient and demand-driven (van der Grinten and Kasdorp, 1999; WRR, 2004). Existing political planning, budgeting and price control instruments were no longer considered to be adequate for realizing these aims. Markets were seen as new instruments to realize policy goals and government started to create market conditions in the

health care sector (Putters, 2001; Helderma et al., 2005; Helderma, 2007). The intention was to limit the role of government and to control conditions for an optimal functioning of markets in the field of health care (Dijstelbloem et al., 2004).

This reorientation towards markets in the health care sector is a long-term endeavour. Initial steps were made 20 years ago, and today the Dutch health care sector is driven by a mix of market forces and governmental planning, budgeting and price control (Dijstelbloem et al., 2004; van der Scheer, 2007). It is not clear whether this mix will evolve towards more market elements, as this strongly depends on the colour of governmental coalitions. This creates substantial uncertainty about the ultimate importance of markets in Dutch health care. At the same time market conditions are becoming incorporated in the way the sector functions and develops. New logics of appropriate actions are disseminated through government guidelines, legislation, and practices of inspection and audit regimes (Noordegraaf et al., 2005; van der Scheer, 2007). Entrepreneurial risk is created for providers and insurers. Established market positions are breaking down. Price competition brings growing attention for cost management and productivity. Private payments are added to the traditional public funding of health services, etc. (Varkevisser et al., 2008). As a consequence, executives of health care organizations are facing a situation in which their management routines – the rules of the game that belong to the public administration management tradition – rapidly become obsolete in substantial parts of their work (Pollitt and Bouckaert, 2000; Grit and Meurs, 2005; Goodwin, 2006; Kirby, 2006; Noordegraaf, 2007). The emerging market conditions require other, more business-like knowledge and competencies of executives in health care (van der Scheer, 2007; Noordegraaf and van der Meulen, 2008). In order to retain legitimacy it makes sense for executives to adapt to the new logic and incorporate the new entrepreneurial way to go about things and engage entrepreneurial innovations (Clarke and Newman, 1997).

The strategy of adaptation may be perceived as legitimate from one perspective but abject from another perspective; it may be wise considering external claims and expectations, but wrong considering what traditionally is believed to be morally just in health care. Legitimacy is not only a matter of complying with law and state agencies (regulative legitimacy) but is also about what is perceived as morally just (normative legitimacy) and about respecting accepted, taken-for-granted scripts (cognitive legitimacy), especially in such an institutionalized field as health care (see Scott and Meyer, 1991; Ruef and Scott, 1998; Scott et al.,

2000; Scott, 2001). What may contribute to the external legitimacy of executives and organizations (from the point of view of politicians, policy-makers, insurers, etc.), may be at the expense of internal legitimacy (from professionals and clients). According to this institutionalist point of view, legitimacy and institutionalization are virtually synonymous (Suchmann, 1995). Organizations are likely to resist innovations that are inconsistent with performing known tasks. Some even believe revolutionary changes in public sector organizations are impossible to implement because of the many constraints (interdependencies, strong traditions, tied relationships, involved interest groups) that govern the activities of public agents (Terry, 1996; Mouwen, 2006). Putters (2001) calls this the 'institutional trap', referring to the pressure on executives of health care organizations to conform to the demands of the health care field. How to innovate in such a field?

The executive role in an institutionalized sector

According to Terry (1996) the very function of public managers, such as health care executives, is to be responsive to the demands of political elites, the courts, interest groups and the citizenry, and at the same time preserve the integrity of public organization. The word integrity refers to the reasons for existence of the organization, its desired social function and its collective institutional goals that legitimizes its actions. It refers to 'the completeness, wholeness, soundness, and persistence of cognitive, normative and regulative structures that provide meaning and stability to social behavior' (Terry, 1996, p. 27, see also Scott, 2001). In line with Selznick (1984), Terry (1990) argues that serving the public good is a task which is about preserving the organization's distinctive values, roles and competences. According to this point of view executives themselves should also be selective in adapting to external demands and should resist pressures and demands that weaken the organization's integrity because of erosion of its regulatory, normative and cognitive systems. This does not mean health care executives should have an antagonism toward change, on the contrary, controlled adaptation to changing circumstances is obviously an ongoing necessity. The thing is that change and innovation in such vital fields as health care should be guided by respect for existing belief systems and traditions and by loyalty to its values and unifying principles (the very reasons for their existence). What is more, innovative courses of action are required to preserve organizational integrity (see Friedrich, 1961 in Terry, 1990).

External events that threaten the organization's integrity may justify a radical break with the organization's established conduct, but they will

also put executives for the difficult task to respect and simultaneously distance themselves from institutional pressures and to act strategically. It asks of executives to challenge and change the very same institutions that constrain them. This controversy is often referred to as the 'paradox of embedded agency', requiring of actors to alter institutional logics without disembedding from the institutional world (see e.g. Scott and Meyer, 1991; Suddaby and Greenwood, 2005; Battilana, 2006; Leca and Naccache, 2006; Slyke, 2006). It suggests executives can become 'institutionally active agents' and find new logics of legitimization that *break*, rather than *break with*, traditional bases of legitimacy (also Terry, 1996; Newman, 2005; Battilana, 2006). Answers to how this can be done are sought in the enabling circumstances under which change is possible (see Koppenjan and Klijn, 2004; Dorado, 2005), in the enabling role of individuals' social position or the institutional awareness of individuals (see Battilana, 2006). Others believe we should focus on exploring meanings actors attribute to their roles, on exploring their beliefs, preferences and how they take on particular forms of identity (Newman, 2005; Suddaby and Greenwood, 2005; Leca and Naccache, 2006; Rhodes, 2007). In this chapter we follow the latter strategy, for we want to find out how the new entrepreneurial way of thinking has affected the perceptions and actions of health care executives and what sort of innovation strategies are undertaken. As mentioned in the introduction we distinguish between two sorts of innovations: entrepreneurial innovations and institutional innovations.

Entrepreneurial and institutional innovations

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

accompanied by its own beliefs, languages and practices, thus affecting *executive identities* as well as *organizational practices*, *executive perceptions* and *actions*.

Where entrepreneurial innovations focus on instruments and measurements, institutional innovations focus on people and values. The first form seeks the objective: the facts function as proof for organizational effectiveness, which is used to enhance and prove output legitimacy. Plans are concrete, feasible, and have a clear beginning and end. The aim is to ensure organizational continuity by strengthening the competitive position of the organization (see for further elaboration Drucker, 1985; Terry, 1990; Osborne and Brown, 2005; van der Scheer, 2007; Exton, 2008). In this *business model*, new services (products) are developed in order to attract more patients (customers). Executives are encouraged to reinvent themselves to become more entrepreneurial and business-like managers, to take on images of competitive behaviour as requiring hard, macho or 'cowboy' styles of working (Clarke and Newman, 1997) and to become risk-takers and produce radical changes like 'real' entrepreneurs do (Terry, 1996). Executives who advocate entrepreneurial innovations should do well to learn from their private sector counterparts, to enlarge their knowledge about finances, rationing mechanisms and other private sector technologies and practices. Moreover, in a more market-driven context with a rising emphasis on matters of efficiency and accountability, a call for yet another 'type' of manager can be heard: managers from 'outside' health care, who are supposed to run health care organizations more as 'normal' businesses (Grit and Meurs, 2005).

The second form of innovating seeks the subjective or the social: change is an outcome of social interaction between multiple parties (see e.g. Denis et al., 1996; Ruef and Scott, 1998; Scott et al., 2000; Kirkpatrick and Ackroyd, 2003). Institutional innovation seeks recognition and support for new ways of thinking and working. The aim is to preserve the institution's distinctive values, roles and competences by re-shaping social orders without losing legitimacy. Therefore, health care executives have to consider patients' and professionals' interests, as well as private and public interests. In addition to measurable results and rules, professional values and client wishes need to be respected; for health care remains a matter of 'people processing', which depends on human contacts and trust. Quality is influenced by whether clients feel at home, and whether they are listened to, which are important ways to build and enhance input legitimacy. It requires of executives to cultivate and maintain a variety of supportive relationships, both internal and external, and a continuous effort to maintain a favourable public image

(Terry, 1996). This calls for managers who not only manage *downward*, controlling organizational operations, nor *outward*, achieving measurable results, but who also manage *upward* and actively seek support from internal and external interest groups (Moore, 1995). The corresponding leadership role is that of an intermediary in between multiple parties and interests; a role which requires a good insight in and feeling with the specific field of action, as one develops through long-standing experience.

Both types of innovations are summarized in Table 9.1, as well as the expected consequences on *executives' competences, organizational characteristics, perceptions and actions*.

Table 9.1 Entrepreneurial innovations versus institutional innovations

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

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

The empirical research

Empirical data come from a large-scale survey that was sent to all (approximately 800) members of the Dutch association of Health Care Executives (NVZD), in 2000 as well as in 2005. Between 2000 and 2005, competition became a core issue in health care policy and major legislative changes were implemented, changing the Dutch health care system. Purchaser and provider splits were formalized, health care insurers became decisive, and a new cost-driven financing system was established (Den Exter et al., 2004; Helderma et al., 2005; van der Scheer, 2007). For this study we wanted to explore how executive competences, organizational characteristics, actions and perceptions have changed during the years 2000–2005. Do executives follow policies and opt for entrepreneurial innovations, or do they find innovative ways to combine entrepreneurship and other health care logics, and opt for institutional innovations?

The survey

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

Table 9.2 shows the survey data used to study executive competences, organizational characteristics, perceptions and actions.

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

Table 9.2 Questionnaire: Relevant data

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

Respondents

The respondents are all Dutch health care executives, with so-called 'end responsibility'. They are members of the strategic apexes of different types of health care organizations, such as hospitals, organizations for mentally ill people, organizations for disabled people, organizations for elderly care and home care. The survey was sent to all members of the NVZD, which can be considered a representative sample. In 2000 the overall response rate was 46 per cent, and in 2005 the overall response rate was 42 per cent (i.e. 17 per cent of all Dutch health care executives). Table 9.3 shows the response rate per sector for the 2005 survey. For the 2000 survey a division per (sub)sector was not available.

Methods

To answer our questions we explored correlations between the 2000 and 2005 outcomes, and between (sub)sector outcomes and the mean. To find associations, chi-square was used for nominal variables, Spearman's rho for ordinal variables, and Pearson's correlation

Table 9.3 Response, 2005

Type of organization (sub)sector	Population N	Sample n (members NVZD)	Response i.r.t. population N	Response i.r.t. sample n
Hospital	312	200	22%	35%
Organization for mentally ill people	204	122	30%	51%
Organization for disabled people	305	134	19%	43%
Organizations for elderly care and home care	1030	271	9%	35%
Total	1851	727	17%	42%

coefficient for interval and ratio variables. The values of Pearson's correlations and Spearman's rho were tested against '0' by means of a t-test approximation. The differences between independent groups were tested by the chi-square test in cases of nominal variables. In cases of ordinal, interval and ratio variables a one-way analysis of variance (ANOVA) was used. When there were three or more independent groups and, subsequently, in cases of significant differences, post hoc tests for multiple comparisons were carried out using Bonferroni intervals. With t-tests, unequal variances were assumed. In all cases, only significant outcomes ($p \leq 0.05$) are mentioned.

When relevant, outcomes are illustrated with tables.

Results

Executives' competence

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

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

- Executives of organizations for elderly care and home care are more experienced managers than the mean.

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

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

Organizational characteristics

Between 2000 and 2005 health care organizations have changed in multiple ways.

With respect to *size*, outcomes show:

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

With respect to *structures*, outcomes show:

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

Management structures have also been adapted. Most organizations have changed from a board of 'directors', with a clear-cut jurisdiction, to a CEO structure, with an executive board with a broad jurisdiction and a broad set of responsibilities.

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

With respect to *product development*, outcomes show:

Table 9.4 Work experience, in years and number of (management) positions

	2000	2005
Years since first managerial position	19.3	21.2
Number of management positions	3.3	4.4
Number of end-responsible positions	1.9	2.2
Positions in health care	2.3	3.2
Positions outside health care	1.0	1.3

Table 9.5 Work experience, in different types of health care organizations (percentage)

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

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

With respect to *work experience*, respondents in 2005 appear to be more experienced health care managers than the respondents of 2000. Tables 9.4 and 9.5 show: they have been working as a manager for a longer period of time; they have had more management positions (with and without end responsibility); they have had more managerial positions in health care organizations; they have worked more often in different types of health care organizations.

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

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

- organizations increasingly invest in the extension of services and commercial activities.

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

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

Executive perceptions

Two questions were related to the executives' role perception. They were asked: (1) to rank the importance of different roles on a scale from 1 to 5: strategist, figurehead, entrepreneur, process manager, intermediate and administrator; (2) to rank how well they put the different roles into effect on a scale from 1 to 5. The outcomes are presented in Table 9.6.

Table 9.6 Role: Importance and performance (scale 1–5)

Roles	Role importance		Role performance	
	2000	2005	2000	2005
Figurehead	4.2	4.2	4.0	4.1
Strategist	4.7	4.6	4.4	4.4
Administrator	3.1	3.2	3.0	3.2
Process manager	3.0	3.1	2.8	2.9
Intermediate	3.3	4.2	3.4	4.1
Entrepreneur	4.3	4.3	4.0	3.9

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

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

We posed several questions with respect to the way executives interpret policy terms, such as *entrepreneurship*, *required change*, *effectiveness* and *accountability*. All questions were only posed in the 2005 survey, so only cross-sectional correlations could be analysed.

With respect to *entrepreneurship* we asked respondents how they realized or practised entrepreneurship. Answers show entrepreneurship can mean many things. Table 9.7 shows the outcomes per sector on a 1–5 scale.

It appears executives of organizations for elderly care and home care interpret entrepreneurship more *economically* than the others do. For them, entrepreneurship is not just an attitude or a way to improve performance but also a 'market strategy'. In elderly care and home

Table 9.7 The meaning of entrepreneurship

	Hospitals	Organizations for mentally ill people	Organizations for disabled people	Elderly and home care	Mean
Creative use of resources	3.8	3.6	3.7	3.9	3.8
Optimizing work processes	3.8	3.6	3.5	3.4	3.5
Initiating commercial activities	3.0	2.6	2.3	3.2	2.8
Stimulating professional innovations	4.1	3.8	3.7	3.8	3.9
Realizing cooperation in order to meet regional demands	3.7	4.1	3.8	4.1	4.0
Entering new markets	3.1	3.2	3.2	3.8	3.4

care, entrepreneurship is more about 'entering new markets', the 'introduction of commercial activities', as well as about 'creative use of resources'. Executives of hospitals interpret entrepreneurship more *professionally* in terms of 'stimulating professionals to innovate' and 'optimizing work processes'.

We also asked how important the following *changes* are for their organizations: a more business-like attitude which focuses on results, a more professional attitude with more attention for the professional development of employees, a more entrepreneurial attitude with more attention for realizing innovations, more attention for quality of care, more attention for broader public issues with respect to health care and a better price/quality ratio (answers could be given on a 1-3 scale). The outcomes show that, generally speaking:

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

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

With respect to *executive effectiveness*, we asked respondents what decisive criteria for success are: to be able to deal with tensions and dilemmas; to realize changes; to achieve good financial results; to formulate a binding vision; to stimulate employees; to adapt to the situation (only one answer was possible).

Respondents of different types of organizations appear almost unisonous in their answers.

- Executives believe 'realization of changes' is the most important criterion for success, followed by formulating a 'binding vision'.

With respect to *accountability*, we asked respondents what they feel most accountable for and would prefer to be judged upon: complying to political commissions; optimizing logistics; financial results; competitive position; quality of care; public responsibilities (a maximum of two answers could be given).

Again, respondents of different types of organizations mostly agreed.

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

Combining the outcomes regarding executive perceptions, we can draw several preliminary conclusions. First, executives strongly focus on entrepreneurship. Executives believe a more entrepreneurial attitude should be stimulated throughout the organization in order to realize change, and that they themselves should act more as 'entrepreneurs'. Yet entrepreneurship appears difficult to put into practice, especially in hospitals. Both the meaning of entrepreneurship and the opportunities to put entrepreneurship into practice differ per organizational field. Secondly, executives believe realizing change is an important criterion for success. The change they feel most necessary for their organization is a more entrepreneurial attitude. It suggests the entrepreneurial role is virtually synonymous to the role of change agent. Yet, thirdly, executives themselves are not mostly concerned with change or competitive position, but with quality of care and financial results. That is what they feel they should really be held accountable for. Fourthly, the intermediate role – acting in between different parties inside and outside the organization – has gained importance to executives. In addition, realizing a binding vision is believed to be important to succeed. Apparently, executives believe they need to have a binding function for people inside and outside the organization.

Executive actions

In order to gain more insight into what relationships executives maintain we asked respondents: what stakeholders and sort of meetings they attend to; and in what ways they participate in public debates.

With respect to *internal contacts*, outcomes show:

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

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

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

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

Executives might seek support for their position in the *public debate*, for example, through participation in political parties, direct contacts with politicians and civil servants, participation in the board or a committee of sector organizations, and by mobilizing colleague executives and by using the media (more than one answer was possible). This question was newly added to the 2005 survey. The outcomes show:

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

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

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

Conclusions

In this chapter we wanted to explore how the new entrepreneurial way of thinking has affected the perceptions and actions of health care executives and what sort of strategies are undertaken to combine innovations and legitimacy. We distinguished between two sorts of innovations: entrepreneurial innovations and institutional innovations. The

latter type of innovations is especially interesting because long-lasting changes in health care call for innovations that connect old and new logics and that can provide legitimacy to new ways of organizing and operating. This means executives will have to *blend* rather than *break* existing institutional frames, by building on existing values and belief systems. We also looked for changes in executives' competences.

We conclude executives engage in both entrepreneurial and institutional innovations, and that in practice both innovation strategies mingle. Changes in size, structure and products indicate that between 2000 and 2005 many entrepreneurial activities took place, but also that executives adapt strategies to the specific field of action (subsector). Local and sector-specific circumstances, habits and traditions influence executives' perceptions and actions considerably. For instance, when executives were asked what is meant by 'entrepreneurship', the executives of the different types of organizations answer differently. Executives in elderly care and home care interpret entrepreneurship the most *economically*, executives of hospitals more *professionally* – in terms of 'stimulating professionals to innovate' and 'optimizing work processes'. It shows how executives reinterpret an abstract policy term such as entrepreneurship, by seeing it from prevailing institutional logics, and by matching it to local settings. In that sense, the intentional and radical nature of innovation strategies must not be exaggerated. Even 'real' entrepreneurial innovations are institutionally biased – they flow from and are softened by existing institutional surroundings. Besides a pre-occupation with change and entrepreneurial activities, executives put considerable effort in realizing support for new ways of thinking and working from a variety of internal and external parties, and in maintaining a favourable public image. Executives aspire an entrepreneurial role, and feel that to realize change a more business-like, entrepreneurial attitude is necessary throughout the organization. At the same time executives aspire more and more an intermediary role that binds internal and external parties. This double loyalty also shows in the way they are educated and trained. Executives combine long-standing experience in health care management with new business knowledge. Becoming a health care executive is preceded by an extensive process of socialization and education in health care and ample experience in managing health care organizations. Health care executives are *specialized* managers. Nevertheless, executives continuously seek to extend their knowledge, especially on matters of finance and business management. Not only executives' background but also their loyalties appear to be strongly related to their institutional roots. Despite all efforts to realize a more entrepreneurial

way of thinking and working, most respondents' main priority is quality of care.

Further, we conclude the strategic space to operate and realize changes is more limited in organizations with high complex work processes and self-employed professionals. Executives of organizations for elderly care and home care appear to be the most entrepreneurially minded and institutionally active, and executives of hospitals the least. The latter are the least satisfied about the way they perform. They have more attention for professional affairs and less for external/political affairs and public issues/debates. It seems strong professional logics cannot only prevent existing institutional frames to break, but also to bend. In elderly care and home care entrepreneurial changes are more easily realized, but a break with traditions too, including the risk of long-term loss of legitimacy. We conclude, therefore, that thoughtful innovating in an institutionalized field such as health care requires the necessary 'diplomacy', which is so typical for steering networks, or 'management by negotiations', as Rhodes (2007, p. 1248) calls it. In daily practice this means executives have to act as liaisons: balancing between new and old stakeholders and between politically driven ambitions such as entrepreneurship, on the one hand, and prevailing institutional logics, full of local and sector-specific habits and traditions, on the other hand. Innovating in health care requires support from and dealing with professionals, as well as politicians, the media and the 'public' in general. As a result, the work of health care executives has 'politicized' too. Executives have to deal with many perspectives, parties, interests and issues, and are held accountable for many things they do not directly control.

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

Part IV

Discussion