Emerging Organizations
In between Local Translation, Institutional Logics and discourse

Waldorff, Susanne Boch

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The Doctoral School of Organisation and Management Studies (OMS) is an interdisciplinary research environment at Copenhagen Business School for PhD students working on theoretical and empirical themes related to the organisation and management of private, public and voluntary organisations

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In between Local Translation,
Institutional Logics and Discourse

Susanne Boch Waldorff

Department of Organization

Copenhagen Business School

Denmark

sbw.ioa@cbs.dk

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1.ACKNOWLEDGEMENTS

I've been taking off and landing but this airport's closed
And how much thicker this fog is gonna get God only knows
Just when you think that you've got a grip
Reality sneaks up it gives you the slip
As if you ever knew what it was taking you down the line

John Hiatt / Buffalo River Home

This dissertation would not have been possible without the support of a lot of people. In fact, the past three years have been about more than just writing this dissertation, they have also been about meeting interesting researchers and practitioners and about building up a network of relations. And, it has been a personal journey. Sometimes filled with doubts, sometimes confidence, I have entered a whole new area. All in all, it has been an exciting journey and I have certainly learned a great deal.

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2. INTRODUCTION

We often hear about newly developed organizations within the public sector. Policies, regulations, technologies, and demands constitute a vibrant platform for new practices to occur and stimulate new ways of organizing these practices. Thus, public organizations emerge continuously as manifestations of such change processes. However, we know only little about why organizations are framed into a particular organizational form with a specific focus and structure, and who gets to participate in these developments.

In this dissertation, I focus on national reform of the Danish public sector (the Reform). In January 2007, the provision of health services was decentralized and certain services were delegated to local municipalities. The Reform facilitated that municipalities could manage the new tasks in a "health care center" in order to meet specific local demands and improve primary health care. However, this new organizational concept was not governed by detailed legislative reform. The municipalities could therefore develop the organizational forms they wanted to within the overall aims of the reform. And although the concept is still fairly new, it has developed rapidly across numerous municipalities. Various actors at the local level, such as politicians, medical professionals, and social welfare professionals, participate in these developments. The case of health care centers constitutes an interesting context for investigating emerging organizational forms, as they focus differently on health promotion and rehabilitation and show great variation in their structure, including their governance, physical framework, and external relations. In particular, the way in which local actors construct specific organizational forms as legitimate local manifestations of the new national policy is intriguing.

This dissertation takes a neo-institutional approach, linking two theoretical frameworks that have so far been treated separately in the literature: the existence of multiple institutional logics and local processes of translation. First, it posits multiple institutional logics and discourses, which simultaneously enable and constrain the local actors' agency. The logics and discourses exist at multiple analytical levels, including not only the national level, but also the local level. Second, the local actors are assumed to have agency, and they utilize available institutional logics and discourses to create a particular legitimate meaning when they translate a new organizational concept into their specific local contexts. Moreover, specific

actors are granted the opportunity to participate in these local processes of translation due to a specific discourse, while others are not. The integration of these approaches constitutes a coherent theoretical framework that enables me to analyze the following research question:

- ***How does the heterogeneous institutional context influence local actors' translation of an abstract organizational concept into a specific organizational form?***

This research question implies that local actors ascribe meaning to institutional logics when they translate the health care center concept into a specific organizational form. In my analysis, I focus on the space between contextualized translations and overarching institutional logics and discourses. Social meaning creation among the various actors is situated in this space.

I examine the research question in three complementary analyses. The first analysis shows that although most of the involved municipalities drew upon the same logics, they nonetheless create different organizational forms. All of the municipalities constructed legitimizing accounts that drew upon three institutional logics embedded in the reform, including the logic of equal access, the logic of quality, and the logic of efficiency. Yet, the municipal accounts also drew on two institutional logics embedded at the local level, including the logic of organizational identity and the logic of economic sustainability. The local interpretations of these local logics created great variation in the organizational forms. The second analysis, apart from exploring the focus of the health care centers, analyses why they target different social groups. The analysis shows that the distinctions did not derive from the socio-economic variables in the community context, such as the municipal health profile, but had to do with the local actors' ideological or professional embeddedness in broader institutional contexts. Accordingly, the politicians and professionals drew upon different institutional logics underlying health care provision – the rehabilitation logic targeting patients and the lifestyle logic targeting citizens. Finally, the third analysis focuses on the process of translating the health care center concept within one specific municipality, and investigates how discourses position specific actors as powerful in this process. I identified two societal discourses that, in different ways, comprise the institutional logics identified

in the two previous analyses. The analysis demonstrates that over time the healthy citizen discourse became more dominant than the patient discourse because it facilitated the participation of a broad range of actors in health provision, and because these actors used discursive strategies to legitimize their translation of a health care center focusing on health promotion. These strategies successfully linked the discourse to the local political context, constructing a positive narrative about health promotion organization and moralizing on the need for health promotion activities. Furthermore, the analysis shows that there was a close link between discursive strategies and activities at the practice level. The weak rehabilitation discourse was linked to relatively few rehabilitation activities, whereas the dominating healthy citizen discourse was linked to a variety of health promotion activities. Section 6, which presents the three analyses, includes a summary of each analysis.

3. EMPIRICAL CONTEXT

a. Reform of the Danish public sector

In June 2004, a political agreement concerning a new structure for the Danish public sector was negotiated by the government (Agreement on a Structural Reform, 2004). This agreement initiated major changes within the health care sector and took into account the development of public health, the development of the health care sector organization, and the on-going political debate on the structure of the public sector.

The good news in the area of public health is that we live longer. In 2006, the average age for Danish men was 75.9 years and 80.4 for women (National Institute of Public Health, 2007). On the other hand, the number of elderly citizens is growing, and this is often raised as a societal problem because the elderly often need more treatment, care, and hospitalization (Iversen, 2008). Moreover, although many citizens are becoming generally healthier, some are expected to live longer with a chronic disease. In Denmark, the number of citizens with a long-term disease is expected to increase from 34.2% in 1987 to 44.3% in 2020 (National Institute of Public Health, 2007:461). In particular, chronic diseases, including heart disease, pulmonary disease, diabetes, asthma and allergic conditions, are expected to increase. At the same time, more citizens are becoming obese and drink more alcohol than recommended. This development in public health facilitates a massive demand for treatment. Yet, it also nurtures a growing need for health promotion and prevention as an instrument to reduce expensive long-term diseases, which places responsibility with the public as well as with the individual (Højlund and Thorpe Larsen, 2001). Fortunately, citizens are showing an increased interest in health as they demand greater quality of life and better general health (Iversen, 2008). On the other hand, there is substantial social inequality regarding the quality one's health as some social groups are particularly exposed to health risks stemming from their lifestyle, working environment, living conditions, etc. (National Institute of Public Health, 2007). All together, these developments in public health are pushing the health care sector towards prioritizing health promotion and prevention.

Centralization was another element of the political agreement concerning structural reform (National Institute of Public Health, 2007:383). Driven by new results in medical research and technological developments, patient treatment is becoming more specialized and is provided at fewer hospitals. This also means that patients should not expect long-term recovery in the hospital after their medical treatment. If needed, they will receive successive treatment, rehabilitation, ambulant care, or home visits by health professionals. Thus, the organizational development demands non-specialized health service in the patients' local environment. But, at the same time, this challenges the coherence in patient service as more organizational units become involved in providing treatment, rehabilitation and care.

Finally, the political agreement concerning structural reform was the culmination of an extended political debate on the structure of the public sector (Borum, 2006). The discussion was heated, as a reform not only touches upon many sectors of economic activity, but also the fundamental issue of centralization versus decentralization. The discussion included whether Denmark should maintain the regional governmental level and how large the municipalities should be in order to ensure local democracy and quality services. Several political parties argued that the governmental structure needed to change as it inhibited collaboration across sectors and governmental levels. One example of this is the health risks faced by citizens caught between regional and municipal services, a position that jeopardized the coordination and financing of patient rehabilitation after hospitalization. The Local Government Association called for stronger municipalities in order to solve these problems (Klausen, 2001; Borum, 2006). The regions, on the other hand, defended their role as providers of health service. Professional groups also participated in this debate. The Danish Nurses' Organization and the Health Confederation (*Sundhedskartellet*), which include occupational therapists, social counselors, nutritionists, etc., emphasized the need for broad collaboration within health care and were in favor of decentralizing health tasks at the municipal level. On the other hand, the Doctors' Association defended the maintenance of health tasks at the regional level, keeping general practitioners as key gatekeepers in health care service. Thus, many conflicting views and interests were monitored in the debate on the structure of the public sector.

Combined, public health development, centralization of the health care sector, and the debate on the public sector's structure contributed to the agreement between the conservative government (*Venstre* and *Konservative*) and a right-wing party (*Dansk Folkeparti*) that a reform of the public sector was to take effect on

January 1, 2007 (Agreement on a Structural Reform, 2004). The Reform merged fifteen counties into five regions and 289 municipalities into larger units with at least 20,000 citizens, subsequently resulting in a reduction in their number to 98. The reform also facilitated a new distribution of tasks between municipalities, regions, and the state. The regions would continue to manage hospital services and general practitioners. Yet, after the counties' disappearance, only the state and the municipalities would be collecting taxes, and the new regions' activities would be financed primarily by the state with a co-payment from the municipalities. A municipality is the lowest governmental level in the Danish public sector and manages most welfare tasks in a specific geographic area. The municipalities, via their financial contribution to the regions, were intended to become new actors in health care. The municipalities also became fully responsible for health promotion, prevention, and any rehabilitation not taking place during hospitalization.

b. Introducing the health care center concept

The Reform initiated the establishment of health care centers in municipalities. The idea of health care centers was not a new concept internationally or in the Danish context. It can be traced back to the late seventies and in particular the eighties, where it was proposed as a possible organizational solution to the challenges within the health care sector, i.e. the need for coherence and collaboration (Borum, 2006). Yet, the Reform revitalized this concept by suggesting that the municipalities should be able to find new solutions, especially within prevention and rehabilitation, and develop health care centers (Agreement on a Structural Reform, 2004). However, the organizational concept was very ambiguous. The prioritization of tasks was not specified, nor what constitutes "good health" or a suitable level of service. The concept provided only a general idea of how an organization can or ought to be structured; beyond this, it was flexible and open to interpretation, allowing local contextualization and adjustment (Bentsen and Borum, 2003; Røvik, 1998).

The concept of health care centers was also weakly enforced; neither the development of centers nor the integration of centers into the established health care sector became mandatory and regulated by law. This was in line with the general development within the public sector moving from a management system based on rules and procedures to a system based on decentralized decision making, perfor-

mance measurement and auditing (Power, 1997; 2007). Accordingly, 'soft' regulation with largely informal policies open to local interpretation and adjustment was put forward more frequently (Mörth, 2004; Kirton and Trebilcock, 2004; Kjær and Sahlin, 2007; Sahlin and Wedlin, 2008). These mechanisms broadened the scope of organizational behavior that might be considered compliant (Edelman, 1992). This situation also clearly brought into view how public organizations seek to construct what counts as a legitimate organization (Suchman, 1995). The local governments were required to demonstrate not only the results of their activities, but also to explicitly legitimate their interpretation of the national policy.

c. Health care center development

On December 21, 2004, the Danish Ministry of Health informed all municipalities about the possibility of attaining national funding for the development of health care centers. By February 1, 2005, the ministry had received sixty-three municipal applications, and on August 31, 2005, eighteen of these municipalities were selected and granted national funding.

In line with the general explosion of audits and monitoring technologies in society (Power, 1997; Kjær and Sahlin, 2007), the selected centers were evaluated externally by the impartial National Institute of Public Health. The evaluation showed considerable variation in the services provided. The municipalities were designing health care centers that differed regarding the focus given to particular social groups. Some centers emphasized the importance of the rehabilitation of patients with medical diagnoses, whereas others promoted a healthy lifestyle for all citizens or socially marginalized groups of citizens (Due, Waldorff, Aarestrup, Laursen and Curtis, 2008). The centers' organizational structures also showed considerable variation. Some centers were located physically in a building, whereas others were designed as networks of collaborating partners; some had open access for all citizens to health services, while others insisted upon receiving patient referrals from general practitioners. Finally, some centers were governed by the municipality alone, whereas others were managed in a public-private partnership.

By mid-2008 forty-two percent of all Danish municipalities were developing health care centers and twenty percent planned to do so (Ramboel Management, 2008). This indicates that the idea of creating a health care center to manage health

care services was becoming extensively diffused across municipalities. Yet, the health care centers should not be confined to being a question of the diffusion of organizational forms. As Borum (2006) argued, the new health care centers became an element in a major on-going reform of the established health care field. The Reform facilitated a new role for municipalities in health care provision and, thus, the emergence of a new municipal health care field to bridge an existing health care field oriented towards medical treatment with an existing municipal field oriented more towards social welfare. This new "organizational field", in DiMaggio and Powell's (1983) sense, includes municipal suppliers of health care (politicians, managers, employees, welfare professionals, medical professions, schools, daycares, and workplaces), resource and product consumers (patients and citizens), regulatory agencies (the Ministry of Health and Prevention, the National Board of Health, and the association of Danish municipalities, Local Government Denmark), and other organizations that produce similar services or products (regions, patient organizations, general practitioners, and hospitals). The definitions of a field are further explained in the following theoretical section.

An emerging field is an especially interesting setting in which to explore the emergence of new organizational forms. In contrast to a mature field, an emerging field is not defined by well-structured configurations of actors who interact through patterns of domination, subordination, conflict and cooperation (DiMaggio and Powell, 1983). Instead, instability and uncertainty impel (new) actors to behave strategically and theorize about new organizational problems and solutions as they sense opportunities for influence. New patterns of interaction as well as new organizations are likely to emerge. In this case, the vague concept of a health care center could be used as a strategic tool, as it was to be translated into a local context. This called upon the involvement of many different actors as well as many different interpretations of the concept. Already, the observed variations in the health care centers' organizational forms indicated that different issues must have been taken into account in the shaping of the centers. The development also suggested that different actors, such as politicians and professionals, were involved in the process, and that the actors were probably using different discursive strategies to legitimate their interpretation of the concept. Consequently, I found the case of health care centers promising with regard achieving a fruitful exploration of the emergence of organizational forms.

4. Theoretical platform

a. Introduction - meaning is key

The dissertation's research question calls for a theoretical framework that recognizes actors' creation of various social meanings. The creation of meaning is far from a new matter in neo-institutional theory. The theory, rooted in social constructivism, states that individuals form concepts or mental representations of each other's actions, and that these concepts eventually become habituated or institutionalized into relational roles (Berger and Luckmann, 1966). Thus, neo-institutional theory understands social action as basically role driven and structured by institutions. Institutions are "cultural rules giving collective meaning and value to particular entities and activities, integrating them into larger schemes" (Meyer, Boli and Thomas, 1987:13). Institutionalization is the process by which a given set of units and pattern of activities come to be normatively and cognitively taken for granted.

Literature that deals with diverse meanings and uses qualitative research methods is still somewhat peripheral in the mainstream institutional field (Zilber, 2008). Yet, after having long emphasized how institutional structures in the external environment shape organizational homogeneity and stability, neo-institutional researchers have increasingly come to focus on heterogeneity and change. Scholars have shifted their attention to multiple co-existing or conflicting logics (Friedland and Alford, 1991, Thornton and Ocasio, 1999), agency and institutional entrepreneurship (DiMaggio, 1988, Greenwood and Suddaby, 2006; Boxenbaum and Batilliana, 2005; Dorado, 2005), power and struggles (Lawrence, 2008; Lounsbury, Ventresca, and Hirsch, 2003; Clegg, Courpasson and Phillips, 2006), and the mutual interaction between practice and institutions (Lounsbury and Crumley, 2007; Strandgaard Pedersen and Dobbin, 2006; Phillips, Lawrence and Hardy, 2004). Along these lines, institutional studies more often include the micro-level, analyzing the interplay between several analytical levels (Haveman and Rao, 1997; Lounsbury, 2007; Marquis, Glynn and Davis, 2007), and the work of creating, maintaining and disrupting societal institutions (Lawrence and Suddaby, 2006). The focus on various social meanings brings pluralism and variety into institutional theory and sheds light on the dynamic processes of institutionalization.

In this chapter, the first step I take is to explain my conceptualization of an organizational form. Next, I look at how neo-institutional research has set out to ex-

plore how organizational forms become alike as an outcome of the process of institutionalization. This includes more recent literature that acknowledges that actors create various theorizations of organizational concepts as a stage in the process towards institutionalization and isomorphism. Then, I conceptualize the broader institutional context for this study, including the organizational field and the geographically bounded community, as well as the existence of multiple institutional logics. I subsequently present an alternative theoretical approach, suggesting that researchers should not treat institutionalization as a process of diffusion and the adoption of a fixed concept, but instead investigate how interacting actors make sense of a new organizational concept as it travels into their local context. In my analyses, I draw upon this latter approach of translation, emphasizing the creation of local meaning by drawing upon multiple institutional logics. Further, I discuss critical discourse analysis, which I employ to explore discursive legitimizing strategies, but also how a discourse positions specific actors as powerful in the translation process. Finally, the chapter outlines the overall theoretical framework for this dissertation. My argument is that we need to investigate how the heterogeneous institutional context, i.e. multilevel institutional logics, has an impact on the actors' creation of a local social meaning and, thus, the emergence of specific organizational forms.

b. Organizational form as a symbolic construction

The object of my analysis is the actors' construction of social meaning related to emerging organizational forms. Like others, I concur with shifting attention from understanding an organization as a solid, fixed and formal structure to studying it as a fluid, contradictory, fragmented and ephemeral phenomenon (Hardy and Phillips, 2002). Yet, the organizational form itself has become a common institution in modern Western culture (Zucker, 1983; Røvik, 2007; Forsell and Jansson, 1996). Brunsson (2000) argues that the organizational forms are in fact the way organizations are presented to the external world or to their own members by authorized people such as managers. The organizational forms tend to be highly rationalized as they are presented as a means to legitimate ends or as a solution to important problems. Or, as Scott argues, a way to symbolize a serious commitment to achieve goals or protect values (1992: 165). Accordingly, I take into account that an organization, no matter how fluid it might be, is presented as a symbolic construction in the shape of a particular organizational form.

I also acknowledge that the discursive justification of a particular organizational form is part of an on-going organizational development process. Like most neo-institutional researchers, I understand an organization as basically a cultural entity or meaning system interacting with its environment. Scott defines organizations as open systems that are coalitions of interest groups highly influenced by their environments (1992:26). This allows for a dynamic approach in studies of organizational forms. Likewise, Greenwood and Hinnings (1996) suggest that an organizational form is an archetypical configuration of structures and practices given coherence by underlying values regarded as appropriate within an institutional context (in Greenwood and Suddaby, 2006:30). These approaches imply exploring how organizations embody changing institutional logics in their environment (Scott, 2004:11). As Kraatz and Block point out, the purposes and control structures of organizations are transformed over time as a result of broader historical shifts in institutional logics (2008). For instance, Molin and Christensen showed in a study of the Danish Red Cross how the changing institutional orders in the environment affected the development of problems and solutions that became defined as relevant task for the organizations (Molin and Christensen, 1995).

Yet, organizations are not just open systems influenced by their unstable and heterogeneous institutional context, they are also constructed in a particular way by organizational actors. Building upon Selznick's (1957) early institutional work on 'organizational selves', Kratz and Block argue that institutional pluralism creates a type of self-governing pluralistic organization with "the capacity to constitute itself by choosing its identities and commitments from the menu of choices presented by its would-be constituencies and by society at large" (Kraatz and Block, 2008: 255). This approach emphasizes organizational actors' agency. For instance, when Borum and Westenholz (1995) analyzed the development of the Copenhagen Business School, they discovered that as a supplement to exogenously generated change, several interacting internal and external actors contributed actively to shaping the institution.

Thus, I analyze organizational forms as the symbolic construction of an organization. An organization is an open system embodying logics in the institutional context and constituted by interacting actors constructing social meaning.

c. Institutional mechanisms and process

The processes by which organizations become so alike have increasingly gained attention in neo-institutional research. Initially, DiMaggio and Powell (1983) suggested capturing this process as institutional isomorphism; organizations face similar institutional pressures that force them to conform to specific organizational forms in order to obtain legitimacy. Specifically, three mechanisms of institutional isomorphic change were identified: coercive isomorphism by which organizations face regulative or political pressures, mimetic processes by which organizations experience uncertainty and unclear goals facilitating mimetic behavior and, finally, normative pressures by which organizations are influenced normatively by professionals.

However, other researchers have developed models of change that more explicitly include the creation of meaning as a stage in the institutionalization of a new organizational form. These models accentuate that the cognitive beliefs of actors influence institutionalization. Tolbert and Zucker (1996) suggest that institutionalization begins with 'habitualization', which is the generation of innovations and new structural arrangements in response to a specific organizational problem. 'Objectification' follows and involves the emergence of a social consensus concerning the value of a structure and the increased adoption of this model by organizations. This stage also involves the actors' creation of meaning – or 'theorization'. Theorization is a means to justify new ideas and innovations; as Strang and Meyer write: "By theorization we mean both the development and specification of abstract categories and the formulation of patterned relationships such as chains of cause and effect" (1993: 492). However, Tolbert and Zucker constrain theorization to a particular stage in institutionalization instead of acknowledging that it is an on-going social process of linking problems and solutions. They argue that theorization is conditioning the process of diffusion through a linguistic simplification and generalization of an organizational form presented as a necessary solution to a problem. The last stage is "sedimentation", which is defined by the complete spread of a particular organizational form in a field and a decline in organizational variance.

Greenwood, Suddaby and Hinings (2002) elaborate upon this model by accentuating that theorization is a process in which new ideas become justified and legitimated as part of the institutionalization process. Theorization in this model involves actor specification of general organizational failings, the justification of an abstract possible new solution, and the construction of the moral and/or pragmatic

legitimacy of this solution. Still, theorization only occurs at a certain stage in the institutionalization process.

d. Institutional context – organizational field and community

The process of institutionalization takes place within an institutional context. In institutional theory, the most dominant conceptualization of context has become the institutional field. Scott emphasizes that field actors share common cognitive understandings (2004). Accordingly, an institutional field is: "a community of organizations that partakes of a common meaning system and whose participants interact more frequently and fatefully with one another than with actors outside of the field" (Scott, 1994: 207-8). However, as I explore the simultaneous existence of multiple meanings, I draw upon Meyer's suggestion to distinguish the organizational field from the institutional field (Meyer, 2008:525). This distinction draws attention to the heterogeneity of institutionalized patterns and the co-existence of multiple interpretation frames. Accordingly, I conceptualize the field as an organizational field of interacting actors defined by multiple, potentially competing institutional orders or logics. As the organizational field does not anticipate shared meaning, it builds upon the more functional definition by DiMaggio and Powell which suggests that a field is "those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce services or products" (DiMaggio and Powell, 1983:148). Further, DiMaggio and Powell acknowledge not only that contention but also that struggling to write the rules and control the resources are part of the construction of an organizational field (Scott, 2004:22). Likewise, Hoffman stresses that "fields become centres of debates in which competing interests negotiate over issue interpretation" (1999: 351). An organizational field has to be defined empirically; thus, I point to the previous section on empirical context which provides further description. The concept of organizational field, i.e. the municipal suppliers of health care, is included in all three analyses in this dissertation.

In the second analysis, I examine not only organizations as situated within an organizational field constituted by their collaboration, but also as situated within different geographically bounded communities that influence the emerging organizational forms differently. Institutional analysis has overlooked the influence of geographic communities. Despite Selznick's (1949) early work, which emphasized

how local contexts have a strong influence on organizational behavior, actors are not commonly linked to any specific geographical area in contemporary field-level analysis. However, the inclusion of the level of geographically bounded community is of considerable significance here because communities, unlike fields, are typically defined by political boundaries, i.e. they are jurisdictions. Jurisdictions are explicitly intended to allow the expression of differences in political views. Different expressions become manifest in public policies and spending patterns – that is, jurisdictions reveal some of the implications of institutional processes for different societal groups that arise from the institutions of election. But jurisdictions are also important sites, because they are places where professions often exert their influence. In most jurisdictions, professionals practice their craft in the provision of public services. Recently, the possible role of community processes has been advanced by numerous researchers (Molotch, Freudenberg, and Paulsen, 2000; Romanelli and Khessina, 2005; Freeman and Audia, 2006; Marquis, Glynn and Davis, 2007; Lounsbury, 2007; Greenwood, Diaz, Li and Lorente, 2009). As mentioned, I include the context of the geographically bounded community – a jurisdiction – in the second analysis, which compares how eighteen different municipal contexts influence the development of the health care centers' organizational forms.

e. Institutional logics

Both organizational fields and geographically bounded communities include institutionalized belief systems that motivate and guide the behavior of the interacting actors. A recent development allowing for a heterogeneous approach in neo-institutional theory (Scott et al., 2000; Kitchener, 2002; Reay and Hinings, 2005, 2009; Lounsbury, 2007) is the concept of an institutional logic. Friedland and Alford define an institutional logic as "a set of material practices and symbolic constructions – which constitutes its organizing principles and which is available to organizations and individuals to elaborate" (1991:248). As such, logics provide the ground rules for social behavior and the criteria by which options and possibilities are to be assessed. Later, Thornton and Ocasio elaborate on this definition, arguing that logics are "the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (1999: 804). I assess this definition of logic as it emphasizes the socially constructed patterns actors use in the creation of social meaning. Thornton

later developed six ideal types, the market, the corporation, the professions, the state, the family, and religions, which are characteristic for several different institutional sectors and useful for studying multiple logics in conflict or consensus (Thornton, 2004). Further, Scott highlights that in order to be active, logics require carriers such as individuals and organizations that affirm, embody, transmit, and act in accordance with the principles (2004: 16).

As this dissertation analyzes health care, I build upon research by Scott, Ruef, Mendel and Caronna (2000), who identify three institutional logics that emerged in U.S. health care between 1945 and 1995 in the San Francisco Bay Area. Scott and his colleagues showed that after decades of domination by the medical professions' logic of quality of care, the state emphasized democracy and the logic of equity of access as part of a transformation of the health care delivery system. This further paved the way for a managerial logic of efficiency in the form of managed care and new organizational forms such as HMOs. The change resulted in the destructuration of the field, implying that consensus on the institutional logics was reduced. Although I employ the theoretical conceptualization of thee three institutional logics existing within health care, I take into account that Scott et al. were focusing on U.S. health care, which is a more market-oriented field compared to the Danish welfare system. Thus, in the first analysis, I explore the health care centers' emerging organizational forms and the existence of the three institutional logics guiding this development. Apart from confirming this, I also discover two additional logics at the local level –the logic of organizational identity and the logic of municipal economic sustainability. This first logic emphasizes that a municipality is a historically and socially constructed organizational entity that is a central feature for carrying out service in a highly decentralized public sector. Yet, a municipality is not a fixed and solid organization but is subject to change and, thus, also to on-going re-constructions of its' organizational identity. The second logic emphasizes that an organization requires an economically sound platform for its agency and survival. This shows that logics at national and local levels are drawn upon in the local conceptualizations of the health care centers' organizational forms. In the second analysis, I narrow my analytical focus to the construction of an organization's focus. Specifically, I find that two institutional logics underlie the centers' provision of health care services. Each logic is supported by different ideological and professional groups – a rehabilitation logic is supported by social democratic politicians and medical professions, and a lifestyle logic is supported by conservative politicians and social professions.

f. Translation and the creation of localized meaning

As much as the dominant analytical contributions explain how institutionalization happens and include the actors' creation of various meanings drawing upon multiple logics, they pay only little attention to what it actually means to adopt an organizational concept and how the organizational actors are involved. Furthermore, the anticipated outcome of the process is isomorphism rather than variation in organizational forms. Scandinavian institutional researchers, in contrast, imagine that in order for a concept to diffuse, the actors must create localized legitimate meanings through 'translation' (Brunsson, 1989; Brunsson and Olsen, 1993; Czarniawska and Sevón, 1996; Czarniawska, 2008; Røvik, 1998, 2007; Sahlin-Andersson, 1996; Sahlin and Wedlin, 2008; Erlingsdottir and Lindberg, 2005). Czarniawska and Joerges describe translation as a process in which actors disembed an idea such as a management concept from its institutional surroundings, and translate it into an object such as a text, a picture or a prototype, which is able to travel from one time and space context to another context (Czarniawska and Joerges, 1996:22; Czarniawska, 2009:425). This idea is then translated to fit the new local context, materialized into practice, and, if repeated, institutionalized until it again might be disembedded and translated into another time and space. This definition is based on the ideas of translation as conceptualized in actor-network theory (Callon and Latour, 1981; Latour, 1986). Translation emphasizes movement and transformation.

The concept of translation has itself undergone translation as it travelled into the neo-institutional context. Whereas the actor-network theory builds upon a constructivist ontology that emphasizes that the social world along with the material one co-construct knowledge of reality, the approaches in the neo-institutional version of translation are more straightforwardly *social* constructivist (Scheuer, 2003). In other words, the neo-institutional theory investigates actors' creation of localized social meaning and specific use of language as part of the translation process, while actor-network theory explores activity, including the translation and enrolment of heterogeneous interests into a coherent powerful network of human as well as non-human actors – a so-called socio-technical network. For instance, Adolfsson (2005) analyzes the translation of the idea of environmental concern into actions and objects in the city management of Stockholm, i.e. how air and water were measured by machines, transformed and presented in reports enabling the

enrolment of various actors, and then used as scientific data signaling that the city is green and clean.

The emphasis on language in the neo-institutional version of translation is shared with the concept of theorization as used in the diffusion models of institutionalization I described earlier. Yet, while theorization stresses the actors' specific problematizations and creations of a link between rationalized means and ends, the concept of translation is then more than justifying and legitimizing language; it is the whole process of travelling and the transformation of a concept from one specific time and space context into another; it is the actors' collective and relational interaction that produces the power of a specific concept, and it is the materialization of a concept into practice. Furthermore, while theorization anticipates a growing field-level consensus, and is conceptualized as a stage towards isomorphism, the concept of translation allows for cognitive heterogeneity and enduring organizational variation and distinctiveness. Translation offers both a conceptual and methodological way for neo-institutional theory moving beyond the totalizing view of institutions and institutional outcomes (Lawrence and Suddaby; 2006:243). Ideas are interpreted and made sense of by actors within each organization; and, because actors arrive at different understandings, they respond differently to institutional pressures. Thus, there is more than one way in which an actor can interpret an idea within a given context, and the institutionalization is an on-going process, not a fixed process of mechanisms or stages towards isomorphism.

The studies on translation demonstrate a preference for intensive, rich, process-oriented qualitative approaches to the study of organizational practice (Røvik, 2007; Sahlin, 2008; Czarniawska, 2008; Boxenbaum and Pedersen, 2009). Particularly, researchers seek to identify important mechanisms of the translation process by analyzing how an idea such as an organizational concept, label, form, or practice is materialized and translated into a new context. Some of these studies focus on organizational mechanisms and consequences. For instance, Sahlin (2008) explored the use of language, describing it as 'editing'. Actors follow rule-like patterns to present ideas in familiar and commonly accepted terms as well as use a specific communication structure in each setting. An idea is presented with a reconstructed logic that fits the local setting, and with a specific label that makes sense and attracts attention. Hedmo, Sahlin-Andersson and Wedlin (2005) studied the translation of a U.S. business school model into Europe and identified the existence of three modes of imitation (Sevon, 1996), i.e. broadcasting, chain and mediated as part of an emergence of field. And in a study of Swedish health care, Erlingsdottir and Lindberg (2005) analyzed the translation of new management ideas

into three different contexts and found that the organizational consequences of translation were not only isomorphism (homogeneous forms), but also isopraxism (homogeneous practices) or isonymism (homogenous labels for different forms and practices).

While some studies explore the mechanisms and consequences of a concept being translated, other studies explore why one organizational response is chosen over another. Some of these studies focus on organizational features. Scheuer (2003) compares two hospital clinics and analyzes the meeting between a reform idea and clinical practice. He finds that the translation output was influenced by the clinics' technology and social structure, as well as the organizational actors' interpretations of environmental demands. Frenkel (2005) investigates how the past, including organizational memory and managerial traditions, is significant for the translation of the family-friendly organization into Israeli companies. Powell, Gammal and Simard (2005) studied how the responses of 200 U.S. non-profit organizations to ideas about new practices were conditioned by key features of the respective organizations, the nature of the carriers that exposed the organization to the new idea and selective aspects of the encounter itself. Furthermore, a few studies include the impact on translation of field-level institutions. Forssell and Jansson (1996) study how the corporatization of organizational forms in three different contexts – Swedish savings banks, railways and local government – was conditioned by institutionalized organizational forms and the redefinition of future activities. Boutaiba and Strandgaard Pedersen (2003) analyzed how the Copenhagen Business School's translation of an MBA identity into a specific program was conditioned by institutional forces at the field level, including early and late adopters, accreditation and ranking lists, as well as internal forces at the organizational level, including strategic actors, the enrolment process, and symbolic communication. Finally, Boxenbaum (2005) investigates how the American concept of diversity management travelled into Danish and Canadian contexts by blending with the prevailing national institutional logic.

Yet, I argue that there is a need to take this curiosity even further. With Powell et al. (2005) being a prominent exception, only few studies have compared similar organizations situated in different contexts in order to understand what influences the outcome of the translation process. And even more importantly, although researchers recognize the influence of institutions as the process of translation, it is not always conscious and strategic; it is often implicitly governed by institutionalized beliefs and norms (Sahlin-Andersson, 1996), circulating templates (Sahlin, 2008), master ideas (Czarniawska and Joerges (1996), or management fashion

(Czarniawska and Sevón, 2005). The studies on translation have paid little attention to how the institutional context has an impact on actors' creation of a local social meaning. Particularly, conceptualizing the institutional context as the existence of heterogeneous institutional logics and discourses within an organizational field or a geographically bounded community will contribute to a better understanding of what influences the local translation of an idea into a specific organizational form.

g. Discourse analysis

Researchers have increasingly combined neo-institutional theory with discourse analysis in order to analyze actors' discursive legitimation of new organizational practices. Elsbach (1994) studies the California cattle industry, showing how organizational actors constructed verbal accounts in order to manage perceptions of organizational legitimacy. Creed, Scully and Austin (2002) study how legitimating accounts were constructed in local settings for and against workplace discrimination policies. Suddaby and Greenwood (2005) show how the organizational actors in five big accounting firms used rhetoric to shape the legitimacy of new multidisciplinary partnerships by drawing on two contradictory institutional logics – expert and trustee – that underpin a professional logic. Other researchers examine discursive legitimation as part of an institutionalization process. Skålén (2006) analyzes the institutionalization of Total Quality Management in Swedish health administration, highlighting how discourse disciplined the organizational actors' construction and perception of social reality. Green, Li and Nohria (2009) analyze the same concept within the American business community, suggesting the conceptualization of the institutionalization process as changes in arguments that legitimize and justify material practices over time. Finally, treating institutionalization as a process of translation, Zilber (2006) shows how four discursive rational myths were constructed in the Israeli high tech environment around the millennium, while Maquire and Hardy (2009) show how the deinstitutionalization of DDT was a result of actors carrying out disruptive and defensive work by authoring texts changing the underlying discourse.

In the third analysis, I build upon this literature and combine the approach of translation with discourse analysis in order to explore further how local actors socially construct the legitimacy of emerging organizational forms. However, organizational discourse analysis comprises multiple approaches. Some researchers focus on actors' interaction and use of language, including conversation, narratives,

rhetoric and tropes, while other researchers emphasize the social and historical context of discourse, i.e. pragmatics, socio-linguistics, institutional dialogue, systemics and critical discourse analysis (Grant, Hardy, Oswick and Putnam, 2004). Alvesson and Kärreman (2000) propose capitalizing the word discourse in the second sense and, thus, distinguishing between an analysis of local situated linguistics – a discourse, or an analysis of powerful ordering institutional forces – a Discourse. Yet, among the Discourse analysis approaches, I find that critical discourse analysis (Fairclough, 1992, 1995; Wodak and Meyer, 2002, Phillips and Hardy, 2002; Vaara, Tienari and Laurila, 2006) offers a particularly interesting analytical lens as it allows the exploration of not only the actors' discursive work, but also of how a discourse positions actors with heterogeneous access to power.

Like Phillips and Hardy (Phillips and Hardy, 2002, Hardy and Phillips, 2004), I conceptualize discourse as a form of discursive agency, i.e. organizational actors' use of specific language in legitimating new practices, as well as institutionalized rules providing meaning to society. A discourse is defined here as "structured collections of texts, and associated practices of textual production, transmission and consumption, located in a historical and social context" (Hardy and Phillips, 2004:300). Thus, discourses originate from actors producing texts, while simultaneously giving meaning to these actions, thereby constituting the social world. Yet, whereas Phillips and Hardy (2004) suggest that the organizational actors seek to make sense of a new situation and use rhetorical strategies embedded in discourses to legitimize the organization, I do not anticipate that these strategies are developed intentionally in order to further the actors' interests, nor do the actors possess the power to do so.

Instead, I pay specific attention to the heterogeneous context in which more competing discourses exist and how these discourses position organizational actors with different access to power (Nexø and Koch, 2003; Torfing, 2005; Cooper, Ezzamel and Willmott et al., 2008). The critical discourse analysis emphasizes the Foucaudian concept that actors do not posses power (Foucault, 1970, 1972), but power is provided to specific subjects by discourse. Thus, I do not analyze power in terms of juridical power, or in terms of a resource or capacity one can possess as perceived by Dahl and Bacharach and Baratz, or as a relation of hegemonic dominance as Lukes suggests (Clegg, Courpasson and Phillips, 2006; Cooper, Ezzamel and Willmott, 2008). I explore how some individuals warrant a louder voice than others by virtue of their position in the discourse (Hardy and Philips, 2004:302). I argue that combining the approach of translation with critical discourse analysis contributes to analyzing the legitimacy of a new organization as

not only socially constructed within a local context, but also as influenced by actors positioned as powerful due to available discourses. This implies analyzing which discourses constitute particular actors with access to power in the process of translation and, furthermore, how these actors employ discursive strategies to legitimize their specific translation of a health care center embedded in this discourse.

Accordingly, I include overarching societal discourses (Foucault, 1970, 1972) in the analysis. Discourses act as socially constructed systems in the organization's institutional environment, and their features define what can be considered as legitimate. Yet, critical discourse analysis conceptualizes discourses as heterogeneous and never completely cohesive or able to determine social reality entirely (Hardy and Phillips, 2004: 304). Thus, multiple discourses are available to create a space as well as a resource for actors to construct organizational reality in such a way as to justify or legitimize particular actions or outcomes. Particular matters are constructed as positive, beneficial, ethical, understandable, necessary, or otherwise acceptable to the community in question. In contrast, other matters are negative, intolerant, or, for example, morally reprehensible (Vaaro et al., 2006).

I also analyze how actors at the micro level develop discursive strategies in order to co-construct senses of organizational legitimacy. These discursive strategies are embedded in legitimizing discourses. The analysis draws in particular upon a study by Vaara, Tienari and Laurila (2006), who identify five discursive legitimizing strategies used in the media to make sense of an international merger: normalization, authorization, rationalization, moralization and narrativization. Vaara et al. build upon earlier work by Van Leeuwen and Wodak (1999), but establish normalization as a fifth strategy instead of a sub-category to rationalization because their analysis of data indicate this. However, whereas Vaara et al. analyze the strategies as they became visible in the media, I investigate the development of discursive strategies within an intra-organizational context. I explore the strategies in order to examine how they are used by organizational actors, whose discourses they link to in order to derive legitimacy, whether their use has an impact on the domination of a particular discourse and, finally, how they constitute a link between discourse and the level of practice.

Finally, I reflect upon how discourses and power are mutually constitutive. Inspired by Michel Foucault, the tradition of critical discursive analysis focuses on how power has productive aspects and constitutes individuals as subjects and objects (Foucault, 1970, 1972; Fairclough, 1992, 1995; Torfing, 2005). As an example, the discourses on health shape – and change over time – how individuals

such as "patients" are constructed, which roles they are permitted, and with which purposes they are included in specific policy documents (Pedersen, 2008:5). Different constructions result from specific forms of problematization (Foucault, 1972). Power is furthermore the 'conduct of conduct' – a disciplinary power regulating actions by means of shaping the identities, capacities, and relations of subordination of the social actors. In line with this, "governmentality" concerns the whole range of practices and activities that are undertaken by various agencies and authorities in order to shape the conduct of citizens and subjects (Foucault, 1973; Rose, O'Malley and Valverde, 2006; Dean, 2006). In this study, I discuss whether health care centers are perhaps a so called governmentality technology shaping the behavior of citizens.

The combination of neo-institutional theory on translation with critical discourse analysis constitutes a coherent theoretical framework for analyzing legitimacy of a new organization as not only socially constructed within a local context, but also as influenced by actors positioned as powerful due to available discourses.

h. Accepting the complexity – "my take" on translation in a local institutional context

I draw on a tradition of institutional research that treats the diffusion of new organizational ideas as a process of translation. Actors within an organization translate ideas into solutions that fit their locally constructed problems. Organizational concepts are thus socially constructed into various organizational forms. However, not much attention has been paid specifically to how the heterogeneous institutional context guides this translation and the emergence of specific organizational forms. In this dissertation, I focus on the part of the translation process when a new organizational concept has become abstract and has begun to travel as interacting organizational actors make sense of it and translate it into their local contexts. This focus allows me to explore how the institutional context guides the actors' early interpretations and conceptualizations of the new organizational forms in a specific way. Due to the recentness of the health care center concept, I will not, though, be able to explore the later part of this process when the new idea might have become taken for granted and institutionalized as a specific organizational form. I conceptualize an organizational form as the

symbolic construction of an organization. An organization is an open system embodying logics in the institutional context and constituted by interacting actors constructing social meaning.

The translation process takes place within an institutional context. I conceptualize this context as an organizational field or a geographically bounded community. These levels are not ontologically conflicting, but explore the emerging organizations as positioned within diverse contexts and boundaries; respectively organizations constituting an emerging municipal health care field, and organizations within different jurisdictionally and geographically bounded local communities. Together, the levels create a synergetic theoretical framework for my analyses of the institutional context's influence on the actors' creation of meanings and the development of particular organizational forms.

I argue that we need to investigate how the local process of translation is guided by multiple institutions embedded at more analytical levels. Thus, I include the concepts of institutional logic and discourse. These concepts are similar as they both emphasize a socially constructed system providing meaning in an institutional context of actors and organizations. Furthermore, both concepts provide an important dynamic link between structure at the macro level and agency at the micro level. On the one hand, the logics and discourses guide and constrain actors' agency, while on the other hand, they are legitimizing tools that can be employed by actors. Multiple logics and discourses exist, creating a space for local actors' interpretations and agency.

Applying the discourse analysis also means exploring the role of language. I employ critical discursive analysis to investigate how actors use legitimizing texts as part of their translation of an organizational concept into their local context, and further how competing discourses provide different sources of legitimacy to organizational forms as well as provide local actors with heterogeneous access to power. In this way, the discourse analysis helps to explain which specific actors are positioned as powerful and involved in translation, and why specific organizational forms are legitimate in a particular way.

The theoretical considerations and choices in this dissertation imply the construction of social reality as plural, heterogeneous and complex on-going processes. This fluid theoretical approach is informed by poststructuralist thinking in the sense that it acknowledges the variety of individual experience and interpretations, and emphasizes difference and contextualization. I seek to explore how different regimes of "truth" emerge from different logics and discourses

within different contexts. I also acknowledge that these multiple institutions, rather than just constraining actors' agency and entrepreneurship, also enable them. While this is not an entirely new approach in institutional theory, so far few researchers have explored how the multiple overarching institutions interact with the diversity, fragmentation, and conflicts in everyday social life. In particular, focusing on how actors at the micro level create a specific localized social meaning while drawing on multiple institutional logics is fruitful. This approach sheds more light on the complex processes of institutionalization, and by bringing heterogeneous institutions into processes of translation, it allows for a more dynamic perspective in neo-institutional theory.

5. METHODS

In this section I first explain my strategy of analysis, which is primarily a qualitative bottom-up policy analysis. Then, after presenting my approach to studying organizational forms, I explain the design of my study as a case study and as a longitudinal design in one of the analyses. I also clarify which qualitative and quantitative data I collected, and how I used method triangulation in the process. Finally, I describe the overall analytical model of this study comprising three separate analyses.

a. Strategy of analysis - qualitative method and bottom-up policy analysis

As the actors' creation of social meaning is at the core of my dissertation, I apply a strategy of analysis that is primarily qualitative. The strategy is a bottom-up policy analysis (Sabatier, 1986; Hjern and Hull, 1987; Bogason and Sorensen, 1998; Reff Pedersen, 1999; Gjelstrup and Sorensen, 2007), which is an open analytical approach focusing on actors at the micro level. I investigate the actors' subjective interpretations of a policy initiative, and their creation of social meaning within a local context. Underlying this approach is the theoretical assumption that local actors construct what to consider as a problem (Sahlin-Andersson, 1996), and they construct legitimate solutions for this problem that fit their local context.

In recent years, bottom-up policy analysis has gained renewed interest among researchers as the perception of public governance has changed (Gjelstrup and Sorensen, 2007). Moving away from a focus on formally assigned bodies of government, the focus is now on the complex, situated processes of interaction between formal and informal actors. The bottom-up approach is also a reaction to top-down analysis. Top-down analysis focuses on the actors formally responsible for policy initiatives and investigates whether a policy initiative has been implemented correctly and efficiently. However, the top-down approach does not capture the actors' social construction of meaning as it provides little understanding of why a policy succeeds or not, and it neglects the impact on areas other than those intended by the policy.

The qualitative approach emphasizes that there is not just one objective reality or truth (Kvale, 1995). The qualitative method explores research questions using an inductive process aimed at revealing details about what is unique and typical, as

well as overarching patterns and themes (Mainz, 1995). Or as Zilber argues, the qualitative methods allow an investigation of the particular, contextual, political, and on-going processes (2008:151). Thus, I apply qualitative methods in order to produce new knowledge about various local actors' social constructions of meaning.

Yet, I also apply quantitative methods in one of the analyses. Apart from being designed to verify or reject hypotheses, quantitative methods estimate prevalence and incidence (Mainz, 1995). Specifically, I use quantitative methods in order to compare socio-economic and political variables across municipalities and to explore the impact of these variables on the shaping of health care centers.

b. Analyzing organizational forms

I analyzed the actors' creation of meaning related to various organizational forms. Like Marquis, Glynn and Davis (2007) and D´Aunno, Sutton and Price (1991), I conceptualize these organizational forms in terms of the organizations' 'focus' and 'structure'. The focus describing the domain that is targeted, i.e. the service provided by health care involving health promotion or rehabilitation, and the scope of service being focused or broad, as well as the centers' structure describing the manner in which the organization engages with that domain, such as its governance, physical framework, and relations to the health sector through an open access to service or mandatory referrals of patients. The Reform allowed many different organizational forms to emerge. For instance, the same focus on service being health promotion or rehabilitation could be combined with different organizational structures such as the physical framework being either a network of collaborating local organizations or the provision of health service from a new building.

In practice, it was difficult to define the boundaries of each health care center. This was a considerable challenge because of the fundamental principal prevalent in the Danish public sector which provides local municipalities with a broad range of freedom regarding organizational developments. Accordingly, the municipalities positioned their health care centers differently within the internal municipal divisions, such as within a health care division or within a social welfare division. And sometimes the health care centers were located with services for the elderly and sometimes with services for the youth. To solve this problem, I decided to include the documents that each municipality submitted to the National Institute of Public

Health as part of the external evaluation of the centers. These documents monitor the organizational form of the health care centers in 2007, including their focus and structure.

c. Case study and longitudinal design

From the beginning, the study was designed as a case study (Yin, 1989; Lunde and Ramhøj, 1995; Curtis, 2001) focusing on health care centers. Specifically, a case study offers an opportunity to learn and is of value for refining theory (Stake, 2000).

In the first and second analyses, I chose to include each of the eighteen health care centers selected to be co-financed by the Ministry of Health for a three-year period. These centers were participating in a mandatory evaluation by the National Institute of Public Health which provided me with easy access to a large amount of data and close contact with the informants. I include each of the eighteen municipalities in order to maximize the possibility of variation (Miles and Huberman, 1994; Flyvbjerg, 2006) and to improve my knowledge about local translation processes. Further, the multiple sites enable me to identify patterns of variations and similarities across translations.

In the third analysis, I take advantage of the opportunity to focus on a single municipality and to carry out an in-depth longitudinal study (Pettigrew, 1995) lasting from January 2006 until June 2009. I selected a municipality that I believed would be an extreme case (Miles and Huberman, 1994; Flyvbjerg, 2006). One indication of this was that this particular municipality had changed its center's activities, an act that indicated a change in discourse. An extreme case often reveals more information because it activates more actors and more basic mechanisms in the situation studied (Flyvbjerg, 2006). I focus on the actors' production of legitimizing documents during a process of change, i.e. their use of discursive legitimizing strategies, which provides insights into change in organizational legitimacy over time.

d. Data collection

I collected primarily qualitative data, including archival materials, interviews, and observation studies, but also some quantitative data such as statistical documentation and survey data.

Qualitative data

Specifically, I collected qualitative data in order to investigate the actors' unique and various interpretations and creations of meaning within the municipalities. I used archival materials, interviews, and observation studies.

The archival materials include formal applications from sixty-three municipalities, which initially applied for financial support for a health care center from the Ministry of Interior and Health in February 2005. These applications were standardized and describe the planned health care centers' purpose, aims, activities, and budget. Furthermore, I include law regulations and published reports from national government bodies, interest organizations, and other research on topics related to health care centers. I also collected policy documents from national and municipal websites in order to explore the political ideologies and constellations within the municipalities. For the single case, study I collected additional data, including strategic documents, documentation of the center's organization and activities, policy documents, charts of the center's placement in the municipal organization, speeches held by the health care center manger and the responsible politician, as well as articles in the local media.

I conducted interviews in the spring of 2006 and again in 2008. To help avoid the problem of retrospective rationality, the interviews were conducted in real time during the early visioning and development of the health centers. The interviews were carried out in collaboration with the National Institute of Public Health. We visited each of the eighteen municipalities, and for each municipality we interviewed at least one senior politician and one senior manager responsible for the municipal health services, one health care center manager, and representatives of general practitioners, hospitals and other collaborating partners (patient organizations, private companies, pharmacies, and schools). On average, we conducted five interviews a year in each municipality adding up to a total of nearly 200 interviews. I made a strategic choice (Mainz, 1995) when I selected the interviewees for this dissertation. In order to capture various subjective interpretations, I decided to include every interviewee. This implied both the actors participating due to their formal position in the decision-making process, as well as the more informal partners collaborating with the municipality or the center. Yet, due to my research questions, I only use the interviews from 2006 in the present analyses, while the interviews from 2008 work as background information. In 2009, I conducted an additional interview with the health care center manager in the single case municipality in the third analysis. I investigated her interpretation of changes in activities,

alliances in decision making, discursive strategies and impact on practice during the period of investigation in order to gain a more in-depth understanding of the development process.

Finally, I carried out a few observation studies in the selected single case municipality. This included an internal staff meeting in June 2009 where the health care center's results, goals and future strategy were discussed, as well as a national conference held in January 2009 by Local Government Denmark, an association of Danish municipalities, on organizing public health in which the center manager presented the health care center.

Quantitative data

I use quantitative data, i.e. in the second analysis, which include municipal socio-economic variables. Data was generated from the archival materials, including responses to surveys conducted by the National Institute of Public Health that document each health care center's organization, activities, and patients in 2007. This data collection was standardized, enabling comparison of the health care centers' organizational forms, including their focus and structure, across municipalities.

I also gathered statistical information on the eighteen centers from *The National Health Interview Surveys*, a database run by the National Institute of Public Health containing indicators of the health status of the Danish population as a whole and of various population groups (categorized by age, education, income, etc.) by region.

In addition, I gathered statistical information from Statistics Denmark (statbank.dk), which has a national database containing detailed information on variables such as income, industry, social status, education, population and elections.

Documentation on the total health services of each of the ninety-eight Danish municipalities as well as their total health spending in 2007 was collected in order to put the activities and size of each health care center into perspective.

e. Method triangulation

In addition to the considerations mentioned above, I use method triangulation in order to strengthen the internal validity of the study (Denzin, 1990; Miles and Huberman, 1994; Holstein, 1995). Method triangulation is used to explore the same

phenomena with a combination of different methods and to contribute to the data interpretation with different views.

First, I supplement qualitative methods with quantitative methods. In the second analysis the qualitative methods, i.e. the interviews, contribute to providing insight into the actors' subjective interpretations of local translation processes, whereas the quantitative method, i.e. the analysis of the socioeconomic variables, confirms a specific translation pattern across more contexts.

Second, I supplement qualitative data with quantitative. In the first analysis, I compare the qualitative interviews exploring the actors' construction of legitimizing accounts with the municipalities' quantitative (structured and detailed) registrations of their organization forms, including their specific focus and structure. This contributed to insights into how legitimizing accounts is linked to specific organizational forms. In the second analysis, I use qualitative data describing the differences in focus, the local ideological values, and the participation of professionals in the centers' development, and quantitative data to compare the eighteen sites in order to explore the impact from socio-economic variables and to find patterns across the municipalities. Furthermore, in the third analysis, focusing on a single municipality, I explore the translation process through different qualitative data sources, including formal policy documents, interviews and observation studies. This triangulation of data contributes to my understanding of the data as the formal documents demonstrate the discursive strategies of the municipality as a whole, while the interviews and observation studies provide insights into the individual interpretations.

Finally, I involve a number of researchers and members of the municipal health care field in my interpretation of the data (Mainz, 1995). Accordingly, I discuss my interpretation of data with colleagues at the National Institute of Public Health. In addition, parts of the coding of interview data were conducted separately by me first and then by a research assistant at the Copenhagen Business School. I also apply the method of "informed basic research", which is one of four models of engaged scholarship suggested by Van de Ven (2007). In this method, I adopt a detached outside perspective on the social system being examined, but seek advice and feedback from practitioners. The engagement varies from talking informally with a few informants to conducting a formal review session. This method is especially relevant and fruitful in the third analysis, which focuses on a single municipality. After having drafted the analysis, I presented it to the health care center manager. We discussed the findings and this contributes to the validity of the study. Yet, access to the field is not only about formalities, but also a question of

interpersonal relations (Svenningsen, 2004). I deliberately use my knowledge about the health care field to build relationships with the informants and to understand their viewpoints. I have previously worked within the health care sector at both the ministerial and municipal levels. Furthermore, I am part of several settings that discuss health issues such as the National Institute of Public Health, the Centre of Health Management at Copenhagen Business School, and a network of health care center managers facilitated by Local Government Denmark.

My engagement in the empirical field gave rise to on-going ethical considerations about my role as a researcher. At the beginning of this dissertation, I was working at the National Institute of Public Health as a research assistant participating in an evaluation of the eighteen new health care centers in which their forms and development processes were evaluated and resulted in a final report in August 2008. My position enabled me to have access to every health care center as well as to collecting a large amount of data. Furthermore, I was able to discuss data and analysis with knowledgeable research colleagues. During this process, I was aware of my delicate position as both an independent researcher and a representative of an evaluation institute. I was especially concerned with two issues. The first was my participation in meetings in a network of health care center managers in which I presented results from the evaluation on an ad hoc basis. However, I made specific efforts to minimize my own influence on the actors' interpretations. The meetings gave rise to fruitful, detailed insights and discussions about center developments. The second issue concerned the validity of the informants' responses. Informants might be relatively open in the answers they give for a research project, but they might be more strategic in the responses they give to an evaluation institute. Thus, throughout the data collection I was aware of how questions were formulated and emphasized their purpose. Besides, because the topic of this dissertation is far from being a performance measurement and instead investigates how diverse actors interpret and conceptualize their vision of a future or emerging organizational form, the informants seemed less concerned about the controversy of their responses.

g. Constructing an overall analytical model comprising three separate analyses

The analytical strategy for this study is an open bottom-up policy analysis (Sabatier, 1986; Hjern and Hull, 1987; Bogason and Sorensen, 1998; Reff Pedersen,

1999; Gjelstrup and Sorensen, 2007) focusing on the micro-level actors' subjective interpretations and construction of social meaning within a local context. Primarily, I employ qualitative methods supplemented with one quantitative analysis as this fit my research question, which explores the local actors' translation of an organizational concept within more contexts. Hence, my strategy of analysis is situated somewhere in between an ontologically oriented research strategy (Andersen, 1999) rooted in neo-institutional theory and a more epistemological approach, broadening the analysis to include an exploration of actors' subjective interpretations.

The explorative bottom-up policy analysis is particularly fruitful for my first analysis as it provides substantial new knowledge to my understanding of the empirical field. I investigate which legitimizing accounts (Scott and Lyman, 1968; Strang and Meyer, 1993; Elsbach, 1994; Creed, Scully and Austin, 2002; Suddaby and Greenwood, 2005) the eighteen municipalities construct and to which multiple national and local institutional logics (Friedland and Alford, 1991, Thornton and Ocasio, 1999) they link. I assemble these accounts into four groups of translations which correspond to four specific organizational forms. I analyze the organizational form based on its focus and structure. In particular, I analyze each of the interviews from 2006 facilitating maximum case variation and then compare these with quantitative data on the emerging organizational forms as monitored in 2007.

In the second analysis, I narrow down my investigation to explore why an organization is constructed with a specific focus targeting either citizens or patients, i.e. I investigate how the socio-economic variables and the institutional context influence the actors' construction of an organizational focus. I use qualitative data describing the differences in focus, the local ideological values, and the participation of professional groups in the centers' development. Additionally, I use quantitative data to compare the eighteen sites in order to explore the impact from socio-economic variables and to find patterns across the municipalities.

Finally, in the third analysis, I continue to analyze the organizational focus but employ critical discourse analysis (Fairclough, 1992, 1995; Wodak and Meyer, 2002, Phillips and Hardy, 2002; Vaara, Tienari and Laurila, 2006). This theoretical lens adds a novel view on how to understand the construction of organizational focus. I explore how discourses position specific organizational actors as powerful in the process of translation, and how these actors develop discursive strategies in order to legitimate their translation of a health care center, linking it to discourse. In particular, I focus on a single municipality as an extreme case and explore the

development of a health care center in a three-year longitudinal study. I draw on qualitative data, including texts, interviews and observation studies.

The three analyses differ in the specific use of methods and data according to their focus. In the following, there is a more detailed presentation of the three analyses.

6. PRESENTATION OF THE THREE ANALYSES

This dissertation presents three separate and yet interrelated analyses of emerging health care centers. The aim is to explore how the heterogeneous institutional context influences local actors' translation of an abstract organizational concept into specific organizational forms.

The first analysis examines the early development of the health care centers. At that time, the eighteen municipalities were trying to understand the aims of the new national reform and created accounts to legitimize their interpretation of the health care center concept. These accounts show great complexity, albeit guided by common institutional logics. The local actors constructed various social meanings by linking their accounts differently to logics at both the national and local levels. The study identifies three logics embedded at the national level: 'quality', 'equal access', and 'efficiency' in public service and two logics embedded at the local level: 'economic sustainability' and 'organizational identity'. Although these logics were combined in a myriad of ways, I identify a pattern in the way they link to accounts. Four groups of translations assemble similar accounts corresponding to four specific organizational forms. The four translations are: 'the outstanding organization', 'the utilizing organization', 'the network organization' and 'the hospital-based organization'. While these groups share internal similarities, variation exists between the groups. Interestingly, the translations are grouped according to how the actors interpret the local logic of economic sustainability, showing a significant impact from this logic on the emerging organizational forms, i.e. the centers' physical location in a new building, in an existing municipal building, at a hospital, or as a virtual network. Perhaps the accounts' links to the national logics serve as an inescapable source to legitimate the emerging local organization, but it is the actors' different interpretations of the logic of economic sustainability which gave rise to different organizational forms. Furthermore, if I had only explored the logics embedded at the national level and only how the health care center concept was adopted within one context, I would not have been able to observe that an emerging organizational form is in fact not just the articulation of one logic. It is the actors' interpretations and combinations of multilevel institutional logics that give rise to specific organizational forms.

The second analysis explores why a health care center is designed to prioritize one type of service over another, and whether demographic or institutional dynamics in the municipal context affect this construction of focus. The services, rehabilitation and health promotion services, represent two different institutional logics. The study suggests ruling out the demographic dynamic as the nature of health care provision is not linked to the health and socio-economic configuration of the municipality. For example, a high rate of patients with diabetes in the municipality did not encourage one center to provide for the rehabilitation of patients with diabetes. The institutional dynamic, by contrast, emphasizes the cultural-cognitive values of politicians and professionals active in the municipal jurisdiction. The study shows that the choice of logic is influenced by the local actors' relationship with an external institutional infrastructure. Members of local political parties adopted and implemented the ideological position of the national party. Similarly, professionals employed locally exhibited and pushed the normative code of their profession. The study shows that geographically bounded communities are important sources of variation as local factors determine which party is in power, thus determining the choice that will be made between particular logics. But the choice was the same across municipalities controlled by politicians and professionals of the same persuasion. In this case, there was little evidence of a distinctly local translation. Yet, it should not be ignored that various political and professional orientations interact in the process of translation, and that the analytical conceptualization of the municipality as a political jurisdiction helped to explain who became able to translate – both due to which political party was in power and also which professional groups were working within the municipality.

Finally, the third analysis explores the process of translating the health care center concept into one particular municipality over a three-year period. The uncertain political and financial future of this new center drove the municipal actors to co-construct the legitimacy of the center while they went about developing its service. The study shows that the actors developed discursive strategies embedded in competing discourses – a 'patient' and a 'healthy citizen' discourse – giving different senses of legitimacy to the organizational form. These two societal discourses comprise the institutional logics identified in the two previous studies differently. The study highlights three essential points. The first point is that a discourse positions specific actors as powerful, and these actors develop legitimizing strategies reproducing this discourse and facilitating its dominance. The openness of the healthy citizen discourse enabled various actors to participate in the translation –

not only health professionals, but a broad range of professionals, private companies, volunteer organizations, and, importantly, municipal politicians. In this way many actors contributed to the increasing domination of the discourse. In contrast, the patient discourse building on a medical-knowledge regime constrained agency to health professionals differently – some of whom did not even support the center. The second point is that when the discursive strategies make a discourse resonate with the local context, in this case a political context, then this discourse becomes dominant. The actors emphasized the local need for health promotion activities and the capability of health promotion activities to implement political goals and improve citizen participation. They constructed a positive narrative on the dynamic health promotion organization, and they moralized about the need for health promotion activities. Finally, the third point emphasizes that there is a link between strategies at the discursive level and activities at the level of practice. The findings indicate that the domination of a discourse can be explained by how successful the discourse can be carried out in practice. In this study, the weak rehabilitation discourse was linked to the relatively few rehabilitation activities available, whereas the increasingly dominating healthy citizen discourse was linked to the many health promotion activities that were available.

The first analysis was presented at the Academy of Management in August 2008, Anaheim, CA. The analysis was invited to a symposium on "Travel of Health Care Ideas: International Perspectives", organized by Trish Reay, University of Alberta, and chaired by Elizabeth Goodrick, Florida Atlantic University. The discussant was Tammar B. Zilber, Hebrew University of Jerusalem. The analysis was also presented in December 2007 at the Nordic Workshop on Health Management and Organization in Gothenburg.

The second analysis is co-authored by Professor Royston Greenwood, University of Alberta, and was presented at the EGOS conference in July 2008 in Amsterdam. Afterwards, the paper was invited into the *Journal of Research in the Sociology of Organizations* in a special edition on the concept of communities and organizations. The paper is under first review. The analysis was also presented in November 2008 at the Health Service Forum (*Forum for Sundhedstjenesteforskning*) in Odense, Denmark, and in December 2008 at the Nordic Workshop on Health Management and Organization in Uppsala, Sweden.

The third analysis was presented at the EGOS conference in July 2009 in Bar-

celona. A shorter version of the analysis focusing more on the findings than the theoretical framework has been translated into Danish and accepted for publication in an anthology on management and patient roles in health care. This anthology is scheduled to be published in the spring of 2010.

7. ANALYSIS 1

Translations of an Organizational Concept into Local Contexts:
Creating legitimizing accounts linked to multilevel institutional logics

Susanne Boch Waldorff

Department of Organization,

Copenhagen Business School

Denmark

ABSTRACT

The analysis explores which legitimizing accounts (Scott and Lyman, 1968; Strang and Meyer, 1993; Elsbach, 1994; Creed, Scully and Austin, 2002; Suddaby and Greenwood, 2005) eighteen Danish municipalities constructed to legitimize their interpretation of a national health care center concept. The study combines the neo-institutional concept of multiple institutional logics (Friedland and Alford, 1991; Thornton, 2004) with the concept of translation (Czarniawska and Sevon, 1996; Sahlin-Andersson, 1996). The study shows that the municipalities constructed various social meanings by linking their accounts differently to logics at both the national and local levels. I assemble these accounts into four groups of translations that correspond to four specific organizational forms. The analysis highlights that an emerging organizational form is not just the articulation of one particular logic. The actors' different interpretations and combinations of multilevel logics, i.e. the local logic of economic sustainability, gave rise to various organizational forms. I analyzed nearly 100 interviews from 2006 from eighteen municipalities in order to facilitate maximum case variation and combined these data with the emerging organizational forms as monitored in 2007.

INTRODUCTION

The adoption of a new organizational concept, namely a health care center, was promoted as part of the reform of the Danish public sector (the Reform) that took effect on January 1, 2007. The Reform made Danish municipalities responsible for managing new tasks within health care. However, since the concept of a health care center, from the outset, was vaguely defined, it drove the municipalities to conceptualize various organizational forms when they translated the new concept into their local context. The situation also urged the municipalities to construct legitimizing accounts that would legitimize their specific translation of a health care center. In this study, I analyze the translations of a health care center within eighteen different municipalities. By investigating which legitimizing accounts these municipalities construct, I explore how multiple institutional logics embedded at the national and local levels have an impact on emerging organizational forms.

I conceptualize the diffusion of the new organizational concept of a health care center as a process of translation. Thus, I draw upon the work of a number of researchers who stress that organizational concepts diffuse through processes of translation and that this involves the actors' interpretations and local constructions of social meaning (Brunsson, 1989; Czarniawska and Sevon, 1996; Latour, 1986; Sahlin-Andersson, 1996). In the translation, the meaning of an abstract idea, for example, how to organize health service, is altered by actors, resulting in variations in organizational forms. Organizational forms are thus not fixed as they emerge in the process of adopting this abstract idea. An important translation mechanism is the use of legitimizing language, which offers a useful dimension for analysis (Scott and Lyman, 1968; Strang and Meyer, 1993; Elsbach, 1994; Creed, Scully and Austin, 2002; Suddaby and Greenwood, 2005). Legitimizing accounts justify an emerging organization by linking it to a broader institutional context. However, so far, the studies on translation have paid only little attention to how multiple institutional logics modify the relationship between institutional context and local translation.

I examine the municipalities' institutional context through the concept of multiple institutional logics, which are organizing principles providing meaning to social reality and available to organizations and individuals to elaborate (Friedland and Alford, 1991; Thornton, 2004). Instead of assuming that one logic dominates the field, it is now widely recognized within neo-institutional theory that multiple logics exist as precipitators of change and sources of organizational variation

(Lounsbury, 2007; Reay and Hinings, 2005; Scott et al, 2000; Suddaby and Greenwood, 2006). I explore how the municipalities' accounts link to multiple institutional logics embedded in the Reform at the national level as well as in municipal policies at the local level. Although institutional logics have been studied at multiple levels of analysis (Thornton and Occasion, 2008), we still need a fuller understanding of how institutional logics at different analytical levels are interpreted locally and manifested in practice (Lounsbury, 2007; Marquis, Glynn and Davis, 2007).

The remainder of this paper is divided into four sections. Section I provides the empirical context including the Reform's promotion of the health care center concept. Section II sets out the theoretical context combining the approach of translation, which offers insights into the construction of social meaning in a local context, with multilevel institutional logics guiding this translation. This theoretical framework allows an investigation of emerging local organizational forms within an institutional context. Section III presents the method used in this study which is an explorative bottom-up policy analysis, while Section IV presents the findings. Here, I identify twelve municipal accounts and explore how these not only refer to three institutional logics embedded in the national reform: 'equal access', 'quality', and 'efficiency', but also to two logics embedded at the local level: 'organizational identity' and 'economic sustainability'. The accounts link to the multiple logics in a myriad of ways, but I identify an underlying pattern: specific accounts are assembled into four groups of translations corresponding to four specific organizational forms. While these translations share internal similarities, variation exists between them. I label the four translations: the 'outstanding organization', the 'utilizing organization', the 'network organization', and the 'hospital-based organization'. Interestingly, the translations are grouped around the logic of economic sustainability embedded at the local level, and the physical location of the new organization. Finally, Section V presents some conclusions and discusses how multilevel institutional logics have an impact on the local translations of an abstract organizational concept into specific organizational forms.

THE EMPIRICAL CONTEXT

The Danish "Local Government Reform" that took effect on January 1, 2007

(Ministry of the Interior and Health, 2005) was the culmination of an extended debate on how to improve the Danish public sector's efficiency. Several political parties argued that the governmental structure needed to change as it was inhibiting collaboration across sectors and governmental levels. An exemplification of this was the health risks faced by citizens who were caught between regional and municipal services, a position that jeopardized the coordination and financing of patient rehabilitation after hospitalization. The association of local municipalities called for stronger municipalities in order to solve the problems (Klausen, 2001). In June 2004, a political agreement on a new structure of the Danish public sector was negotiated to take effect on January 1, 2007 (Agreement on a Structural Reform, 2004). The Reform was intended to improve certain objectives. These objectives were highly similar to the three logics in health care that Scott and his colleagues have identified: the logic of quality, equal access, and efficiency (Scott, Ruef, Mendel and Caronna, 2000). The following quote from the political agreement provides examples of the logic of quality and the logic of equal access:

> The conciliation parties wish to support and promote a strong public health care service that offers patients unrestricted, equal and free access to prevention, examination, treatment and care at a high professional level. Furthermore, the health care service should provide high quality and high level education and research. (Agreement on a Structural Reform, 2004:37)

The Reform contained a new division of municipalities and regions and a new distribution of tasks between municipalities, regions, and the state. As a result of the Reform, the 271 municipalities were merged into 98 larger municipalities. In Denmark, a municipality is the lowest governmental level and is responsible for most welfare tasks in a specific geographic area. The municipalities, which attained the right to impose taxes, also became responsible for most welfare tasks, putting them in the position of being people's main access point to the public sector. The Reform assigned municipalities with new tasks within health care, employment, social services, business services, the environment and planning. Municipalities have become fully responsible for health promotion, prevention, and any rehabilitation that does not take place during hospitalization. Currently, municipalities must now provide health services within close proximity of people's own homes as well as integrate prevention and health promotion with other local tasks, including day care, schools, and centers for the elderly. Municipalities have further

become partially responsible for funding medical treatment, depending on people's use of the health care service. This financial arrangement is intended to give municipalities the incentive to make an extra effort to improve health promotion and physical therapy services as well as to reduce hospital treatments and municipal costs. The following quote illustrates the embedded logic of efficiency:

> Those municipalities that manage to reduce the need for hospital treatment through an efficient effort within prevention and care will be rewarded by having to pay less for hospitalisation of their citizens.
> (Agreement on a Structural Reform, 2004:42)

The former fifteen regions were merged into five larger regions. In Denmark, a region is a larger geographical unit, which primarily is responsible for health care, i.e. hospitals and general practitioners as well as the regional development and operation of a number of social institutions. The regions are financed partly by the municipalities and partly by the state. The state undertakes national tasks, including the police, national security, the legal system, the Foreign Service, higher education and research. Within health care, the central authorities have competences within specialty planning as well as responsibility for systematically following up on quality, efficiency and IT usage.

   The Reform initiated the establishment of health care centers in municipalities. The idea behind the initiative was that municipalities would create organizational forms that would address local health issues and develop better ways of providing primary health care. However, no detailed instructions were given as to how municipalities should provide the health services. The only guidance given was that:

> The municipalities should be able to find new solutions especially within prevention and rehabilitation, e.g. in the form of health care centres.
> (Agreement on a Structural Reform, 2004)

Subsequently, the health care center concept was not mentioned directly in the new law implementing the political agreement, but only in the proposed legislation:

> There might be benefits within care, prevention and rehabilitation such as

improved quality, professional collaboration, recruitment and economies of scale etc. by assembling services in an organization like a health care centre, and by conforming to local demands.
(Proposed health legislation, February 2005)

Thus, the concept of health care centers as set out in the authorizing policy documents is particularly ambiguous. A general idea of how an organization can or ought to be structured is provided; hence, it is flexible and open to interpretation allowing local contextualization and adjustments (Bentsen and Borum, 2003; Røvik, 1998). Put forward as a "soft" regulation, the rules are largely informal, open to a variety of assumptions and adaptations from the municipalities that chose to implement the concept (Mörth, 2004; 2006; Kirton and Trebilcock, 2004; Kjær and Sahlin, 2007; Sahlin and Wedlin, 2008). Thus, although the concept of health care centers is proposed as a central model for managing municipal health care, the definition of the specific goal is less than clear. Tasks are not specifically prioritized according to importance, what constitutes 'good health' is not defined, and no indication of what the proper level of service should be is provided. Furthermore, the concept is weakly enforced as neither the development of the centers nor their integration into the established health sector is regulated by law. Thus, it is up to the municipalities to decide whether or not they will create health care centers and, if they do, what form they might take. These mechanisms broaden the scope of what organizational behavior will be considered as compliant and enable organizations to construct compliance in ways that fit their interests (Edelman, 1992). Local governments and organizations, however, are now required not only to demonstrate the results of their activities but also to explicitly legitimize their interpretation of the national policy. This means translating questions about the organization's aims and the proper structural design. This new situation puts the way an organization in the public sector seeks to construct what counts as legitimate clearly into focus (Suchman, 1995).

Danish municipalities were encouraged to apply to the Ministry of the Interior and Health for financial support for health care centers. The municipalities would be able to receive co-payment for three years. The ministry did not explicitly ask for certain types of health care centers, but announced that it intended to support various models in order to accumulate knowledge from local developments. Sixty-three municipalities applied, and eighteen municipalities were selected and granted financial support in August 2005.

Interestingly, the health care centers emerged despite the lack of regulation making the concept mandatory for municipalities to implement and for hospitals and general practitioners to refer patients to, and also without national guidelines for the implementation. Moreover, even municipalities that are not supported financially by the state developed health care centers. In fact, by mid-2008 forty-two percent of all Danish municipalities were developing health care centers and twenty percent planned to do so (Ramboel Management, 2008). This indicates that the idea of creating a new health care center in order to manage health service has diffused extensively across municipalities.

The Reform, i.e. the abstract concept of a health care center, constitutes a context in which the municipalities are expected to translate a new concept differently into an organizational form. The municipalities certainly do conceptualize various forms of health care centers, but we know very little about what guides this translation, and thus in this study I investigate which legitimizing accounts the municipalities construct and how they link to multiple institutional logics in order to legitimize their specific translation of a health care center. Some municipalities conceptualize the center as a building that is open for patients with chronic diseases to visit, while other municipalities create the center as a network of local organizations that promotes citizens' health in various places such as schools and workplaces.

THEORETICAL CONTEXT

From Diffusion to Translation

The emergence of specific organizational forms has been the main interest for neo-institutional researchers for some time. A major theme has been the observation of organizational similarities and the mechanisms that drive organizations into such homogeneity (Meyer and Rowan, 1977; DiMaggio and Powell, 1983). In recent years, however, researchers have sought to develop theories of organizational heterogeneity. Variation is recognized as present more permanently and not only at the first stage in a diffusion process (Tolbert and Zucker, 1996). For example, Edelman (1992) analyzes how organizations respond differently to new laws on

equal employment opportunity and affirmative action, and how they construct compliance in a way that fits environmental demands but also managerial interests. Fox-Wolfgramm, Boal and Hunt (1998) show how banks respond to the Community Reinvestment Act by developing two different organizational forms: the defender bank and the prospector bank. Moreover, Greenwood and Hinings (1993) emphasize that intra-organizational dynamics affect the processes of adoption. Coalitions of professional interests within an organization respond to institutional processes and thus the particular response depends upon the relative influence of different professionals. The common theme of these studies is that organizations with similar tasks can have a variety of organizational forms.

In this study, I employ a theoretical approach that goes even further in exploring how emerging organizational forms are socially constructed as part of local processes of 'translation' (Brunsson, 1989; Brunsson and Olsen, 1993; Czarniawska and Sevon, 1996; Czarniawska, 2008; Røvik, 1998; Sahlin-Andersson, 1996; Sahlin and Wedlin, 2008). After all, ideas do not just impose themselves on field organizations. Instead, they are interpreted and translated by interacting actors within each organization. Organizational forms, including their focus on service and structural design, are thus socially constructed and translated during the process of adoption leading to various organizational responses. Czarniawska and Joerges describe translation as a process in which actors disembed an idea such as an organizational concept of a municipal health care center from its institutional surroundings, and translate it into an object such as a text, a picture, or a prototype of a specific organizational form, which is able to travel from one time and space context to another (Czarniawska and Joerges, 1996:22; Czarniawska, 2009:425). The idea is then translated to fit the new local context, materialized into practice, and, if repeated, institutionalized. This definition is based on the ideas of translation as conceptualized in actor-network theory (Callon and Latour, 1981; Latour, 1986).

Studies of translation have so far sought to identify mechanisms that condition how an idea such as an organizational concept, label, form, or practice enters a new context (Sahlin, 2008; Hedmo, Sahlin-Andersson and Wedlin, 2005; Erlingsdottir and Lindberg, 2005: Sevon, 1996). Other studies explore why one organizational response is chosen over another according to organizational features (Scheuer, 2003; Frenkel, 2005, Powell, Gammal and Simard, 2005). However, only a few studies have included the impact on translation of field level institutions (Forssell and Jansson, 1996; Boutaiba and Strandgaard Pedersen, 2003; Boxenbaum, 2005).

This is despite widespread emphasis on the fact that the process of translation is implicitly governed by institutionalized beliefs and norms (Sahlin-Andersson, 1996), circulating templates (Sahlin, 2008), master ideas (Czarniawska and Joerges (1996) and management fashion (Czarniawska and Sevón, 2005). In my view, we need to explore more than one or two cases in order to gain insights into how multiple institutional logics are mobilized in the process of translation. Particularly, we need a fuller understanding of how an organizational concept is translated into a specific organizational form when institutional logics at both the national and local levels are available providing various sources to organizational legitimacy (Meyer and Rowan, 1977; DiMaggio and Powell, 1983; Suchman, 1995).

The use of legitimizing language is central to the translation process. Sahlin (2008), for instance, explains the use of language as 'editing'. Actors follow rule-like patterns to present ideas in familiar and commonly accepted terms and use a specific communication structure in each setting. An idea is presented with a re-constructed logic that fits the local setting, and with a specific label that makes sense and attracts attention. Yet, I elaborate upon this approach, analyzing local translations through the municipalities' construction of 'legitimizing accounts' (Scott and Lyman, 1968; Strang and Meyer, 1993; Elsbach, 1994; Creed, Scully and Austin, 2002; Suddaby and Greenwood, 2005). Legitimizing accounts reflect the ways that the social actors use their knowledge of institutional logics to provide meaning and identity – in this case – of an emerging organization. Legitimizing language is especially important in the early development of a new organization facing immense uncertainty. The account provides legitimacy as it links something new or problematic, such as an emerging organization, to something known and unquestioned (Scott and Lyman, 1968). In this study, I do not conceptualize an account as a meta- script for local constructs of social meaning, for instance, such as the concept of a prevailing 'rationalized myth' (Meyer and Rowan, 1977), but as senses of legitimacy co-constructed by interacting social actors (Creed at al., 2002, Zilber, 2007). Particularly, I analyze which accounts interacting actors within different municipalities construct and to which multilevel institutional logics they link.

Responses to Multiple Institutional Logics

In order to explore the municipalities' institutional context I employ the approach of 'institutional logics'. Alford and Friedland (1985) originally introduce

the term to describe the contradictory practices and beliefs inherent in the institutions of modern Western societies. Further, Friedland and Alford (1991) define institutional logics as sets of material practices and symbolic constructions constituting organizing principles available to organizations and individuals to elaborate. Thornton and Ocasio elaborate on this definition by arguing that institutional logics are "the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (1999:804). An element in both of these definitions is that they view cognitive values – in contrast to economic rationality – as a motivation for, and a justification of, action. Behavior is driven not by a logic of consequences, but by a logic of appropriateness (March and Olsen, 1989). This implies that in order to understand the behavior of organizational actors – such as translations of an organizational concept – we need to examine the impact of institutional logics.

Institutional logics provide an important link between institutions at the macro structural level and actors at the micro level. Institutionalized logics at the macro level guide social action at the micro level. Yet, actors are not just subjected to institutionalized logics. Action would be determined by the institutional set up were it not for the fact that the norms, rules, habits and routines that constitute a given institution are always ambiguous, and incomplete, wherefore they are constantly made subject to interpretation, negotiation and transformation by inventive and creative actors (Campbell, 2004). Seo and Creed (2002) develop a dialectical concept of human agency and point to institutional contradictions as not only triggering shifts in actors' collective consciousness, but also as providing alternative logics of action and resources. Nevertheless, the neo-institutional research has favored examining institutional logics at the field level. More research is needed on the micro foundations of institutional logics (Thornton and Ocasio, 2008).

The notion that multiple logics exist, as anticipated early by Alford and Friedland (1985), has recently gained researchers' attention. Greenwood and Suddaby (2006) explore how contradictory institutional logics embedded in historically disparate understandings of professionalism explain the multidisciplinary partnership's rise as a new organizational form. In a study on health care, Scott, Ruef, Mendel, and Caronna (2000) identify the institutional logics that emerged in U.S. health care between 1945 and 1995 in the San Francisco Bay Area. Scott and his colleagues showed that after decades of domination by the medical profession's 'logic of quality of care', the state had begun emphasizing democracy and the 'log-

ic of equity of access' as part of a transformation of the health care delivery system. This paved the way for a managerial 'logic of efficiency' in the form of managed care and new organizational forms such as HMOs. Later, Reay and Hinings (2005) found similar results as they analyzed how competing institutional logics of medical professionalism versus business-oriented health care are driving radical change in the Canadian health care field resulting in the co-existence of the logics. In this study, I employ this theoretical conceptualization of three institutional logics existing within health care as originated by Scott et al. (2000). But I also take into account Scott et al.'s focus on U.S. health care, which is more market-oriented than the Danish welfare field, and thus I explore the existence of these three logics empirically, along with others in the Danish context.

Institutional logics may develop at a variety of different levels, e.g. organizations, markets, industries, inter-organizational networks, geographic communities and organizational fields (Thornton and Occasion, 2008). Logics at the local level have been studied by Haveman and Rao (1997), who show how changes in institutional logics at the societal level affect the formation of distinct organizational forms in the Californian thrift industry when industrial plans embody either a bureaucratic logic or a community logic. And Lounsbury (2007), who examines competing trustee and professional logics in the mutual fund industry, finds that geographic communities (cities) are sites of institutionalization. However, we should not conclude from these studies that a particular institutional logic gives rise to only one organizational form. I argue that the existence of multiple institutional logics allows for multiple interpretations and combinations of these logics to occur in practice and thus the emergence of various organizational forms. Yet, we need a fuller understanding of how logics at different analytical levels, i.e. institutional logics at the national and local levels, are interpreted and manifested in practice (Lounsbury, 2007; Marquis, Glynn and Davis, 2007; Purdy and Gray, 2009).

Elaborating upon this, I argue here that to understand emerging organizational forms, we need to analyze how local municipalities draw upon available multiple logics embedded at the national as well as the local level in order to account for their specific translation of an abstract health care center concept into a specific organizational form. Combining the approach of multilevel logics with the approach of translation focusing on the construction of legitimizing accounts provides a coherent theoretical framework and strategy of analysis that allows a more detailed investigation of how emerging organizational forms are constructed within an institutional context.

METHODS

When investigating the municipal legitimizing accounts and their institutional logics, I apply a qualitative "bottom-up policy analysis" (Sabatier, 1986; Hjern and Hull, 1987; Bogason and Sørensen, 1998; Pedersen, 1999; Gjelstrup and Sørensen, 2007). This method is an open analytical approach that focuses on actors at the micro level. The method enables me to investigate the actors' subjective interpretations of policy initiatives, and their creation of social meaning in a local context. In particular, I investigate which institutional logics the actors draw upon when they create legitimizing accounts of health care centers. Underlying this theoretical assumption is the premise that local actors discursively define what to consider as a problem (Sahlin-Andersson, 1996), and they construct legitimate solutions for these problems that fit their local context. In recent years, bottom-up policy analysis has gained renewed interest from researchers as the perception of public governance has changed (Gjelstrup and Sørensen, 2007). Moving from a focus on formally assigned bodies of government, attention is now focused on the complex situated processes of interaction between formal and informal actors.

This study has been designed a case study (Yin, 1989; Lunde and Ramhøj, 1995). Specifically, a case study offers an opportunity to learn and is of value in refining theory (Stake, 2000). I chose to include each of the eighteen health care centers selected by the Ministry of Health to be co-financed for a three-year period. They were participating in a mandatory evaluation by the National Institute of Public Health (NIPH) which provided me with easy access to a large amount of data and close contact with informants. I include each of the eighteen municipalities in order to maximize the possibility of variation (Miles and Huberman, 1994; Flyvbjerg, 2006) and to improve my knowledge about local translation processes. Further, the multiple sites enable me to identify patterns of variations and similarities across the local translations.

Data Sources

The empirical data sources include documents and textual materials as well as interviews with actors in eighteen municipalities. I coordinated the collection of

empirical data with the National Institute of Public Health.

The documents and textual materials include formal applications from the sixty-three municipalities that applied to the Ministry of Interior and Health in February of 2005 for financial support to establish health care centers. Standardized, the applications describe the planned health care centers' purpose, aims, activities, and budget. The eighteen municipal centers that received financial support were further obliged to participate in an evaluation conducted by the NIPH. As part of this evaluation, the municipalities forwarded survey data to the NIPH. I draw in particular upon the survey describing the health care centers' emerging organizational forms in 2007. Furthermore, I include published reports from national government bodies, interest organizations, and other research on topics related to health care centers.

In the spring of 2006, I conducted interviews with local actors in each of the eighteen municipalities participating in the creation of health care centers. In general, for each municipality, I interviewed at least one senior politician and one senior manager responsible for the municipal health services, one health care center manager, and representatives of general practitioners, hospitals and other collaborating partners (patient organizations, private companies, pharmacies, and schools). Table 1, below, summarizes the ninety-eight interviewees. On average, five local actors in each municipality were interviewed. In some municipalities the interviews included more than one interviewee, because they were working in specialized teams or because participants were in the midst of changing positions. In a small number of municipalities, talking with some of the interviewees on the day of our visit was not possible. Thus, a number of telephone interviews were carried out, but in a few cases, conducting interviews turned out to be impossible.

Table 1. Number of interviewees from March to May 2006

Municipality	Municipal politician	Municipal senior administrator	Municipal health care center manager	Physician	Hospital	Other collaborating partners	Total
Bornholm	1	1	1	1	1		5
Broenderslev	1	1	2	2	1	1	8
Copenhagen	1	1	1	1	1	1	6
Fredensborg	1	1	1	1	1		5
Faaborg-Midtfyn	1	1	1	1	1	1	6
Hilleroed	1	2					3
Horsens	1	1	2	1	1		6
Lyngby-Taarbaek	1	1	2	1	1		6
Naestved	1	2	1	1	1	1	7
Odense	1	1	1	1	1	1	6
Odsherred	1	1	1	1	1		5
Ringkoebing-Skjern	1	1	1	1	1		5
Samsoe	1	2	1		1		5
Soenderborg	1	1	1	1	1		5
Vejle	1	1	1	1	1		5
Vesthimmerland	1	1	1	1	1		5
Vordingborg	1	1	1	1	1		5
Aarhus	1		1	1			3
	18	**20**	**20**	**17**	**16**	**5**	**96**

The interviews lasted from thirty minutes to one and a half hours. The interviews were semi-structured and the questions were the same across all municipalities. As the health care centers had not yet been developed at that point, my questions explored how the actors interpreted the aims of the Reform, as well as what objectives and visions they would apply in developing a health care center in their local municipality. The municipal politicians were asked questions about the center's history and background, other types of organizational forms proposed, the local debate, the importance of local issues as well as the center's purpose, effect and collaboration with other partners. In addition to the same questions, the municipal senior administrators were also asked more detailed questions about the organization's focus and form. The health care center managers were only asked the questions about focus and form as these actors had typically been hired later in the

process when the project had already been granted financial support. The collaborating partners were asked questions about the center's organization and effect, the local debate and the center's collaboration with other partners. I informed the interviewees that their interview would be used in a research project. A research assistant taped and transcribed each interview while it was taking place. NVivo was used to structure, examine and compare the textual data.

Data Analysis

In the analysis, I explore the interviews and, specifically, which accounts the local actors construct when translating the health care center concept into their local context. The interviews were coded using techniques and recommendations made by Huberman and Miles (2002) for carrying out qualitative analysis. The coding was conducted in Danish and the citations have later been translated into English for the purpose of publishing the findings.

The first task was to assemble all interviewees into eighteen different groups according to the municipality they belonged to. This facilitated an analysis of the local construction of social meaning within each municipality. In particular, I explore which specific issues or problems the interviewees construct and use to account for the local conceptualization of a health care center. Examples of such accounts are to 'improve citizens' health' and to 'prevent public expenses'. In order to conceptualize the construction of accounts within each municipality, I aggregate the individual interviewees' interpretations. Thus, I explore whether an account is repeated by more than one interviewee, and, crucially, which actors present this account. I put greater weight on statements presented by actors centrally positioned in the formal municipal organization and decision-making process, including politicians and senior managers. However, if the interviewees pointed to other influential actors in the development of the center, I also recognize their statements as important. All together, I identify twelve accounts across the eighteen municipalities. Table 2 provides an overview of the accounts.

Table 2. Coding categories – an overview of municipal accounts linked to institutional logics at the national or local level

	National level embedded			Local level embedded	
Institutional logics	Equal access	Quality	Efficiency	Organizational Identity	Economic Sustainability
Municipal Accounts	Open Access	Improve Citizens Health	Prevent Public Expenses	Internal Project	Utilizing (municipal) Resources
	Close Geographic Proximity	Educational Approach	Manage Patient Flow	External Branding	Prevent (municipal) Expenses
		Coherence in Patient Flow			Create Wealth Locally

Second, I match the identified twelve accounts with the three institutional logics identified by Scott et al. (2000): 'quality', 'equal access', and 'efficiency' in order to explore whether or not and how they are interrelated. I do this in part by analyzing each account in order to discover its implicit construction of a legitimizing social meaning, and in part by comparing this to the social assumptions and principles underlying each logic. The analysis provides an understanding of which logics the municipalities' accounts are linked to. Table 2 provides an overview of how the accounts and institutional logics interrelate. The analysis reveals that some accounts are linked to the three categories of institutional logics embedded in the Reform and identified previously by Scott et al. (2000). The accounts labeled 'open access' and 'geographically close' are linked to the logic of equal access, the accounts labeled 'improve citizens health', 'educational approach', and 'coherence in patient flow' are linked to the logic of quality, and the accounts labeled 'prevent public expenses', 'manage patient flow', and 'decentralizing' are linked to the logic of efficiency. A number of accounts remained, however, that had no direct link to any of the three logics. After analyzing the content of these accounts further, I discovered that they are linked to two institutional logics, which I had not found embedded in the national reform in the first place. These logics were only situated at the local municipal level and concerned the interviewees' consideration of local issues and problems. I named these logics 'organizational identity' and 'economic sustainability'. The accounts 'internal project' and 'external branding' are linked to

the logic of 'organizational identity', whereas the accounts 'utilizing (municipal) resources', 'prevent (municipal) expenses', and 'create wealth locally' are linked to the logic of economic sustainability. All in all, the construction of categories of accounts shows how the municipalities draw upon multilevel institutional logics in their vision of a health care center. Moving back and forth between the data, I use an iterative process to try to gain an intuitive understanding and to develop meaningful categories before matching the data with theoretical assumptions. At the last stage of analysis, I merge the groups of citations collected into matrices for each conceptual category in order to provide an overview of the data.

Notably, during this part of this process, I notice two additional logics emerging within the public provision of health service. One logic stresses the importance of rehabilitating patients with chronic diseases in order to improve their health and to reduce public costs, while the other logic emphasizes the promotion of a proper lifestyle in order to prevent citizens' from developing chronic diseases. However, I also find that nearly every municipality conceptualized a health care center as providing both rehabilitation and health promotion. As a result, I decided not to analyze these particular logics as part of this analysis. Yet, as the one logic is often more dominant than the other, I consider later exploring why municipalities would draw on a particular logic in health when they construct a health care center's focus.

As a third step, I match the municipal translations with the health care centers' organizational forms. Thus, I examine the survey data describing the eighteen health care centers' organizational forms as they developed in 2007. Like Marquis, Glynn and Davis (2007) and D'Aunno, Sutton and Price (1991), I study the organizational forms in terms of both the health care center's 'focus' and 'structure'. The former describes the domain that is targeted, i.e. whether the provided service is health promotion or rehabilitation, as well as whether the scope of the service is focused or broad. The latter, on the other hand, describes the manner in which the organization engages with that domain, such as its governance, physical framework and relationships with the health sector through open access to service or mandatory referrals of patients. The Reform allowed many different organizational forms to emerge because the same emphasis on service could be focused or broad as well as combined with different organizational structures.

Finally, I analyze the correspondence between the municipalities' accounts and the emerging organizational forms. This contributes to the conceptualization of the

local translations of the organizational concept into an organizational form. The task was to investigate different clusters of municipalities and look for patterns across their translations. Through this iterative process a significant pattern emerged. In particular, grouping the municipalities according to how their accounts link to the logic of economic sustainability embedded at the local level reveals a significant pattern across the translations. This logic corresponds to a specific variation in the health care centers' physical framework. Four ways of assembling the accounts emerge from this pattern. I label the four translations as: 'outstanding organization', 'utilizing organization', 'network organization' and 'hospital based organization'.

The relatively large dataset provides insights into a rich variety of local interpretations and organizational responses to institutional pressures. The data collection was conducted in real time – during the early visioning and development of the health care centers. This enables the identification of the participating actors and the analysis of their interpretations while they could still be recalled. The interviews reveal the actors' subjective interpretations and their social construction of meaning related to a health care center in the municipality. Furthermore, they reveal which logics the actors' draw upon in the conceptualization of specific types of health care centers. The archival data – the municipalities' applications for financial support – supplement the interview data as these applications also describe how the health care centers were expected to implement the aims of the Reform. Finally, they provide structured and detailed data on how the actors' envisioned the centers' organizational form.

FINDINGS

In this section I identify the relevant municipal accounts and the institutional logics they are linked to in order to legitimize the local translations. First, I present the accounts linked to the logics embedded in the Reform. This includes two accounts linking to the logic of efficiency, i.e. the importance of professional collaboration in patient flow management and preventing public expenses; three accounts linking to a logic of quality, i.e. with emphasis on coherence in patient flow management, developing an educational approach in health services, and improving citizens' health; and, finally, two accounts linking to a logic of equal access,

i.e. the importance of geographical closeness or open access to health services. I then present two logics embedded at the local level that emerge from my analysis. Two accounts emphasizing the health care center as an internal project creating organizational coherence or as an external branding of the municipality were linked to the logic of organizational identity, while three accounts stressing the importance of utilizing existing resources, preventing municipal expenses, and creating municipal wealth were linked to the logic of economic sustainability. Next, I analyze how these twelve accounts form a pattern as groups of accounts link to specific organizational forms. Four groups of translations emerge from the analysis. While these groups share internal similarities, variation exists between the groups. The four organizations are the outstanding organization, the utilizing organization, the network organization and the hospital based organization.

Municipalities drawing on logics embedded at the national level

The following presents which accounts I discovered were constructed within the municipalities and also which institutional logics they each link to at the national level. I present them here based on my analysis of each accounts' implicit construction of a legitimizing social meaning, which I compare to the social organizing principles underlying each logic. This provides an understanding and an overview of which logics the municipalities' accounts link to as illustrated in Table 3 (see appendix for a definition of abbreviations). The table shows that twelve municipal accounts link to either three institutional logics embedded at the national level or two logics embedded at the municipal level.

Table 3. Municipal translations: Coded categories of accounts and their correspondence to institutional logics and organizational forms. Municipalities grouped into four types of translations.

| Municipalities | Institutional logics | | | | | Organizational form | | | | |
| | The national level | | | The local level | | Gover-nance | Structure | | Focus | |
	Efficiency	Quality	Equal access	Organizational Identity	Economic sustainability		Physical frame	Relations to health sector	Scope of service	Type of service
The outstanding organization										
Copenhagen	MPF	CPF+E	-	EB	-	PPP	B-new	R	F	R
Aarhus	MPF	CPF+E	OA	EB	-	M	B-new	R	F	R+HP
Odense	MPF	CPF+E+ICH	OA+G	EB	-	M	B-new	OA	B	HP
Vesthimmerland	MPF	CPF+E	OA+G	EB	-	M	B-new	R+OA	B	R+HP
The utilizing organization										
Soenderborg	MPF+PPE	CPF +ICH	-	EB+IP	UR	M	B-nurs.hm	R	F	R
Broenderslev	MPF+PPE	CPF+E+ICH	OA+G	EB+IP	UR	PPP	B-various	R+OA	B	R+HP
Horsens	MPF+PPE	CPF+E	+G	EB+IP	UR	M	B-nurs.hm	R	B	R+HP
Naestved	MPF+PPE	CPF+E	-	EB+IP	-	PPP	B-nurs.hm	R+OA	B	R+HP
The network organization										
Hilleroed	PPE	ICH	OA	EB	UR	M	N	OA	F	HP
Fredensborg	MPF+PPE	CPF+E+ICH	OA+G	EB+IP	UR+PE	M	N	OA	B	R+HP
Lyngby-Taarbaek	MPF+PPE	CPF+E+ICH	OA+G	EB	UR+PE	M	N	R	F	R+HP
Faaborg-Midtfyn	MPF	CPF+E	G	EB	UR+PE	M	N	OA	B	HP
Vejle	MPF+PPE	CPF +ICH	-	EB	PE	M	N	R	F	HP
Bornholm	MPF+PPE	CPF+E+ICH	OA+G	IP	PE	M	B-various	OA	B	R+HP
The hospital based organization										
Ringkoebing-Skjern	MPF+PPE	CPF+E+ICH	OA+G	EB+IP	PE+CWL	M	B-hospital	OA	B	R +HP
Odsherred	MPF+PPE	CPF+E+ICH	G	EB+IP	UR+PE+CWL	M	B-hospital	OA	B	R+HP
Samsoe	PPE	CPF+E+ICH	OA	EB	UR+PE+CWL	M	B-new	OA	B	R+ HP
Vordingborg	PPE	CPF +ICH	OA+G	EB	UR +CWL	M	B-hospital	R	B	R +HP

The logic of efficiency

The municipalities construct accounts that call for *prevention of public expenses* in the provision of health services and for *management of patient flow.* I interpret these accounts as linked to the legitimizing logic of efficiency.

The municipalities envision health care centers that aim to reduce hospitalization and people's need to use the expensive regional health care sector. A senior health manager explains:

> I believe that our patient program can show that if we do some things for the chronically ill that make them better able to tackle their disease physically and gain more knowledge about this, then I think their need for moving on in the health system will be reduced.

Another account stresses that the center should shorten the path a patient has to follow through the health care sector by facilitating rational collaboration and communication among professionals. One center manager emphasizes:

> We need to develop the information technology platform, so we can ensure the management of patient flow, agree on action and decide what each of us should offer and how we refer to each other. At the same time, it enables us to face the challenge of working in a more evidence-based manner.

The logic of quality

The municipalities create three accounts which I interpret as linked to the legitimizing logic of quality *improving citizens' health*, developing an *educational approach,* and creating *coherence in patient flow.*

Some municipalities find that the health care center should help people develop a healthy lifestyle. One center manager states:

> I am hoping that it is possible, that we might be able to move some of the people with the "It's pointless" attitude that many obese people and smokers have. And they know they have to change, but the task is simply too big. If you could just reach a few people in the first six months and say, here's someone who was too fat, smoked and didn't exercise enough, but now she has successfully been referred to a smoking cessation course and has been placed with others like her and now they exercise in the woods twice a week. So change happens in small steps.

A senior health manager points to a specific municipal advantage in rehabilitation and health promotion building on the municipality's close relationships with its residents, knowledge and experience, and the fact that it offers something that is not taken care of at the hospital:

> But why do we look so differently on health promotion in hospitals and in municipalities? Well, I know why. The hospital looks at the body and the disease, while we look at how everything, both the physical and spiritual aspects, can continue to work together with their surroundings to create a good life.

Another account develops an educational approach and emphasizes empowerment and people's ability to govern their own lives and enhance their quality of life. The center is envisioned as a model supporting the individual; in particular, patients with chronic diseases that are often hospitalized. One center manager emphasizes that educating patients is an important goal:

> Our main task is primarily the patient program, which is half of what we do and takes up the most space. Our aim is to support people with a chronic disease, to educate them to manage their illness better.

The aim of the third account is to coordinate health services and to create coherence in patient flow through the health care sector by facilitating collaboration and communication among qualified professionals as well as by supporting the individual. This account envisions a health care center that facilitates synergetic collaboration among professionals and offers people access to most health services. Some actors point to a location at the local hospital. One municipal senior health manager emphasizes:

> General practitioners are one of our most important partners. Beyond them, there is also the management in hospital departments, which provide service for people with lifestyle related diseases; we should also get in contact with them.

The logic of equal access

The local municipal accounts emphasize that health service should be provided either with easy and *open access* or *geographically close* to people. I interpret this as a link to the legitimizing logic of people's equal access to health care.

One account stresses that the health care center should offer easy, open access to a broad range of services without mandatory referrals from hospitals, general practitioners or other collaborating partners. One center manager who finds a referral structure constraining says that:

> … I expect that we will become the open door where everybody can enter and get some health advice.

Another account emphasizes that health care service should be provided in close geographic proximity to the residents. Located in a new or existing public building or provided at various locations in people's neighborhoods, such as daycare centers, schools, and workplaces, they should be a part of people's daily lives. One general practitioner emphasizes that:

> The very obvious advantage of this center is the location, because this is an area with a large population, but with an extremely poor representation by the health system. One practitioner who was employed out here retired a while ago and could not sell his clinic. So he closed it down, which meant the provision of health care disappeared with the exception of nurses and home helpers, etc., but no doctors. This is why there is a giant hole that the health center located here covers.

In summary, when actors translate the health care center concept into their local context, they construct different accounts drawing on the available national logics. Yet, all municipalities link to the three institutional logics and only a few of the municipalities differ in their construction of accounts. Whereas most municipalities link to the logic of efficiency by emphasizing that the center should create shorter

patient paths, one group does not agree with also preventing public expenses through reduced hospitalization. And while most municipalities link to the logic of quality by emphasizing coherence in patient flow as well as offering an educational approach to health, this group of municipalities again does not agree that the centers' aim is to improve citizens' health. Concerning the logic of equal access, however, no significant pattern occurs across the municipalities. They all emphasize the importance of open access or access within close geographic proximity to health services. Turning now to the way the municipal accounts link to the logics at the local level, the findings show an even more considerable pattern across the municipalities.

Municipalities drawing on logics embedded at the local level

The following shows how the municipalities construct accounts which are linked to institutional logics embedded at the local level. I describe these logics separately in order to illustrate that institutional logics are embedded at more analytical levels. I identify two logics: the logic of organizational identity and the logic of economic sustainability.

The logic of organizational identity

Some municipalities create accounts establishing the health care center as an organizational process, i.e. an *internal project*, whereas others stress the importance of an *external branding* of the municipality as a healthy place to live. I do not interpret these accounts as linked directly to any of the above-mentioned institutional logics embedded in the national Reform. Instead I conceptualize the actors' concern for the municipal identity as an institutional logic embedded at the local level. This logic emphasizes that a municipality is a historically and socially constructed organizational entity, which is a central feature for carrying out service in a highly decentralized public sector. Yet, a municipality is not a fixed and solid organization but is subject to change, and thus also to on-going re-constructions of its' organizational identity.

Establishing a health care center is understood by some as an organizational project or a means to create organizational coherence and shared values within a municipality, i.e. between politicians from different geographical areas, or after the reforms, a merging of smaller municipalities. The concept is part of a process defining the municipal policies and service. One municipal senior manager points out:

> We need to pay attention to the political level as it is now composed of five for-
> mer municipalities. Someone asked, slightly frivolously, whether the center could
> be placed in a specific part of the municipality. We need to think about the skele-
> tons in the closet because not everyone has started thinking of us as "the new mu-
> nicipality". There are many people from the former municipalities taking care of
> their small units.

Another account points to the importance of branding the municipality through the provision of health service. Health service – both municipal and regional – should constitute the municipal identity. One politician highlighted how public health is an important growth strategy in those particular communities and a means to attract more people:

> I hope it can help to put the municipality on the map as a place where we priorit-
> ize public health compared to other places. We are in a geographical area that
> people move away from, or at best, the population level is stagnant. It may help to
> say that our municipality is a fine place to live because we are very conscious
> about providing care to our residents.

The logic of economic sustainability

I also identify another logic embedded at the logic level. The logic of economic sustainability emphasizes that an organization requires an economically sound plat-form for its agency and survival. And as the public sector is organized as a non-profit organization financed by taxes, municipal budgets are repeatedly subject to public debate and cutbacks. Thus, most local actors construct accounts that envi-sion a health care center that aims to *utilize municipal resources*, *prevent municipal expenses* for hospitalization and even perform as a means to *create wealth locally* by maintaining or creating activities and jobs in the municipality.

Some actors emphasize that the health care center should utilize municipal re-sources and draw on existing and available resources in the municipality such as staff, competences, experience, and already established service and activities. The center should be located in existing buildings such as a former hospital or in sec-tions of a hospital that is downsizing. Also, former nursing homes for the elderly are taken into consideration. In areas without these types of buildings, the center is translated into a network of collaborating professional groups from existing activi-ties and institutions. One politician explains:

… there's no doubt about the economic aspect. If we can prevent illness and improve health, then we will improve the economy in other service areas. If we can, we get ahead, which is very crucial to me, and if we are better at intervening early in things, then we will have a better municipality and better finances, in principle, in what I call the other "basic service areas". This is important because it is not a matter of high growth rates, but rather a question of doing this effectively and efficiently.

Another account stresses that the health care center should prevent municipal expenses, i.e. municipal co-payments for hospitalization. The center should educate patients with chronic diseases, so that they can manage their diseases, feel comfortable, and reduce their use of regional hospitals and general practitioners. One politician points out that there are several things the municipality should do:

… provide physical rehabilitation, visit patients, prevent more costly diseases. We must understand that one reason for a local politician to think differently is the cash payments made to the hospital sector if our citizens use it too much … It can also be measured in our health expenses for hospitalizations, etc., if they (patients) fall below the regional average.

Another way to prevent municipal costs is to reduce social welfare given to people who are unemployed by facilitating their return to work. One municipal senior administrator emphasizes that politicians are examining the health care center project and are interested in whether it would help more people get work:

They (the politicians) would like to see – with this project focusing on the unemployed who are ill – if money can be saved. It will be a big focus for them. It is the project dealing with the rehabilitation of people who are sick who are unemployed.

Finally, the logic of economic sustainability is linked to accounts legitimizing the health care center in terms of its contribution to the strengthening of the local economy. The centers should create wealth within the municipal geographical boundaries by maintaining or creating new activities and employment. One politician said straight out that enhancing job opportunities was part of the basis for creating the health care center:

It is of course the hospital downsizing. What will happen to that building? Could we find something to put in it and still maintain some jobs?

In summary, when the municipalities link to institutional logics embedded at the local level, they create accounts which are similar, but not used as equally much. This indicates not only that similar local issues are taken into account, but also that the particular local contexts provide different senses of legitimacy. Whereas nearly all municipalities link to the logic of organizational identity in order to legitimize the health care center as a means to construct an external identity branding the municipality as a healthy community, only half of the municipalities point to the center as a means for creating organizational coherence within the municipality. The logic of economic sustainability shows even stronger variation. One minor group of municipalities does not link to this logic at all; another group only emphasizes that the center should utilize existing resources; a third groups agrees on this, but also stresses that the idea is to prevent municipal expenses for hospitalization; and, finally, a fourth group adds to this the importance of creating the center as a means to create wealth locally by maintaining or creating activities and jobs in the municipality. Combining how the municipalities draw upon the logics at the national and local levels shows that the municipalities that do not draw on the local logic of economic sustainability also do not emphasize the national logic in terms of preventing public expenses. However, this is not that surprising as both of these accounts emphasize the importance of economic efficiency. The following section shows the municipal translations of the health care center concept into organizational forms with – in particular – an impact from the local logic of economic sustainability.

Municipal translations of the health care center concept into organizational forms

So far the analysis has shown how multiple municipal accounts emerge drawing differently on logics at both the national and the local level. Yet, the following section shows that although the variation appears dominant at first, a pattern underpinning the municipalities' accounts can be found. The accounts are linked to each other, and this assembling of specific accounts illustrates the different ways in which municipalities translate the concept of a health care center into a specific organizational form. The municipalities are grouped according to how their accounts interpret – and are linked to – the logic of economic sustainability embedded at the local level. Accounts linking to this logic correspond to a specific varia-

tion in the health care centers' organizational form, i.e. their physical framework. Four groups of municipalities are clustered into four groups of translations: the outstanding organization, the utilizing organization, the network organization and the hospital based organization. The logics embedded at the national level do not indicate any significant pattern in their impact on the municipal accounts and their correspondence to specific organizational forms.

The outstanding organization

Municipalities in the first group draw in particular on the national logics of quality, but also on the national logic of efficiency, translating the health care center concept into an organization which develops an educational approach in health as well as more coherence in patient service. The aim is to increase the level of health service to support the individual patient and to enhance the patients' quality of life. At the same time, the municipalities draw on the local logic of organizational identity and emphasize the importance of providing health locally and branding the municipality as a healthy place to live. One particular feature is that the prevention of public expenses is not prioritized, nor do the municipalities draw on the logic of municipal economic sustainability, i.e. utilizing resources and preventing municipal expenses.

The health care center is translated into a municipally governed organization that focuses on specific groups of patients with chronic diseases or specific marginalized groups of citizens in a particular geographic area lacking health care service. The center provides mainly, but not in all cases, the rehabilitation of patients with referrals from hospital or general practitioners. The municipality intends to invest in a new building for the location of the center.

The utilizing organization

The second group of municipalities draws, in particular, on the national logics of efficiency and quality, and conceptualizes the center as a means of preventing public expenses, of managing patient flows efficiently and of providing an educational approach in health services in order to improve quality but also to reduce hospitalization. Linking to the local logic of economic sustainability further emphasizes that the center should utilize resources in the former municipalities. One

specific feature is that the municipalities draw on the local logic of identity and interpret the health care center as an internal organizational project, which engages the former independent municipalities in a process constituting a new municipal organization. In this way, the center takes into account the internal competition between politicians and local ethnocentrism.

The health care center is conceptualized as an organization that provides a broad range of services, but in particular the rehabilitation of patients through open access to health services or referrals from hospitals and general practitioners. The health care center should educate patients and facilitate changes in the individuals' lifestyle in order to reduce hospitalization. As the organization utilizes existing resources, the center is located in municipal buildings such as former nursing homes. Furthermore, some of the municipalities envision that the center should be governed as a public-private partnership.

The network organization

The third group of translations draws on the national logics of efficiency and quality by preventing public expenses, creating collaboration and coherence in the patient flow management, creating an educational approach in health services and by improving citizens' health. Furthermore, the municipalities draw on the municipal logics of identity and economic sustainability, stressing the importance of providing health service locally, whilst utilizing existing resources and preventing municipal expenses. One particular feature is that the aim is to prevent expenses, and that the health care center should brand the municipality by providing health promotion for all citizens, including children, youth, adults and the elderly.

The center is conceptualized as a municipally governed network organization that aims at creating collaboration among health professionals and social workers in the municipality, health professionals at the regional level and local volunteers in local patient and sports organizations. The service is organized with open access and activities provided in all areas of the municipality. The center initiates activities at various municipal institutions such as daycare centers, schools and nursing homes, as well as work places and public spaces.

The hospital based organization

Finally, the fourth group of translations is guided by the national logics of efficiency and quality and the actors emphasize prevention of public expenses, collaboration and coherence in patient flow management, an educational approach in health services and improving people's health. One distinguishing feature is that the actors draw on the municipal logics of identity and economic sustainability, stressing the importance of creating wealth in the municipality, i.e. jobs and activities, by providing health service locally, utilizing resources and preventing municipal expenses.

The health care center is conceptualized as an organization that provides open access to rehabilitation for a broad target group. The municipal economy is interpreted as constrained and the development of a health care center is seen as a way to maintain the local hospital, which in return provides local service and employment. The health care center is envisioned as located in or strongly linked to the local hospital.

There is a pattern across the translations. The pattern illustrates how the multilevel logics are interpreted differently in practice, corresponding to a variation in the organizational forms. Interestingly, the analysis shows that the pattern emerges from the way the municipalities link to the local logic of economic sustainability corresponding to a specific variation in the organizational forms, i.e. the physical location of the health care centers. Municipalities that emphasize the importance of utilizing resources create health care centers in former nursing homes; municipalities that both utilize resources and prevent expenses create organizational networks without buildings; and municipalities that stress the creation of municipal wealth through jobs and activities locate the center in former hospitals. Municipalities that do not draw on the logic of municipal economic sustainability, in contrast, invest in new buildings. Of course, the identified pattern is very simplistic, and in each case a unique meaning underlies the development of a new organization. However, the pattern does show that variations as well as similarities emerge across translations. The similarities are especially interesting, because they emerge simultaneously across various units and geographic areas.

CONCLUSION AND DISCUSSION

In this study, I examine the translation of a new organizational concept in the Danish public sector. The analysis shows how the concept of a health care center is translated differently into the local contexts by municipalities that draw on both national and local institutional logics. However, some of these translations shared similarities as they constructed organizational legitimacy by interpreting the same institutional logics in the same way. The analysis shows that all of the municipalities construct accounts that draw on the three national logics embedded in the Reform, including the logic of equal access, the logic of quality, and the logic efficiency. The municipal accounts also draw on two institutional logics embedded at the local level, including the logic of organizational identity and the logic of economic sustainability, but with great variation in their interpretations. The local logic of economic sustainability in particular is interpreted differently and not drawn upon by all municipalities. The different interpretations create a variation in the organizational forms, particularly in the organizations' physical frameworks. In what remains of this analysis, in addition to discussing how my findings contribute to the concepts of translation and multiple institutional logics, I suggest some ideas for future research.

This study contributes theoretically to building on how previous studies on translation explore emerging organizational forms. So far, these studies have not investigated how translating actors draw upon multiple institutional logics, including logics embedded at a variety of levels. Yet, as this study shows, the municipalities interpret the multilevel logics differently and this creates variation in the organizational forms. I discovered four groups of translations that were specific combinations of logic interpretations and organizational forms. While variation exists between these groups, they share internal similarities. The four translations are the outstanding organization, the utilizing organization, the network organization and the hospital based organization. The translations are grouped around the logic of economic sustainability embedded at the local level corresponding nicely with a variation in the organizational form, i.e. the physical location of the new health care center. The municipalities that translated the health care center into former nursing home locations emphasize the importance of utilizing resources; municipalities that envision organizational networks emphasize the importance of utilizing resources and preventing expenses; and municipalities put the center in former

hospitals stress the importance of maintaining local jobs and activities. In contrast, municipalities that envision a new building for the health care center do not draw on the logic of economic sustainability; instead, their legitimizing accounts are linked to the national logic of quality and the local logic of identity. Thus, what seem to be local issues involving utilizing resources, preventing expenses and maintaining local jobs are in fact local expressions of the same institutional logic of economic sustainability embedded at the local level in a number of municipalities. The logic of economic sustainability emphasizes that an organization requires an economically sound platform for its agency and survival. The point here is that the interpretations of the local level logics has a particular impact on the emerging organizational forms. In fact, all of the four groups of translations are clustered around the way the municipalities constructed centers as solutions to locally constructed problems or issues. If I had restricted the analysis to exploring only the national logics as presented in the national Reform, I would not have found this significant institutional impact from the local level. Hence, I argue that studies on translation would benefit from exploring how actors draw upon multiple institutional logics, including logics at the local level.

The study also contributes expanding how previous studies have used the concept of multiple institutional logics to explain differences in emerging organizational forms. The analysis shows that although most of the involved municipalities link to the same logics, embedded at either the national or local levels, they nonetheless create different organizational forms. This implies that a given logic does not give rise to a particular organizational form. Instead, multiple institutional logics are interpreted and combined differently, resulting in various organizational forms. All of the municipalities' translations draw upon the three logics embedded at the national level; the municipalities' accounts link, i.e. to the logic of efficiency and quality and, to a lesser degree, to the logic of equal access, showing only little variation in the interpretations of these logics. Only the outstanding organization did not emphasize the need to prevent public expenses. This pattern indicates that national logics, perhaps, are particularly relevant for the legitimation of an emerging local organization. The fact that the particular organizations depend on state funding might have accentuated this. However, although most municipalities – as already highlighted – draw upon the local logic of economic sustainability, it is their different interpretations of this logic, including the need to utilize resources, to prevent expenses and to maintain jobs, which created variation in the organizational forms. In addition, the municipalities also draw upon the local logic of orga-

nizational identity, albeit interpreting this similarly by emphasizing the need to brand the municipality externally in competition with other municipalities. Thus, the study does not show that a given institutional logic gives rise to a particular organizational form.

The Design of the Study

The bottom-up policy analysis captures the way actors at the local level make sense of a policy initiative, in contrast to a top-down focus on whether a national policy is implemented or not. While this approach is designed to capture variation, i.e. how various actors interpret the health care center concept, this study identifies important similarities in these translations. This suggests that the choice of method does not constrain the analysis.

The inclusion of eighteen municipalities enabled the identification of organizational variation between cases, but it also revealed the similarity in the municipalities' translation of the health care center concept. I would not have been able to reach the same conclusion, if the study had only focused on a few municipalities. By identifying the institutional logics and organizational forms separately, I also open up for the exploration of the link between local translations and organizational forms. If I had instead identified a particular organizational form and then looked for the underlying logics, a far more constrained analysis would have resulted.

It should be noted that in a few municipalities there were actors who said that they took into consideration what kind of center would be most likely to obtain support from the ministry in the formal application for financial support. The actors simply saw an opportunity to control costs. The design of this study was not able to capture the significance of these municipal tactics. Still, even though municipalities were aware of which types of health care centers would be able to obtain support, they would still need to translate the center into a particular model that fit both the logics of the Reform and the local context.

Future Research

More research is needed to develop these findings in a number of areas. The analysis indicates that the local geographic context has an impact on the develop-

ment of health care centers. It would be interesting to analyze how institutional forces within different local communities play a role (see Maguire et al., 2007; Scott, 2001). Although institutional theorists acknowledge that organizational forms are contextualized within specific organizational environments (Selznick, 1949; Scott, 2001; Lounsbury, 2007), most researchers include the level of the field but overlook the local community as an influential level of analysis; more research is needed in this area (Marquis et al., 2007; Greenwood et al., 2008).

The design of this study did not facilitate an analysis of how the collaboration between the municipality, hospitals, physicians, patient organizations and private companies influences the construction of the health care centers. Yet, actors in most of the municipalities emphasize that their experience with local collaboration, conflict and negotiation had an influence on the organizational forms. It would thus be relevant to analyze the local processes and the differences in the interpretations held by groups of actors such as health professionals, politicians and managers. Although it was not part of this study, it is clear that the interpretations vary between groups. In one municipality, the aim of the health professionals was for the health care center to provide rehabilitation for patients with chronic diseases. The aim of the politicians, on the other hand, was for the center to provide health services, i.e. health promotion, for everyone.

Finally, the municipalities have begun designing health care centers that differ in how much focus is put on particular social groups. Some municipalities draw on a logic of rehabilitation targeting patients with chronic diseases, whereas other municipalities draw on a logic that promotes healthy lifestyles. The result is an emerging yet already distinct pattern of variation across municipalities. It would be interesting to investigate why this is occurring in a country that professes to provide uniform health care.

APPENDIX TO ANALYSIS 1 - Definitions of the abbreviations in Table 3

<u>**National logics**</u>

Efficiency

- PPE: Prevent Public Expenses to health service. The health care center should contribute to reducing total public health expenses by reducing hospitalization and people's need to contact the expensive regional health care sector.
- MPF: Manage Patient Flow. The health care center should contribute to shortening the path patients follow through the health care sector by facilitating rational collaboration and communication among relevant professionals.

Quality

- ICH: Improve Citizen Health. The health care center should facilitate the improvement of people's health.
- E: Educational approach. The health care center should empower citizens to govern their own lives and enhance the quality of life. A municipal approach in health promotion and rehabilitation should be developed based on the municipality's relationships with people, its knowledge and experience, but also on evidence-based scientific knowledge.
- CPF: Coherent Patient Flow. The health care center should contribute to creating coherence in the path patients follow through the health care sector by facilitating collaboration and communication among qualified professionals as well as by supporting the individual.

Equal Access

- OA: Open Access to health care service. The health care center should offer easy, open access to a broad range of services that do not require mandatory referrals from hospitals, general practitioners or other collaborating partners.
- G: Geography. The health care center should have close geographic proximity to people. Located in a building, provided at various locations in the neighborhood or as part of people's daily lives: at schools, daycare centers, workplaces or websites.

Local logics

Municipal Identity

- IP: Internal Project. Establishing a health care center is used in an internal process that aims at creating organizational coherence and shared values within a municipality, i.e. between politicians from different geographical areas and in new municipalities constituted by a merger of smaller municipalities as part of the national reform. The concept is part of a process defining the municipal policies and service.
- EB: External Branding. Health service – both municipal and regional – should be part of the service provided in the municipality and brand or constitute the municipal identity.

Municipal economic sustainability

- UR: Utilizing municipal Resources. The health care center should draw on existing and available resources in the municipality such as former hospitals or nursing homes, staff, competences and experience, and already established service and activities.
- PC: Prevent municipal Expenses. The health care center should prevent municipal expenses, i.e. municipal co-financing of hospitalization, by improving people's health and reducing their need to use the expensive regional health care sector. Also reduce municipal welfare services for the unemployed who are ill by facilitating their return to work.
- CWL: Create Wealth Locally. The health care center should maintain or create new activities and jobs in the municipality.

Organizational form

Structure

- Governance mechanism: Municipal governance (M) or public-private partnering (PPP)
- Physical framework: a new building (B – new), a former hospital (B-hospital) or former nursing home (B-nurs.hm.), or a network of partners (N)
- Relationship to health sector: Referral of patients from general practitioners, hospitals or other partners (R), or open access health services (OA).

Focus

- Scope of service: Focused (F) or broad range (B) of activities and target group
- Type of service: Rehabilitation (R) or health promotion (HP)

8. ANALYSIS 2

The Dynamics of Community Translation: Danish Health Care Centers

Susanne Boch Waldorff

Copenhagen Business School

Denmark

and

Royston Greenwood

Alberta School of Business

University of Alberta

Canada

ABSTRACT

We investigate why an organization is constructed with a specific focus. The theoretical framework is neo-institutional theory combining the approaches of multiple institutional logics (Friedland and Alford, 1991; Thornton, 2004), processes of translation (Czarniawska and Sevon, 1996; Sahlin-Andersson, 1996), and geographically bounded communities (Greenwood, Diaz, Li and Lorente, 2009; Guthrie and Roth, 1999a: 1999b; Guthrie, Arum, Raksa and Damaske, 2008; Marquis, Glynn and Davis, 2007; Marquis, 2003; Marquis and Lounsbury, 2007). Specifically we analyze whether demographic or institutional dynamics in the municipal context affects a health care center's focus targeting either citizens or patients. The study suggests ruling out the demographic dynamic. The choice of focus - and underlying logic - is influenced by the local actors' relationship with an external institutional context. Members of local political parties adopt the ideological position of the national party. Similarly, professionals employed locally push the normative code of their profession. Geographically bounded communities are important sites as local factors determine which party is in power, thus determining the choice that will be made between particular logics. We used qualitative methods to analyze the differences in organizational focus, the local ideological values, and the participation of professionals in the centre developments. Additionally, we used quantitative methods to compare the impact from socio-economic variables across eighteen municipalities.

INTRODUCTION

This paper examines how far political and professional interests within local communities in Denmark are influencing the implementation of a national health care centre policy. Our overall aim is to understand whether and why any differences in service provision are occurring. As such, we contribute to the growing exploration of institutional processes occurring at the level of the geographically bounded community. However, and contrary to previous work, the focus here is on the influence of political and professional interests upon the choice of which logic should shape health care provision.

Most health services in Denmark, including all hospital services, are provided by regional authorities but in early January, 2007, health care centers were established in several communities with the goals of improving primary health care and promoting public health. The concept of a health care centre, however, is ambiguous. It was put forward by the Danish Government as part of a package of "soft" regulation with largely informal rules that are very much open to interpretation and adjustment (Mörth, 2004; Kirton and Trebilcock, 2004; Sahlin and Wedlin, 2008). Furthermore, the concept is weakly enforced by law. These features have allowed those implementing the policy to ensure that local health care centers fit their interests.

Perhaps inevitably, local actors are interpreting the policy in different ways and are designing health care centers that differ in the focus given to particular social groups. In particular, there is a struggle over which of two overarching logics, or discourses, should frame the policies and services of the health care centre. Some health care centers emphasize the *rehabilitation* of patients already diagnosed with chronic diseases, whereas others emphasize the promotion of *healthy lifestyles* aimed at the population at large. The former logic focuses upon post-diagnostic assistance ('how to live with a debilitating illness'), whereas the latter focuses upon adoption of healthy practices ('how to avoid illness'). These two approaches constitute competing 'logics of care' and have significant implications for who benefits and in what ways. Understanding the process whereby a particular logic is given priority is thus important because that decision is consequential for the allocation of social benefits.

This study explores how dynamics in the municipalities affected the choice between the two logics. Two dynamics are investigated – one demographic, one

institutional. The first links the nature of health care provision to the health and socio-economic configuration of the municipality. In effect, this explanation anticipates that service delivery will be driven by a combination of local needs and resource availability. The institutional dynamic, by contrast, foregrounds the cultural-cognitive values of politicians and professionals active in the local jurisdiction. By exploring the role of these dynamics we show three things. First, that cognitive schema plays a more important role than 'objective' needs for service and/or resource availability. Second, and more important for the purposes of this *Volume*, the community level of analysis is a significant source of variation *within* an institutional sector, or field; but, the range of variation is heavily constrained by higher-level institutional arrangements. Third, communities should be recognized as political jurisdictions within a decentralized logic of the State (Greenwood et al., 2009) rather than, as has been the tendency in much recent work, as mere clusters of proximate organizations.

In what follows, we first outline the theoretical context and then, in Section III, provide a summary of the empirical context. Section IV describes the methods applied in this study, followed, in Section V by the analysis. Section VI discusses issues raised and theoretical insights.

THEORETICAL CONTEXT

For decades, institutional researchers have included the organizational field as a comprehensive level of analysis. DiMaggio and Powell (1983: 148) define a field as "those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce services or products". This definition clarifies the actors and roles within the field. Later, Scott (1994: 207-8) suggested a more explicitly social constructivist approach, defining a field as "a community of organizations that partakes of a common meaning system and whose participants interact more frequently and fatefully with one another than with actors outside of the field". This definition pays attention not only to the actors within a field, but also to their common cognitive understandings.

The field is the dominant level of analysis within institutional analysis and has generated considerable insights (for a review, see Wooten and Hoffman, 2008)

because, as Scott (2008: 86) notes, it is where institutional forces "are likely to be particularly salient". But, one consequence of the focus upon the field is that analysis has tended to overlook the possible influence of geographic communities as a foci of institutional processes. Despite early work (e.g. Selznick, 1949; Gouldner, 1954; Zald, 1970), which emphasized how local contexts have a strong influence on organizational behavior, most institutional accounts, until very recently, did not link organizations to any specific geographical area (for an exception see Galaskiewicz, 1985: 1991).

Recently, there has been a renewal of interest in exploring the possible role of community processes (for a summary see Marquis and Battilana, forthcoming). One theme of this research begins from the premise that local communities have 'identities', traces how such identities arise, and considers the path-dependent implications (e.g. Marquis, Glynn and Davis, 2007; Marquis, 2003; Marquis and Lounsbury, 2007). Marquis, Glynn and Davis (2007), for example, studied corporate social action and theorized how cultural-cognitive factors at the community level are developed and sustained and how they produce intra-community isomorphism and variation across communities. A central interest in this theme is the uncovering of mechanisms by which community norms are diffused and take effect. Social networks and social comparison processes are frequently highlighted. The emerging conclusion is that these and other mechanisms result in homogeneity *within* a community but variation *across* communities. For example:

> "The central idea is that standards of appropriateness regarding the nature and level of corporate social action are embedded within local communities, and organizational conformity to these institutionalized practices yields systemic patterns that vary by community". (Marquis et al., 2007: 926).

Other research has given more attention to the nuances of community identities (e.g. Molotch et al. (2000; Romanelli and Khessina, 2005). Molotch et al., for example, detailed the 'overarching attributes' and 'city traditions' that make Denver and Toledo 'durably distinct' (2000: 791). Showing a similar interest in how historical and cultural forces make a community distinct, Lounsbury (2007) analyzed how the mutual fund industry developed differently in New York and

Boston and concluded that: "practice variation was importantly associated to geographic heterogeneity" (2007: 290).

Community identities have consequences. Molotch et al. (2000), for example, link them to investment opportunities and constraints. Similarly, Romanelli and Khessina (2005) observed how the distinctive identity of a region's industrial configuration influenced how outside audiences perceive and react to the region, and contributes to its subsequent prosperity. Greenwood, Diaz, Li and Lorente (2009) show the influence of non-market logics upon the economic decisions of regionally embedded firms. They found that the intensity of regional sentiments in Spain was associated with a willingness of firms to act in the interests of the region rather than those of the firm. Guthrie and colleagues, in a series of studies (Guthrie and Roth, 1999a: 1999b; Guthrie, Arum, Raksa and Damaske, 2008) have shown how implementation of federal policies varies across municipalities with consequences for particular social groups.

This study builds on the above ideas, but takes a different stance. For us, the shift to the level of geographically bounded community is of considerable significance because many, perhaps most, communities, unlike fields, are typically defined by political boundaries; that is, they are *jurisdictions*. In most western States, the dominant logic of the State is decentralist, pushing some degree of autonomy to local and regional levels of government (Greenwood et al., 2009). These jurisdictions are intended to allow expressions of political ideology that become manifest in public policies and local spending patterns. That is, jurisdictions reveal some of the implications of political institutions for different social groups. But jurisdictions are also places where professions often exert their influence. In most jurisdictions, professionals practice their craft through the provision of publicly funded services and are involved in the preparation and realization of important social policies that significantly affect the life chances and life opportunities of different social groups. In effect, the community, politically defined, is an arena for making social choices and those choices engage political and professional interests and actors. As such, the community adds an important dimension to the institutional story because it is both a source and an explanation of institutional heterogeneity, of change, *and* of consequences.

Our emphasis upon geographically-bounded communities as political jurisdictions, in other words, differs from the approach recently taken by organization theorists to understand the sole of 'community'. That approach treats

community as comprised of geographically-proximate organizations linked by organizational ties and relationships, and makes little reference to the community's political status. Admittedly, the potential role of municipalities to establish regulations that provide incentives to local businesses or that authoritatively prohibit certain practices, has been acknowledged in several *theoretical* contributions. Marquis et al. (2007: 937), for example, state that 'local politics and government mandates can temper or promote the nature and level of corporate social action'. But these roles and effects have been little studied. Our starting assumption, in contrast, follows Guthrie's approach, by treating the local jurisdiction as an expression of public policies which, in turn, have significant societal consequences. We seek to understand these processes by examining the choice of logic informing public policy choices.

Local translation of national logics

Institutional logics, introduced by Friedland and Alford (1991), are "the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton and Ocasio, 1999: 804). As such, logics provide the ground rules for social behavior and the criteria by which options and possibilities are to be assessed.

Friedland and Alford's (1991) initial statement anticipated that institutional change would occur at the interstices of conflicting logics. Organizations exposed to multiple logics would be more able to act reflexively. Early applications of their ideas, however, sought, first, to verify the occurrence of logics and, later, their historical contingency (e.g. Thornton, 2004; Westphal and Zajac, 1994). More recent work has turned to uncovering the interplay of multiple logics and the response of organizations to such 'institutional complexity' (Greenwood et al., 2009; Reay and Hinings, 2009), and to the likelihood of institutional change. Scott et al. (2000), for example, studied how a regulatory logic of the state disempowered the prevailing professional medical logics and created an opportunity for managerial-market logics (in the form of managed care) and new organizational forms (such as HMOs) to enter the health care system. Kitchener (2002) analyzed the effect of competing managerial and professional logics on responses to merger initiatives involving U.S. academic health centers. Reay and

Hinings (2005) analyzed how the competing institutional logics of medical professionalism and business-oriented health care are driving radical change in the Canadian health care field.

A critical theme within this work concerns how organizations respond to complexity arising from the concurrent existence of highly legitimated logics. One approach seeks to unravel the micro-processes of choice within an organization (e.g. Balogun and Johnson, 2005). A complementary approach asks why particular organizations are noticeably receptive to the prescriptions of a given logic (Lounsbury, 2001; Greenwood et al., 2009). This approach portrays logics at the field or societal level operating directly upon the organization. Here we take a complementary tack, asking how multiple logics within a given societal sector – in our case, health care – are selected by organizational actors bounded within a local political jurisdiction. We are particularly interested in the role of political parties and professional occupations. Our imagery is that institutional logics are filtered and/or 'translated' by these community-level actors.

Ideas and concepts are interpreted and made sense of by actors; and, because actors arrive at different understandings and have different resource opportunities, they generate different organizational responses to higher-level institutional prescriptions through processes of *translation* (Brunsson, 1989; Brunsson and Olsen, 1993; Czarniawska and Sevon, 1996; Czarniawska, 2008; Sahlin and Wedlin, 2008). Translation is not always conscious and strategic; it may be implicitly governed by institutionalized beliefs and norms (i.e. logics). It follows, therefore, that a way to understand how Danish local community actors responded to the national health policy is to assess the play of logics in the processes of translation. What logics guide the translation process, and why exactly those logics? Whereas previous work on translation has emphasized the cognitive and normative underpinning of translation processes, and downplayed the effects of political behavior, we spotlight the role of interests by showing how particular professional groups and political ideologies motivate local translation processes.

EMPIRICAL CONTEXT

Reorganization of the Danish public sector took effect on January 1, 2007. The new structure, set out in the *Agreement on a Structural Reform* (2004), contains 5

regions and 98 municipalities. The Regions are responsible for the provision of health care, regional development and the operation of several social institutions. Health care services are divided into primary health care sector – services provided by professionals such as general practitioners, specialist physicians, dentists, physiotherapists, etc., who deal the treatment and prevention of general health problems, and the hospital sector. Primary sector services are available to all citizens, whose initial contact with the health system is through this sector. The secondary sector – hospitals - deals with medical conditions that require more specialized treatment and equipment and more intensive care. Both the secondary sector and the primary sector (in conjunction with municipalities) are the responsibility of the regional authority.

Municipalities are responsible for the provision of education services and for most welfare tasks. They operate as the citizen's main point of access to the public sector. The recent *Reform* gave municipalities additional responsibilities for developing health promotion, prevention, and the provision of any rehabilitation services that do not take place during hospitalization. The guiding philosophy underlying this extension in responsibility is that municipalities should provide health promotion and education services close to the citizen's own home, and that they should be integrated with other municipal responsibilities, such as day care services, schools, and facilities for the elderly. Because municipalities are partly responsible for the funding of regional hospital services, they have an incentive to improve health promotion and rehabilitation and thus reduce demands upon hospital services.

Importantly, the Danish health system is publicly funded and a core principle is equal access for all citizens. Therefore, a primary aim of the *Reform* was to improve the quality of health service available to *all* citizens:

> The…parties wish to support and promote a strong, public health care service that offers patients unrestricted, equal and free access to prevention, examination, treatment and care at a high professional level. Furthermore, the health care service should provide high quality and high level education and research (*Agreement on a Structural Reform*, 2004: 37).

However, *how* municipalities should provide the health service was left unspecified. The only guidance was that they "… should be able to find new

solutions especially within prevention and rehabilitation, e.g. in the form of health care centres" (*Agreement on a Structural Reform*, 2004: 37). Moreover, the health care center concept was not mentioned directly in legislation. Instead, it was referred to in the *Proposal* to the law:

> There might be benefits within care, prevention and rehabilitation, such as improved quality, professional collaboration, recruitment and economies of scale etc., by assembling services in an organization like a health care centre, and by conforming to local demands (*Proposal*, February 2005: 39)

From the outset, in other words, the concept of health care centre was very ambiguous. Legislation did not specify which tasks are the more important, or the proper level and form of service that should be provided, or for whom. In effect, the relevant legislation is an example of enabling and "soft" regulation, open to interpretation and adjustment by any municipality that chose to implement it. It was left to municipalities to decide whether they would create health care centers, and, should they do so, the form that they might take.

It quickly became evident that municipalities are, indeed, approaching the health care centre idea in very different ways (Waldorff, Kristofferson and Curtis, 2006). Some centers are providing health promotion and educational programs for all citizens, whereas others are targeting patients with chronic diseases. The former are more concerned with services that advise on, or encourage, a healthy lifestyle; the latter emphasize rehabilitation programs for those recovering from, or learning to live with, disease post-hospitalization. As noted earlier, these differences converge around two fundamentally different logics of care. The rehabilitation logic is consistent with the idea of sick people receiving customized rehabilitative care. The lifestyle logic involves providing programs intended to enhance health education targeted at broad social categories rather than individuals.

Under the rehabilitation logic, the centre's purpose is to cooperate with the traditional health care field, located in the regional institutions, and receive referrals of patients from general practitioners and hospitals. Services delivered are intended to be based on medical scientific knowledge and provided to individuals. In this way, the health care centre conforms to the 'scientific' medical logic that dominates the wider health care field. Its mission is to focus on improving the ability of patients diagnosed with conditions such as diabetes, heart problems, and

chronic obstructive pulmonary disease, to continue to lead a productive life. The centre assists patients in tackling life with their affliction. Frequently, these centers are located in or in close proximity to a hospital, reflecting their status as adjuncts to the primary health care sector. From a financial perspective, a health care centre of this type is a means by which municipalities can reduce their contribution to the Regional Authority by reducing the costs that arise from long-term hospitalization.

Under the lifestyle logic, the health care centre promotes advice to all citizens of the municipality. The centre's *raison d'etre* is access for all citizens to locally provided education and guidance on a healthy lifestyle. These centers draw upon the knowledge and experience of traditional medical specialists, but also, even especially, from non-medical and ancillary fields, such as social work, nutritionists and exercise counselors. The centre's mission is to prevent illness and reduce inequalities in citizens' life chances that might arise from lack of understanding of issues such as nutrition and the need for exercise. In effect, the centre's strategy is to promote a healthy lifestyle by integrating that perspective into the municipality's services to its citizens, including socially marginalized groups such as the unemployed or the elderly. Services provided by these centers often include communication with staff in daycares and schools about nutrition so that services in these settings can be improved. Programs are also delivered for those (such as the unemployed) who risk falling permanently out of the labor market due to illness. Practical applications of exercise options, such as hikes in the forest in order to promote fitness, or the counseling of citizens about lifestyle-related conditions, are typical. From the financial perspective, investment in health promotion reduces the expenses incurred in hospitalization by generally improving the citizens' health so as to *avoid* hospitalization and by reducing the numbers of the unemployed. In broad terms, the municipality aims at increasing its citizens' average life expectancy and productivity.

These two logics clearly differ in the social groups which are targeted. As such, the act of choosing between the logics is a deliberate allocation of benefits. Thus, the *Reform* is an interesting vehicle through which to explore the consequences of institutional practices, a hitherto relatively neglected theme of institutional scholarship (Greenwood et al., 2008; DiMaggio and Powell, 1991). It also allows us to explore how and why those choices are made *within* a community jurisdiction.

Our starting point was to uncover how far local choice is driven by socio-demographic factors, such as the relative incidence of diagnosed health cases, and/or of economic factors. As such we were informed by the tradition of Dye (1966), Hofferbert (1966) and Sharkansky (1968: 1971), who explored whether environmental characteristics – in their case, per capital income, education, urbanization and industrialization – outweigh the influence of political system characteristics upon State expenditures in the United States. Socio-demographic factors represent the demand or need for services. Economic factors provide the resource base and thus the ability to pay for their provision. Both socio-demographic and resource factors have been established as determinants of budgetary expenditures in US municipalities (Hoffman and Prather, 1972).

Socio-economic and demographic variables are only one manifestation of the context within which strategic decisions are made and policies framed. Institutional theory has long emphasized the role of widely shared social expectations that prescribe appropriate ('legitimate') behaviors. Such prescriptions are conveyed and put into force at the local level by professionals and politicians, translating and reflecting wider social preferences. As Chattopadhyay, Glick and Huber (2001: 937) note, senior managers 'filter and interpret incoming information and make decisions based on those interpretations'. Unlike Chattopadhyay et al., we see the process of interpretation and translation as constrained and prescribed by the ideological/cognitive frames of politicians and professionals that derive from their membership of wider normative communities. That is, as we will show, politicians and professionals may operate at the local, municipal level, but their identities and cognitive frames are provided by intellectual communities *beyond* the immediate geographical community.

METHODS

The basic research design is pragmatic and exploratory. The Danish Government chose 18 municipalities to receive financial support for implementation of the health care concept, with the proviso that these municipalities be open to research on their experiences. Our study is part of this wider monitoring of the *Reform's* consequences. Given that implementation of the *Reform* began in 2007, the account provided here is an early snapshot of an

unfolding process in the 18 municipalities.

Data sources. We utilized two sources of data: archival materials and interviews. Archival materials included surveys conducted by the National Institute of Public Health (NIPH) that document each health care centre's organization, activities, and patients treated in 2007. The NIPH's data collection was standardized and enabled separation of the 18 municipalities into those pursuing the rehabilitation logic and those observing the lifestyle logic. The rehabilitation logic was measured by whether the policies and services of the health care centre match most of the following criteria: (i) the main target group is patients with diagnosed medical problems such as "diabetes", "heart problems", "COPD", "cancer", "dementia", "apoplectic", and "depression"; (ii) the services provided are "patient education", "patient schools", "longer patient programs", "rehabilitation", "alcohol abuse treatment", and "acute observation and treatment of elderly"; (iii) the service requires referral from a general practitioner or hospital; and (iv) the health care centre is physically located within, or close to, a hospital, acute clinic, or general practitioners. The lifestyle logic is defined by the following criteria: (i) the target group is citizens in general (all, children, youth, adults, and elderly) or marginalized groups (ethnic minorities, unemployed and frail elderly) irrespective of their current health status; (ii) the activities provided are more preventive in nature, such as "quit smoking courses", "individual health check and counseling", "physical therapy", "education of the municipal staff in daycares and schools in order to facilitate nutritious food for children", "weight losing courses"; (iii) citizens have open access to service in the centre; and (iv) services are often provided as part of citizens' daily life – e.g., in daycares, schools, nursing homes, families, work places etc. and do not require a referral. The ideal types used in our study were externally validated by two researchers from NIPH working with the survey data on health care centers.

Statistical information on the eighteen municipalities was gathered from *The National Health Interview Surveys*, a database run by the NIPH containing indicators of the health status of the Danish population as a whole and of various population groups (categorized by age, education, income, etc.), arranged by region. In addition, statistical information was gathered from *Statistics Denmark* (statbank.dk), a national database providing detailed information on variables such as income, industry, social conditions, levels of education, population size and

electoral results. This data set provides evidence on whether the differences across the municipalities are a function of local health needs. In addition, policy documents were collected from national and municipal web pages. Basic statistics on population and budget spending are provided in Table 1.

Table 1: Population and Budget Statistics for Danish Municipalities

Municipality	Population	Budget (DKK per capita)
Rehabilitation		
• Bornholm	43,040	65,282
• Copenhagen	503,699	65,046
• Horsens	79,020	62,496
• Naestved	80,133	60,693
• Odsherred	32,980	68,986
• Ringkoebing-Skjern	58,112	55,235
• Soenderborg	76,825	55,591
• Aarhus	296,170	66,769
Lifestyle		
• Broenderslev	35,445	63,786
• Fredensborg	39,303	66,782
• Faaborg-Midtfyn	51,612	58,912
• Hilleroed	46,354	79,137
• Odense	186,745	61,934
• Samsoe	4,130	70,587
• Vejle	104,101	61,240
Rehabilitation and lifestyle		
• Lyngby-Taarbaek	51,751	61,237
• Vesthimmeland	37,841	62,377
• Vordingborg	46,485	63,942

For each municipality, interviews were conducted in the spring of 2006 with at least one senior politician and one senior manager responsible for the municipal health services, one health care centre manager, and representatives of general practitioners (GP), hospitals and other collaborating partners (e.g. patients' organizations, private companies, pharmacies, and schools). On average, five interviews were conducted in each municipality. Where face-to-face interviewees were not possible telephone interviews were used. All interviews were semi-structured and probed the interviewees' understanding and translation of the concept of a health care centre. That is, we explored how the actors interpreted the aims of the *Reform*, and their early visions of what a health care centre might accomplish in their municipality. Interviews lasted from half-an-hour and up to one and a half hours, were taped and typed.

We investigated whether the municipalities provided rehabilitation and lifestyle promotion services through agencies other than the health care centre. That is, we wished to know whether the lifestyle logic occurs *because* the same activities are provided elsewhere in the municipality. For example, a health care centre might focus upon lifestyle services *if* rehabilitation services are offered in other parts of the municipality. Documentation of the total health service in all 98 municipalities indicates that the policies and practices of health care centers are independent of services provided in other agencies.

The extent to which service provision is driven by 'demand' or resource factors is gauged by socio-demographic factors that indicate the *need* for medical services. We examined two sets of 'market' variables. *Health variables* included the percentage of citizens listed as having diabetes, heart disease, chronic obstructive pulmonary disease (COPD), back pain, heavy obesity, smoking addiction and alcohol addiction. In addition, we used the percentage of 'early retirements on health grounds', and 'average life expectancy' as indicating the overall health profile of each municipality. *Socio-economic variables*, which speak to the resource base of a municipality, included the municipality's average disposable income, rate of unemployment, percentage of citizens with higher education, and the percentage of the population receiving old-age pensions.

Two aspects of the institutional context are of interest. The first concerns the dominant political ideology within the municipality. Valgaarda (2007) has analyzed how differences in the ideologies of political parties in Denmark, as they relate to the health service, have converged around a socialist emphasis upon

governmental responsibility, and a more conservative emphasis upon individual autonomy and personal responsibility. These ideologies are associated, on the one hand, with the Social-Democratic Party (and its local affiliates) and the conservative party (and its affiliate, the Liberal Party, which in Denmark is a right-wing option). Social-democratic health policy emphasizes the need to preserve free and equal access to the health care system for all citizens. It stresses the importance of a publicly financed and democratic controlled health system in contrast to a private system based on private insurance and private hospitals targeting economically privileged citizens. The policy is intended to prevent more citizens from becoming ill and needing treatment (www.socialdemokraterne.dk/politik fra a-å).

As such, the Social-Democratic position leans towards the rehabilitation logic, stressing the societal need to assist those with sicknesses and/or handicaps, irrespective of their social origins. The conservative health policy, in contrast, emphasizes very similar goals but puts particular emphasis on the personal responsibility of the individual citizen. That is, the political ideology of the Liberal and Conservative Parties emphasizes that citizens ought to be responsible for improving their own health, albeit facilitated in doing so by the government, and that the appropriate priority for the local municipality is to educate citizens so that they can take an informed responsibility for their lifestyle choice. (www.venstre.dk/valgløfter/principprogram).

Therefore, we determined whether the dominant political constellation in each municipality was 'social-democratic' or 'conservative'. Our sample consists of 8 conservative-controlled municipalities', 9 'progressive' municipalities, and one municipality – Bornholm - controlled by the 'Local List Party'. This latter party is ideologically close to the Social-Democratic position. In all but two of the eighteen municipalities (Odense and Aarhus) the dominant party had been in power since before the last election in 2005. Therefore, they had the opportunity to impress their normative position upon the policies of the health care centers.

To validate the political persuasion of the ruling party, we consulted policy documents on the web pages of the national *and* of each local political party. These documents provided guidance on the party's stance towards the two logics of health care. We found substantial agreement between the national and local parties and consistency *across* local parties of the same political persuasion.

The second institutional aspect concerns *professional* communities. Scott (2008) has argued that the professions are the most important institutional actors in contemporary society. Therefore, we identified which professions were involved during the early stages of the application and which were particularly active in the subsequent development process. These applications provide an early, formal expression of each centre's philosophy. They specify the centre's purpose, its organization, the proposed pattern of activities and the social groups that would be targeted. Further, the application indicates where the centre will be located and, importantly for our purpose, which professionals would be responsible for its operations. We anticipated that the professions would be keen to be involved in its preparation.

Professions active in a municipality include both traditional health professionals, such as nurses and doctors, and social welfare professions. These two groups might be expected to differ in their approach to the two logics. Traditional health professionals would support policies consistent with the rehabilitation logic, whereas welfare professionals are more likely to champion the lifestyle logic. Our guiding assumption was that the choice of logic embedded in the application, and in the subsequent policies of the health care centre, would reflect the relative involvement of the different professions.

We also investigated the influence of professionals, such as GPs, that are not employed directly by the municipality; but, who, through formal and informal actions, often seek to influence the nature of health care provision. We analyzed the interviews to observe in which municipalities these interested parties were contributing to the development of the local centre. This analysis contributed to the understanding of the relations between professionals in the wider organizational health field and their influence within geographic ally bounded communities.

Data Analysis. Interviews were coded using techniques and procedures recommended by Huberman and Miles (2002). Coding was conducted separately by the first author and by a research assistant in order to validate interpretation of data. NVivo was used to structure, examine and compare the textual data.

All interviews were grouped according to the interviewee's affiliation with a specific municipality. Focusing on the municipal politicians and the responsible professionals working in the municipal administration (i.e., the top health manager

and the health care centre manager), we investigated whether these interviewees emphasized the use of a rehabilitation logic or lifestyle logic in the health care centre. Examples of language indicating the use of the rehabilitation logic are: "We will develop educational programs for groups of patients with chronic diseases starting three or four times a year"; "The general practitioners need to be able to refer patients to the centre and then be informed about the patients' path"; and, "The health care centre will provide outpatient service in order to prevent patients' hospitalization". Examples of language indicating the importance of the lifestyle logic include: "The centre will be the open door, where everyone can get counseling about health"; "We will search for the citizens and visit not only the elderly, but also schools and workplaces"; and "It is important to change the social inequality in health". The coding assisted our analysis of similarities and differences in the accentuation of logics within the groups of interviewees. We were particularly interested in differences in the interpretations held by politicians or professionals working in the municipal administration.

To avoid the problem of retrospective rationality, data collection was conducted in real time, during the early visioning and development of the health care centers. Interviews contributed insights into the actors' subjective interpretations and their construction of meaning related to the concept of a health care centre. Furthermore, interviews sought to capture the actors' interpretation of the *Reform* and their translation of the health care centre concept into the two different logics. The archival data - the municipalities' registrations of activities - provided structured and detailed data on how resources were prioritized and allocated to the target groups.

FINDINGS

Table 2 groups the eighteen municipalities according to which logic pervaded the municipality's application to the State for funding, and the health care centre's policies in 2007. It shows that eight municipalities were applying the rehabilitation logic, seven the lifestyle logic, and that three were applying both logics. Table 2 also compares the socio-demographic characteristics and the resource bases of the three sets of municipalities.

The small number of cases make it difficult to be definitive but the several indicators of health 'need' do not appear to be associated with either the rehabilitation or lifestyle logic. If health care was simply a function of health care need, a significant association would be expected between municipalities with a larger representation of particular diseases and the application of the rehabilitation logic. But this does not appear to be the case. The percentages of citizens suffering from diabetes, heart disease, chronic obstructive pulmonary disease (COPD), back pain, heavy obesity, smoking or alcohol addiction, are not significantly different across the three municipal categories[1]. There is no direct association between health need and adoption of a particular logic of care.

Table 2: Community Needs, Resources and Choice of Logic

	Logic of Care		
	Rehabilitation	Lifestyle	Rehabilitation and lifestyle
	(N = 8)	(N = 7)	(N = 3)
Need/demand			
• % diabetes	3.91	3.71	4.13
• % heart	7.11	7.40	7.60
• %COPD	3.44	3.37	3.43
• %back pain	15.41	15.00	16.13
• % obesity	11.50	10.89	12.17
• % smoking	16.51	16.44	16.87
• % alcoholism	14.61	14.01	14.77
• % early health pensions	1.10	1.12	1.08
• average life expectancy	76.84	77.34	77.23
Resources			
• avg. disposable income	163	172	179
• % unemployed	3.64	3.43	3.33
• % higher education	4.79	5.45	7.69
• % elderly	15.36	16.25	18.13

A similar pattern is found with the resource variables. If health care was a function of the ability of a community to support more expensive treatments and services, higher employment and higher average disposable income would be associated

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[1] We used the Kruskal-Wallis test.

with provision of *both* sets of services because the provision of both services is more costly; or, if a choice is made between the logics, better resource conditions would be associated with the rehabilitation rather than the lifestyle logic because the latter is the least costly option. We might also expect a highly educated population to be more aware of maintaining a healthy lifestyle and less in need of a rehabilitation program. However, these patterns are not shown in Table 2. The municipality's average disposable income, the rate of employment, the percentage of citizens with higher education, and the proportion of the population receiving old-age pensions, all of which indicate the relative affluence of a municipality, do not shape the choice of logic.

Taken together, the results in Table 2 indicate that the distinction between the rehabilitation and lifestyle logics is not associated with the distribution of health issues and/or the socio-economic and educational circumstances of the municipality.

Table 3 turns attention to the possible role of political and professional influences. It indicates, for each municipality, the political party in control in the years immediately preceding and following creation of the health care centers. Specifically, it shows whether the controlling party is 'social-democratic' or 'conservative', the dominant parties at both the national, regional and local levels.

The Table suggests two observations. Social-democratic parties publicly espouse the rehabilitation logic, i.e. they prefer to focus upon the rehabilitation of individuals that suffer a medical condition. At the local level, this ideological position occurs in seven of the ten municipalities where parties of this orientation are in control. In addition, one social-democratic municipality applies both logics. Conservative parties, in contrast, tend to emphasize health promotion and an educational approach, consistent with a philosophical assumption that individuals should assume personal responsibility for their lifestyle. This pattern is found in seven of the eight municipalities under the control of the conservative party. In five of these municipalities, the lifestyle logic alone is found; in two others, both logics are found. Only one conservatively controlled municipality applies the rehabilitation logic. Our small sample means that these patterns may not be robust but the data does suggest that political preferences are at work and that they are significant.

Table 3: Political and Professional Influences on Choice of Logic

	Governing Party	Professionals Involved	External Actors Involved
Rehabilitation logic			
• Bornholm	Social-democratic	Health	None
• Copenhagen	Social-democratic	Health	Patient organization and hospital
• Horsens	Social-democratic	Health & Welfare	Hospital
• Naestved	Social-democratic	Health & Welfare	Private health company
• Odsherred	Social-democratic	Health & Welfare	Regional health dept. & hospital
• Ringkoebing-Skjern	Conservative	Health	Hospital and GPs[2]
• Soenderborg	Social-democratic	Health	GPs
• Aarhus	Social-democratic	Health	GPs
Lifestyle logic			
• Broenderslev	Conservative	Health & Welfare	Sports school
• Fredensborg	Conservative	Welfare	None
• Faaborg-Midtfyn	Conservative	Welfare	None
• Hilleroed	Social-democratic	Welfare	None
• Odense	Conservative	Health & Welfare	None
• Samsoe	Conservative	Welfare	Hospital
• Vejle	Social-democratic	Welfare	Hospital
Rehabilitation and lifestyle logic			
• Lyngby-Taarbaek	Conservative	Welfare	None
• Vesthimmerland	Conservative	Health & Welfare	Hospital, GPs and private company
• Vordingborg	Social-democratic	Health & Welfare	Hospital

However, the fact that local parties that share the same name are making the same policy choices – i.e. choosing the same logic – implies that they are local expressions of the national party. As such, the ideological position adopted during the local translation process is the application of a higher-level normative position. Our interviews confirmed that local politicians asserted the ideology of their national party. Thus, in one municipality, a Social Democrat explained how Conservative politicians preferred a broad range of health services available to all citizens, in contrast to a more focused provision of services targeted at specific groups of patients.

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[2]   GPs = General practitioners

Another possible influence on the shaping of health care centers is the involvement of the professions. Table 3 lists the professions closely involved in drafting the municipality's submission for funding to the State. It shows that when traditional health professions were actively involved in writing the application, the rehabilitation logic typically dominated. Health professionals were involved in twelve municipalities and in eight of them the rehabilitation logic alone prevailed, and in two others both logics were chosen. In contrast, in five of the six municipalities where social welfare professionals were involved the lifestyle logic was favored, and both logics were applied in the sixth municipality.

The point made with reference to the influence of political parties can also be applied to the results of the influence of professionals. The fact that professionals in different municipalities preferred the same logic means that they are applying a cognitive and normative position taken from the national level. Our interviews confirmed that professionals employed at the municipal level were actively involved in wider communities of professionals.

In some municipalities, the manager of the health care centre was a nurse or a physician recruited from a local hospital and these actors all stressed that it was a huge advantage that they knew the "medical language" of the health professionals at the hospital, i.e. the importance of activities based on medical evidence and the monitoring of results in order for the centre to collaborate with the hospital. It was furthermore emphasized by senior municipal managers that this knowledge was crucial for the municipality. Another example came from a senior manager who had become responsible for municipal health service, but who had previously been working as a social counselor and senior manager responsible for municipal welfare services. She explained that she participated in networks with other welfare professionals and discussed with them the development of health services. She was particularly enthusiastic about designing the health care centre to reduce inequalities in health and the targeting of unemployed citizens and ethnic minorities.

Taken together, these observations suggest the following pattern. The logic of care reflected in the plans, policies and services of a health care centre is very typically consistent with the orientation of the political party in power. It is also consistent with the ideology of the professions involved in drafting the funding application. But this pattern is not easy to interpret. We have no definitive information on why particular professions were involved. They may have been

chosen by the local political party, or have been a powerful force in the municipality prior to the *Reform* (we have more to say on this issue in a moment). Nor do not we know how or why particular professionals became involved in the drafting of the submission for State funding. Were they chosen by the political party because they held similar views? Were they involved because they had high status within the municipality? Were they engaged by default, opening up opportunities to advance their status? These questions are intriguing but beyond our data.

One question that we can explore further is whether professional interests reinforce or dominate political preferences. To do so, we look at situations where there are differences in the perspectives of professionals and of the governing party. Three municipalities - Hilleroed, Vejle, and Ringkoebing-Skjern - show the governing party and the dominant professions unambiguously pulling in contradictory directions. Hilleroed and Vejle are governed by a social-democratic party that prefers the rehabilitation logic, but are also influenced by non-traditional health professions oriented towards the lifestyle logic. In Ringkoebing-Skjern, the ruling conservative party promotes the lifestyle logic but is faced with professions promoting the rehabilitation logic. In all three cases, the outcome of this conflict of priorities favored the professions. That is, it was the *profession's* preferred logic that prevailed.

This finding, that professionals can outweigh the preferences of politicians, indicates that professions are not handmaidens to political parties. It does not mean, however, that professionals dictate to politicians, or have moved into a decision-making vacuum. On the contrary, in each case the story is more complex. In Hilleroed, for example, politicians discussed the development of a health care centre as a prestige project. However, this municipality ran into severe economic problems and the politicians decided to implement a smaller project promoting health in daycare and schools as had been suggested to them by the welfare professionals. In Vejle, the welfare professionals suggested a health care centre that would aim at getting unemployed citizens back into the job market. The politicians supported this aim, but the project suffered from a lack of support and was closed down. Instead, a new health care centre was built to provide rehabilitation and health promotion services. Finally, in Ringkoebing-Skjern there existed a long and outstanding tradition for local collaboration between the municipality and the health professionals at the local hospital. When the region had to downsize the hospital, the municipality decided to locate the new health care

centre at the hospital. This physical infrastructure paved the way for the large-scale rehabilitation of patients with chronic diseases once they had been discharged from the hospital. The political preference for health promotion directed at all citizens was still present but the benefits of maintaining local activities and local employment overrode it. Taken together, the three cases suggest that professionals pursued their approach of a health care centre, but that local politicians considered ideology *and* took municipal economic sustainability into account.

Table 3 also shows that some municipalities involved representatives from organizations not directly funded by the municipality. For example, general practitioners (GPs) funded by the regional government took part in the preparation of the proposal for funding in four municipalities. Involvements of this kind indicate links between professionals employed within the municipality and counterparts in the wider field of health care. To the extent that these 'external' professionals might be expected to lend additional weight to the opinions and influence of professional colleagues within the municipality, their presence should increase the probability of "their" logic being adopted. This expectation is supported by Table 3. Twelve municipalities used 'outside' representatives, normally from the traditional health professions, such as GPs or hospital physicians. In contrast, there was only one instance (Broenderslev) of a non-traditional health professional being involved. As expected, in all but two of these twelve municipalities the logic ultimately preferred was consistent with the position of the external professionals.

Our interviews indicate that external professionals were not usually involved deliberately to push a particular logic. In some instances, external involvement was an extension of existing relationships. Some municipal professionals considered cooperation with a local hospital and local GPs to be "normal", and over time had evolved rewarding relationships through local collaboration and productive experiences. For example, in one municipality the health care centre manager explained that she had invited a sports school into the development process because she had previously collaborated successfully with this school. In some municipalities, relationships were further strengthened because the regional authority had downsized the hospital and both the municipality and the local hospital shared an interest in maintaining activities and local employment. Some actors, however, did admit that they had been acting strategically and knowingly invited health professionals to participate, believing that it would facilitate the later integration of the centre into the established health care sector. And finally, in

some instances it was the GP, hospital or patient organization that initiated contact with the municipality and requested that they become part of the development process. Whatever the motivation or rationale for their involvement, our interviews revealed that these organizations or individuals almost invariably possessed strong ideas of how to define a health care centre and were seeking to influence its design. As such, they added weight to 'their' preferred logic.

How far these external participants actually influenced the choice of logic is an intriguing question. To better understand what was occurring, we reanalyzed the interview data and found that in four municipalities where local politicians and professionals were initially sympathetic to *both* logics, the importance and influence of external participants was particularly noticeable. Ultimately, these municipalities leaned in favor of one logic – and in all four cases, the logic ultimately chosen was the same as that preferred by the 'outsider' professionals. Interviews revealed that in all four cases it was the municipality which took the initiative to involve an external actor, i.e., a hospital, a private company or a sports school. Moreover, respondents consistently pointed to the 'assistance' of these outsiders in reaching a decision, indicating that, whenever the responsible actors within a municipality – both politicians and professionals –are ambivalent or undecided in their choice of logic, the logic of the external participant becomes particularly influential.

CONCLUSION AND DISCUSSION

The findings reported here show that health care provision in Denmark varies across municipalities despite a national commitment to universal access to the same level and quality of service. Services vary in terms of the social groups targeted and the nature of the services provided. These differences reflect a choice between two logics of care, each logic having different implications for the type of health care provided, and for whom.

A key observation is that how municipalities define the role of the health care centre cannot be satisfactorily explained by demographic factors. Demographic factors – both health and socio-economic variables - appear to play little role. Instead, values manifested in the policies and principles of political parties, and of

engaged professions, shape which overarching logic of care is adopted, and, in turn, the services provided to particular social groups.

The general picture is that communities are important sources of variation within institutional sectors but in a predictable way. In modern societies, sectors such as health typically house multiple logics (e.g. Reay and Hinings, 2005; D'Aunno et al., 1991). Our case suggests, not surprisingly, that local actors' interpretations of which logics should be applied are important but that the choice of logic is influenced by the relationship with the wider institutional infrastructure. Thus, members of local political parties adopt and implement the ideological position of the national party. Similarly, professionals employed locally exhibit and push the normative code of their profession. In this sense, elected politicians and employed professionals may be guided by alternate logics in their translation of a policy into their community, but there is little evidence, overall, of a distinctly *local* translation. Political parties and professions, nested in wider and higher order institutional arrangements, are more akin to conduits than filters or translators of ideas. Local factors may determine which party is in power, thus determining the choice that will be made between particular logics, but the choice is the same across municipalities controlled by politicians and professionals of the same persuasion. Importantly, however, the fact that different political parties chose different logics reinforces our opening position that communities are *jurisdictions* and that to ignore the role and play of elections is omit a significant influence operating within the community. Political actors, through their authoritative allocation of social policies and benefits, and their ability to modify the framework within which organizations operate, are key exponents of Scott's regulatory pillar.

Having said that, it could be argued that the choice of logic, though fundamental to the distribution and allocation of types of public benefits to different social groups, is a relatively coarse-grained indicator of behavior at the municipal level. Translation processes may be more visible in the finer distinctions that occur as those overall logics are implemented in service delivery and treatments. It may be in the details and nuances of implementation, rather than in the broad overarching philosophy, that local interests and effects become more visible. Furthermore, health policy is a salient arena for politicians and may be especially susceptible to national rather than local interest and influence. Less politically sensitive policy arenas might show more independent local translation.

Moreover, it is important not to neglect that we observed a more distinctly local dimension whenever local actors in a municipality differed in their ideological positions. In these instances, the struggle was contained and played out within the municipality and gave rise to variation across communities. Similarly, we observed that, in some cases, the lack of a definitive commitment to a particular logic opened the possibility of external actors influencing local decisions. These 'outsiders' pulled the centre towards *their* translation of the health care centre concept. As such, this finding reminds us that, although communities are a locus of institutional struggle and variation, the outcome of that variation is sometimes shaped by the nature of the ties and relationships between the community and the higher order institutional field. The geographical community may be significant in the institutional framing of who gets what, when and how, but communities are decidedly *not* oases of social life.

9. ANALYSIS 3

Creating a New Organization: Discursive Legitimizing Strategies

in Danish Health Care

Susanne Boch Waldorff

Department of Organization,

Copenhagen Business School

Denmark

ABSTRACT

The analysis explores the process of translating a new health care center concept into one particular municipality. The analysis combines the neo-institutional approach of translation (Czarniawska and Sevon, 1996; Sahlin-Andersson, 1996) with critical discourse analysis (Fairclough, 1992, 1995; Wodak and Meyer, 2002, Phillips and Hardy, 2002; Vaara, Tienari and Laurila, 2006). The study highlights that a discourse positions specific actors as powerful in the process of translation, and these actors develop legitimizing strategies reproducing the discourse and facilitating its dominance. Second, when the discursive strategies make a discourse resonate with the local context, in this case a political context, then the discourse becomes dominant. Finally, the findings indicate that the domination of a discourse can be explained by how successful this discourse can be carried out in practice. I focus on a single municipality as an extreme case and explore the development of a health care center in a three-year longitudinal study. I draw on qualitative data, including texts, interviews and observation studies.

INTRODUCTION

Generally speaking, the public sector is moving from a management system based on rules and procedures to a system based on decentralized decision making, performance measurement and auditing (Power, 1997; 2007). National "soft" regulation with largely informal policies open to local interpretation and adjustment is put forward more frequently (Mörth, 2004; Kirton and Trebilcock, 2004; Kjær and Sahlin, 2007; Sahlin and Wedlin, 2008). Thus, local governments and organizations are now required not only to demonstrate the results of their activities, but also to explicitly legitimize their interpretation of the national policy. This new situation brings clearly into view the way an organization in the public sector seeks to construct what counts as a legitimate organization (Suchman, 1995; Meyer and Rowan, 1977; DiMaggio and Powell, 1983).

The organization I look at here is an emerging public health organization with responsibility for the provision of public health services. The organization faces immense uncertainty due to a lack of national standards in the relevant policy area, as well as an undecided future, both politically and financially. In order to analyze the discursive strategies by which the organization co-constructs legitimacy, I apply a theoretical framework which combines neo-institutional theory, and especially the approach of translation (Czarniawska and Sevon, 1996; Czarniawska, 2008; Sahlin-Andersson, 1996; Sahlin and Wedlin, 2008), with critical discourse analysis (Fairclough, 1992, 1995; Wodak and Meyer, 2002, Phillips and Hardy, 2002; Vaara, Tienari and Laurila, 2006). Translation emphasizes that organizational actors seek to co-construct organizational legitimacy when they conceptualize a new organizational concept within their local context, and that they translate this concept into new organizational practices. However, translation emphasizes the importance of local context, but downplays the impact from a heterogeneous institutional context. Thus, I include critical discourse analysis to explore how the organizational actors co-construct legitimacy by developing discursive strategies that are embedded in competing discourses providing different senses of legitimacy (Hajer, 2005). These discourses also position actors with heterogeneous access to power (Foucault, 1970, 1972). Thus, combining translation with critical discourse analysis contributes to analyzing the legitimacy of an emerging organization as not only socially constructed within a local context, but also influenced by discourses constituting various senses of legitimacy and positioning particular actors as powerful.

I present an analysis of the way a national concept for health care centers was translated into a local context. The concept of a health care center was initiated in the Danish "Local Government Reform" that took effect on January 1, 2007. The Reform facilitated a new distribution of tasks between municipalities, regions, and the state, making municipalities fully responsible for health promotion, prevention, and any rehabilitation that does not take place during hospitalization. Yet, the municipalities were left to decide whether the new health tasks should be managed in a health care center, and what form this might take. This context reinforces the importance of legitimating each particular organizational solution.

Thus, the organizational actors developed discursive legitimizing strategies (Phillips, Lawrence and Hardy, 2004; Vaara, Tienari and Laurila, 2006). These strategies were embedded in competing discourses constructing different notions of legitimacy, including what to consider as relevant health problems, who to consider as the target group, and who should be involved in service provision. The analysis draws in particular upon a study by Vaara, Tienari and Laurila (2006), who identify five discursive legitimizing strategies used in the media to make sense of an international merger: normalization, authorization, rationalization, moralization and narrativization. I investigate how organizational actors use these discursive strategies to legitimize their specific conceptualization of an emerging organization, and how discourses are stabilized through the actual development of organizational practices.

An evaluation of the early development of health care centers shows considerable variation in the services provided (Due, Waldorff, Aarestrup, Laursen and Curtis, 2008). Some health care centers emphasize the importance of the rehabilitation of patients with medical diagnoses, whereas others promote health for everyone or socially vulnerable groups. The evaluation also reveals that after the first three years of experimental development, four out of eighteen health care centers were subject to political decisions made to close them down or change them radically. Yet, in some municipalities, the decision was made to maintain the new health care center after the first period of organizational development. In one of these municipalities, the center had changed its initial broad focus from the provision of rehabilitation and health promotion to focusing almost solely on health promotion. This empirical case not only indicates that competing discourses exist creating changes in what to perceive as a legitimate organization, but it also constitutes an interesting context for exploring the use of discursive legitimizing strategies.

Previous analyses of public health care highlight that different institutionalized discourses or logics underpin the provision of health care (Foucault, 1973; Scott, Ruef, Mendel and Caronna, 2000; Mol, 2008; Højlund and Thorup Larsen, 2001; Pedersen, 2008; Mik-Meyer and Johansen, 2009; Vinge, Rasmussen, and Ankjær-Jensen, 2009). Particularly, I draw on previous studies identifying institutional logics underpinning the creation of Danish health care centers (Waldorff, forthcoming; Waldorff and Greenwood, forthcoming). These logics contribute to constituting societal discourses, and in this study, I explore two available discourses – a patient discourse and a healthy citizen discourse. The patient discourse problematizes the expanding number of patients with chronic diseases (Ministry of Health, 1999; Dahlager, 2001). The solution is to support the individual patient categorized according to medical diagnoses such as diabetes, heart problems, and chronic obstructive pulmonary disease. In contrast, the healthy citizen discourse problematizes that more people develop diseases due to an unhealthy lifestyle (Ministry of Health, 1999). Some social groups, e.g., people without an education and employment, are particularly prone to an unhealthy lifestyle (Thorup Larsen, 2005). Good health is not only defined in terms of the absence of diseases, but also as a proper way of living, including physical exercise, nutritious food and not smoking.

The study begins by presenting the theoretical context combining the approach of translation with critical discourse analysis. Next, I explain the empirical context and then the applied method. Following this is the case analysis in which I investigate the use of legitimizing strategies and their linking to two discourses, which move from co-existence to domination of the one over the other. The study shows that the healthy citizen discourse became more dominant than the patient discourse as it included more actors in health service, especially local politicians; it resonated better in the local political context, and was materialized into practices. The final section provides a conclusion and a discussion.

THEORETICAL CONTEXT

The institutional approach sheds light on legitimacy as an essential resource for an organization. By drawing upon the notion that an organization depends upon legitimacy as a vital resource for its survival (Pfeffer and Salancik, 1978), Meyer and Rowan (1977) explain further how the organization's adaption to rationalized

myths embedded in its institutional environment will enhance the organization's legitimacy. Later DiMaggio and Powell (1983) suggest that three types of institutional pressures force organizations to conform to specific organizational forms in order to obtain legitimacy. Organizations face regulative or political pressure; they face uncertainty and unclear goals facilitating mimetic behavior; and they are influenced normatively by professionals. Yet, legitimacy is defined and determined only by external forces, and institutional change is explained as organizations' adaptive or passive response to material environmental pressures (Green, Li and Nohria, 2009).

Hence, institutional research is increasingly interested in understanding the active role of organizational actors in the construction of legitimation. Like Suchman, I define legitimacy as "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed systems of norms, values, beliefs, and definitions" (1995:574). Legitimacy emerges within a larger social system, can be quite subjective at times, and the entity itself might participate actively in the process (Deephouse and Suchman, 2008). One line of institutional research focuses on how agency constitutes legitimacy with the potential impact of shaping societal macro institutions, i.e. as executed by "institutional entrepreneurs" (DiMaggio, 1988) or conceptualized as "institutional work" (Lawrence and Suddaby, 2006). Another line of research focuses on the stages in a change process and suggests that the creation of new institutions is activated by social or material events (technology, reforms, regulation, etc.) creating a new platform for entrepreneurial actors to theorize about and legitimize new practices, and resulting in the diffusion and institutionalization of ideas (Tolbert and Zucker, 1996; Greenwood, Hinings and Suddaby, 2002).

In this study, I draw upon a third line of institutional research that, in particular, puts actors' agency and their creation of legitimacy in focus. Accordingly, Scandinavian researchers emphasize that in order for a new organizational concept to be adopted in a local context, the actors create localized meanings through a process of translation (Brunsson, 1989; Brunsson and Olsen, 1993; Czarniawska and Sevon, 1996; Czarniawska, 2008; Røvik, 1998, 2007; Sahlin-Andersson, 1996; Sahlin and Wedlin, 2008; Erlingsdottir and Lindberg, 2005). This approach is based on the ideas of translation as conceptualized in actor-network theory (Callon and Latour, 1981; Latour, 1986). The approach emphasizes that legitimacy is not just determined by external forces, but co-constructed within a local context by organizational actors. Czarniawska and Joerges describe translation as a process in which a

concept travels and is transformed from one specific time and space context into another, gaining power from actors' collective and relational interaction, and materialized into practice (Czarniawska and Joerges, 1996:22; Czarniawska, 2009:425). As part of this translation, the actors use justifying and legitimizing language, a form of editing, (Sahlin, 2008), in which actors follow rule-like patterns to present ideas in familiar and commonly accepted terms, in addition to using a specific communication structure in each setting. An idea is presented with a reconstructed logic that fits the local setting. However, we know only little about what guides this process of translation. In particular, we do not know how the actors draw on discourses in the institutional context as a source to organizational legitimacy, or what constitutes particular actors as more powerful than others in the translation process.

By combining organizational discourse analysis with neo-institutional theory, researchers increasingly focus on the discursive legitimation of new organizational practices within an institutional context. Elsbach (1994), who studied the California cattle industry, shows how organizational actors construct verbal accounts in order to manage perceptions of organizational legitimacy. Suddaby and Greenwood (2005) show how the organizational actors in five big accounting firms use rhetoric to shape the legitimacy of new multidisciplinary partnerships by drawing on two contradictory institutional logics – expert and trustee – that underpin a professional logic. Other researchers investigate discursive legitimation as part of an institutionalization process. Green, Li and Nohria (2009) analyze the concept of total quality management within the American business community and suggest that an institutionalization process implies changes in the arguments that legitimize and justify material practices over time. Yet, only a few studies treat institutionalization as a process of translation linking it to discourses within the institutional context. Zilber (2006) shows how four discursive rational myths were constructed in the Israeli high tech industry around the millennium, while Maquire and Hardy (2009) show how the deinstitutionalization of DDT was a result of actors carrying out disruptive and defensive work by authoring texts changing the underlying discourse. These studies illustrate an increasing interest in exploring legitimacy as discursively constructed. The studies investigate changes at the field level due to the use of language, but they do not explore how actors within an intra-organizational context use discursive legitimizing strategies to make one translation of a new organizational concept more dominant than another. Furthermore,

they do not examine how particular actors influence the outcome of translation due to a specific discourse positioning them as powerful.

In this study, I elaborate upon a theoretical framework that combines neo-institutional theory, i.e. the approach of translation, with organizational discourse analysis. Organizational discourse analysis comprises multiple approaches. Some researchers focus on actors' interaction and use of discursive language, including conversation, narratives, rhetoric and tropes, while other researchers emphasize the social and historical context of discourse, i.e. pragmatics, socio-linguistics, institutional dialogue, systemics and critical discourse analysis (Grant, Hardy, Oswick and Putnam, 2004). Alvesson and Kärreman (2000) propose capitalizing the word discourse in the second sense and thus distinguish between an analysis of local situated linguistics – a discourse, or an analysis of powerful ordering institutional forces – a Discourse. Yet, among the Discourse analysis approaches, I find that the critical discourse analysis (Fairclough, 1992, 1995; Wodak and Meyer, 2002, Phillips and Hardy, 2002; Vaara, Tienari and Laurila, 2006) offers a particularly interesting analytical lens as it allows the exploration of not only emerging societal institutions, but also their impact on practice and social consequences.

Like Phillips and Hardy (Phillips and Hardy, 2002, Hardy and Phillips, 2004), I conceptualize discourse as both a form of discursive agency, i.e. organizational actors' use of specific language in the legitimation of new practices, as well as institutionalized rules providing meaning to society. A discourse is defined here as "structured collections of texts, and associated practices of textual production, transmission and consumption, located in a historical and social context" (Hardy and Phillips, 2004:300). Thus, discourses originate from actors producing texts, while simultaneously discourses giving meaning to these actions, thereby constituting the social world. Yet, whereas Phillips and Hardy (2004) suggest that the organizational actors seek to make sense of a new situation and use rhetorical strategies embedded in discourses to legitimize the organization, I do not anticipate that these strategies are developed intentionally in order to further the actors' interests, nor do the actors possess the power to do so.

Instead, I pay specific attention to the heterogeneous context in which more competing discourses exist and how these discourses position organizational actors with different access to power (Nexø and Koch, 2003; Torfing, 2005; Cooper, Ezzamel and Willmott et al., 2008). The critical discourse analysis emphasizes the Foucaudian concept that actors do not posses power (Foucault, 1970, 1972), but

power is provided to specific subjects by discourse. Thus, I do not analyze power in terms of juridical power or in terms of a resource or capacity one can possess as perceived by Dahl and Bacharach and Baratz, or as a relation of hegemonic dominance as Lukes suggests (Clegg, Courpasson and Phillips, 2006; Cooper, Ezzamel and Willmott, 2008). Instead, I explore how some individuals warrant a louder voice than others by virtue of their position in the discourse (Hardy and Philips, 2004:302). I argue that combining the approach of translation with critical discourse analysis contributes to analyzing the legitimacy of a new organization as not only socially constructed within a local context, but also influenced by actors positioned as powerful due to available discourses. This implies analyzing which discourses constitute particular actors with access to power in the process of translation and, furthermore, how these actors employ discursive strategies to legitimize their specific translation of a health care center embedded in this discourse.

Accordingly, I include overarching societal discourses (Foucault, 1970, 1972) in the analysis. Discourses act as socially constructed systems in the organization's institutional environment, and their features define what can be considered as legitimate. Yet, critical discourse analysis conceptualizes discourses as heterogeneous and never completely cohesive or able to determine social reality entirely (Hardy and Phillips, 2004: 304). Thus, multiple discourses are available to create a space as well as a resource for actors to construct organizational reality in such a way as to justify or legitimize particular actions or outcomes. Particular matters are constructed as positive, beneficial, ethical, understandable, necessary, or otherwise acceptable to the community in question. In contrast, other matters are negative, harmful, intolerant, or, for example, morally reprehensible (Vaaro et al., 2006). In an analysis of discourses in environmental politics in Britain, Hajer (2005) shows how some actors perceive acid rain in a traditional pragmatic discourse as an unavoidable effect related to coal-fired power stations, while actors drawing on an ecological modernization discourse interpret acid rain and pollution as undesirable for society and avoidable. The discourses facilitated different positions on such themes as the meaning of acid rain as a policy issue, the way of making politics, and the importance of science and expertise in decision making.

I also analyze how actors at the micro level develop discursive strategies in order to co-construct senses of organizational legitimacy. These discursive strategies are embedded in legitimizing discourses. The analysis draws in particular upon a study by Vaara, Tienari and Laurila (2006), who identify five discursive legitimiz-

ing strategies used in the media to make sense of an international merger: normalization, authorization, rationalization, moralization and narrativization. Normalizing is in use when texts exemplify "normal" function or behavior. This involves references to similar cases, events or practices in a retrospective or prospective perspective. Authorization is in use when texts make authorization claims, for instance, in the form of references to individuals in whom institutionalized authority is vested, laws, regulations, or conventions. Rationalization is in use when a rationale was provided in the form of, for instance, benefits, purposes, functions, or outcomes. The benefits might be objectified and factualized, but could be based on future expectations. Moralization is in use when texts provide a moral and ideological basis with reference to specific values. And finally, narrativization is in use when texts provide a narrative structure to concretize and dramatize. Telling a story provides evidence of acceptable, appropriate, or preferential behavior. It should be noted that these discursive legitimizing strategies are often intertwined and grow out of practice development rather than part of an intended and formally articulated strategy. Vaara et al. build upon earlier work by Van Leeuwen and Wodak (1999), but establish normalization as a fifth strategy instead of a sub-category to rationalization, because their data analysis indicated this. However, whereas Vaara et al. analyze the strategies as they became visible in the media, I investigate the development of discursive strategies within an intra-organizational context. I explore the use of the strategies in order to examine how they are used by organizational actors, which discourses they link to in order to derive legitimacy, whether their use has an impact on the domination of a particular discourse, and, finally, how they constitute a link between discourse and the level of practice.

In summary, the theoretical framework for this study combines neo-institutional theory, i.e. it emphasizes that organizations seek legitimacy and this legitimacy is co-constructed by organizational actors as part of a local translation processes, with critical discourse analysis exploring the actors' discursive legitimizing strategies and their embeddedness in competing discourses facilitating different senses of legitimacy and actors with heterogeneous access to power.

EMPIRICAL CONTEXT

In June 2004, policy makers reached an agreement concerning a Reform of the Danish public sector (Agreement on a Structural Reform, 2004). The agreement was the culmination of an extended debate on how to improve the Danish public sector's efficiency. And especially how to improve patient rehabilitation was a central issue in the debate. Several political parties argued that the governmental structure needed to change as it inhibited collaboration across sectors and governmental levels. An example of this was the health risks faced by patients caught between regional and municipal services, a position that jeopardized the coordination and financing of patient rehabilitation after hospitalization.

The Reform, which was to take effect on January 1, 2007, facilitated a new distribution of tasks between municipalities, regions, and the state. A municipality is the lowest governmental level in the Danish public sector and manages most welfare tasks in a specific geographic area. The reform facilitated the emergence of a new municipal health care field that bridges the existing health care field with the existing welfare oriented municipal field. Municipalities are now fully responsible for health promotion, prevention, and any rehabilitation that does not take place during hospitalization.

The Reform initiated the establishment of municipal health care center. However, no detailed instructions were given as to how municipalities should provide health service. The only guidance given is that:

> The municipalities should be able to find new solutions especially within prevention and rehabilitation, e.g. in the form of health care centers. (Agreement on a Structural Reform, 2004)

Thus, the concept of health care centers is very ambiguous. The prioritization of tasks was not specified, nor what constitutes "good health" or a suitable level of service. The concept is a general idea of how an organization can or ought to be structured; yet it is flexible and open to interpretation, allowing local contextualization and adjustment (Bentsen and Borum, 2003; Røvik, 1998). The concept is weakly enforced as neither the development of the centers nor the integration of centers into the established health care sector is regulated by law. These mechanisms broaden the scope of organizational behavior that might be considered com-

pliant (Edelman, 1992), and constitute a context in which it is up to the municipalities to legitimize their development of a health care center.

On December 21, 2004, the Danish Ministry of Health informed all municipalities about the possibility of attaining national funding for the development of health care centers. By February 1, 2005, the ministry had received sixty-three municipal applications, and on August 31, 2005 eighteen municipalities were selected and granted national funding. In line with the general explosion of audits in society (Power, 1997), the eighteen health care centers with state funding were evaluated by an external agency. The evaluation was initiated by the Ministry of Health and the Interior and carried out by the National Institute of Public Health. The evaluation showed considerable variation in the services provided. Some centers emphasized the importance of the rehabilitation of patients with medical diagnoses, whereas others promoted a healthy lifestyle for everyone or socially marginalized groups of citizens (Due, Waldorff, Aarestrup, Laursen and Curtis, 2008). Obviously, these variations had considerable implications regarding who was affected by the national policy, but they also indicated that different institutionalized rules were enabling various constructions of organizational legitimacy.

The existence of institutional rules underpinning health care provision has been noted by several researchers already. They emphasize a discourse of clinical medicine (Foucault, 1973), logics of control (Rose, 2001), conflicting logics of quality, equal access and efficiency (Scott, Ruef, Mendel, and Caronna, 2000), conflicting logics of care and patient choice (Mol, 2008), the emergence of a societal health promotion technology (Højlund and Thorup Larsen, 2001), discourses shaping how individuals such as "patients" are constructed over time (Pedersen, 2008), and different logics or rationales underpinning social welfare and health care management (Mik-Meyer and Johansen, 2009; Vinge, Rasmussen, and Ankjær-Jensen, 2009). In this study, I build upon previous studies exploring the existence of institutional logics underpinning Danish health care. One study shows that Danish municipalities draw on the logics of equal access, quality, and efficiency as well as the locally embedded logic of organizational identity and the logic of economic sustainability when they translate the health care center into a specific organizational form (Waldorff, forthcoming). In addition, another study captures the emergence of two logics – a rehabilitation logic targeting patients and a lifestyle logic targeting citizens that underpin the health care centers' provision of health care service (Waldorff and Greenwood (forthcoming). Together, these institutional logics constitute two overarching societal discourses. I call the two discourses 'patient dis-

course' and 'healthy citizen discourse'. The two discourses differ in the way they comprise institutional logics, but also in the way they construct problems and solutions and value different political ideologies (Valgårda, 2007). A law on health care passed in June 2005 illustrates the construction and visibility of the two discourses. The proposal for this legislation divides health services into two types according to whether they target patients or citizens:

> The municipalities' tasks within prevention and health promotion include partly an effort targeting municipal citizens in order to prevent illnesses and accidents (citizen target service), and partly an effort in order to prevent that a disease develops further and to limit or postpone its possible complications (patient target service) (editor's translation) (Proposed health legislation. February 24, 2005).

The patient discourse problematizes the expanding number of patients with chronic diseases resulting in lower quality of life and expensive hospitalization (Ministry of Health, 1999; Dahlager, 2001). The discourse points to a solution supporting the individual patient. The patients are categorized according to medical diagnoses such as diabetes, heart problems, and chronic obstructive pulmonary disease. The political ideology underpinning this discourse emphasizes that the public (the system) has an extended responsibility for the individual's health, and that a health care center should use rehabilitation to enable the patients to tackle their life with a disease instead of having to contact the health care sector. The discourse comprises the logics of quality and rehabilitation supported by medical professionals, the logic of equal access emphasizing that patients should have equal access to treatment and, finally, the logics of efficiency and economic sustainability reducing expensive patient hospitalization. The legitimacy of a health care center embedded in the patient discourse positions medical health professionals as powerful and emphasizes collaboration with general practitioners and hospitals, the provision of services based on medical evidence, the provision of services that target the individual patient with a diagnosed chronic disease, and the reduction of these patients' hospitalization.

In contrast, the healthy citizen discourse problematizes the societal risk that more citizens develop diseases due to an unhealthy lifestyle, resulting in escalating public expenses (Ministry of Health, 1999). Some social groups, e.g. people without education and employment, are particularly linked to an unhealthy lifestyle

(Thorup Larsen, 2005). The discourse not only defines good health in terms of the absence of diseases, but emphasizes the importance of a proper way of living or discipline, including physical exercise, nutritious food and not smoking. The discourse builds upon a political ideology stressing, on the one hand, that "the public" should promote healthy living for everyone and for particularly socially marginalized groups enabling citizens to make healthy choices; on the other hand, it stresses that the public should enable each citizen to make individuals responsible for maintaining good health (Højlund and Thorpe Larsen, 2001). The discourse is a hybrid of the logics of equal access and health promotion emphasizing that everyone should have the right to live a healthy life, the logics of efficiency and economic sustainability preventing the development of costly chronic diseases and, finally, the logic of organizational identity branding the municipality as a healthy place to live. The healthy citizen discourse legitimizes a center which involves a broad range of professionals and politicians, collaboration between municipal, volunteer and private organizations, activities based on more knowledge fields including social services, education and psychology, the provision of services that target everyone or marginalized groups of citizens and, finally, one that reduces the development of diseases due to lifestyle and social inequality.

METHODS

This study is an analysis of a health care center in one particular municipality. The study is part of a larger project examining the development of eighteen Danish health care centers co-financed by the state for a three-year period. For each municipality, I collected qualitative data and quantitative survey data in order to investigate the local creation of social meaning and also to compare the cases. I use interviews, archival materials and observation studies. The interviews were conducted in the spring of 2006 and again in 2008 with at least one senior politician and one senior manager responsible for the municipal health services, one health care center manager, and representatives of general practitioners, hospitals and other collaborating partners (patient organizations, private companies, pharmacies, and schools). On average, five interviews were conducted each year in each municipality adding up to a total of nearly 200 interviews. This research context allows me to compare the findings in this particular study with the findings in the broader sample of cases.

The analysis in this study is designed as a single case study (Yin, 1989; Lunde and Ramhøj, 1995; Curtis, 2001) in order to carry out an in-depth, empirically grounded analysis of organizational actors' development of discursive legitimizing strategies. I selected a municipality that I believed would be an extreme case (Miles and Huberman, 1994; Flyvbjerg, 2006). One indication of this was that this particular municipality had changed its centre's activities, an act that indicates a change in discourse. An extreme case often reveals more information because it activates more actors and more basic mechanisms in the situation studied. I focus on the actors' production of legitimizing documents during a process of change, i.e. their use of discursive legitimizing strategies, which provides insights into change in organizational legitimacy over time. The selected municipality is Fredensborg Municipality, which is a mid-sized municipality with nearly 40,000 inhabitants. For decades, the municipality has been run by a conservative political party (*Venstre*), which controls local government in about half of all Danish municipalities. In this particular municipality, the decision was made to maintain the health care center after the initial period of organizational experiment. Fredensborg Municipality became particularly interesting, because interviews as well as archival documentation reveal that the health care center changed from its initial broad provision of rehabilitation and health promotion activities to focusing almost exclusively on health promotion. This development is an indication of the early stages of domination by the healthy citizen discourse in municipal health provision. I also anticipated that the organizational actors in this municipality would be inclined to execute strategic discursive activities in order to legitimize the changes, therefore constituting a comprehensive case for a discourse analysis.

The duration of the study allowed me to carry out a longitudinal in-depth study of a single case (Pettigrew, 1995). The period of investigation covers the health care center's start and early development from February 2005, at which point the municipality applied for financial support for the center, until the political decision to maintain the center and the operation of the center in June 2009. By focusing on the center's development process over a three-year period, I gain insights into the dynamics of changes in organizational legitimacy over time.

Data sources

I examine selections of texts that embody a particular discourse. The term 'text' should be understood broadly and covers written texts, spoken words, pictures,

symbols, and even artifacts. (Fairclough, 1992; 1995; Philips and Malhotra, 2008). The data sources in this study include archival materials, interviews and observation studies.

The archival data consist of strategic documents generated by organizational actors within the health care center and the municipality. I include formal documentation of the center's organization and activities, policy documents, charts of the center's placement in the municipal organization, speeches held by the health care center manager and the responsible politician, and articles in the local media. All the documents were used by the center in either an internal or external context during the period of research. The documents adhere to the rules for the genre of formal communication presenting the organizational aims, activities and challenges (Phillips and Hardy, 2002). The documents also reveal the power structure within the municipality as they were produced by organizational actors involved in the development process and they were transmitted through formal decision-making channels. Most documents were collected in order to investigate the discursive strategies and their link to discourses providing legitimacy to the organization, whereas fewer documents contributed to revealing which activities were developed at the level of practice.

I conducted interviews in the spring of 2006, 2008 and 2009. The interviewees included the main organizational actors involved in the development of the municipal health care center, i.e. the chairman for the political board on health, one senior manager responsible for municipal health services, and one health care center manager. In addition, I interviewed representatives for the center's collaborating partners, including a local general practitioner, a local hospital, the senior manager for the municipal department for social welfare, and the local division for a national forest organization. The interviewees were interviewed from one to three times each. In 2006, the focus was on the actors' early visions of what the health care center might accomplish in the municipality. In 2008, the focus was on the actors' experience with the development of the health care center. In 2009, I conducted a final interview with the health care center manager focusing on her interpretation of changes in activities, alliances in decision making, discursive strategies and the impact on practice during the period of investigation. The inclusion of the various actor interpretations contributed to empirically grounding the analysis as well as to providing insights into the actors' understanding of the relationship between strategy, discourse and practice.

Finally, I carried out a few observation studies, including an internal staff meeting in June 2009, where the health care center's results, goals and future strategy were discussed, as well as a national conference held in January 2009 by Local Government Denmark (an association of Danish municipalities) on organizing public health, where the center manager presented the health care center. These data allowed me to analyze the organizational actors' verbal communication and the actors' internal and external discursive framing of the center's legitimacy.

Hence, I explore the development process by drawing on different qualitative data sources, including formal documents, interviews and observation studies. This triangulation of data contributes, on the one hand, to my understanding of data as the formal documents show the discursive strategies of the municipality as a whole, while the interviews, on the other hand, provide insights into the individual interpretations. Furthermore, the interviews, observation studies, and the municipality's strategic documents contribute to insights into the actors' subjective interpretations and their construction of meaning related to the health care center, while the archival data, i.e. the municipality's registration of activities, provide structured, detailed data on how resources were actually prioritized and allocated in practice. This triangulation of data sources provides a fuller understanding of the center's development. I conducted the data collection in real time – during the early visioning of the center until it began providing service – this helped to avoid the problem of the interviewees' retrospective rationality. And, finally, when I had drafted the analysis, I presented it to the health care center manager and we discussed the findings. This contributed further to the validity of the study.

Data analysis

The first step in the analysis was to get an overview of the empirical field and the organizational context. I read all of the gathered documents as well as interviews with key actors. More texts were included, since "it is an interrelated set of texts and the associated practices of production, dissemination, and reception that bring an object into being" (Phillips and Malhotra, 2008: 712). I analyze the specific organizational context in order to identify which important boards and committees were created and who was allowed membership. A number of strategy documents were developed within this context and used in the actors' translation of the health care center concept into the specific municipal context. Then, I selected spe-

cific documents for the further analysis of legitimizing strategies and discourse. These documents comprise three formal reports produced in 2006 and 2007 documenting the center's development, a policy document from 2007 used in the decision-making process concerning whether the center would last, an evaluation report produced in 2008 on the center's activities, a speech held in 2008 by the chairman of the political board on health and, finally, an article produced by the center and published in a municipal magazine in 2009.

In the second step, I reflect upon the discourses' positioning of specific actors as powerful. I focus the analysis on investigating the patient discourse and the healthy citizen discourse. The discourses shape – and change over time – how individuals such as "patients" are constructed, which roles they are permitted to play, and with which purposes they are included in specific policy documents (Pedersen, 2008:5). This part of the analysis is informed by the methodology of Nexø and Koch (2003) and explores in particular which objects, concepts, or categories are established, how are they established, what their relationship is, and which ones are excluded. This part also examines how the objects are problematized in a discourse – and what solutions are applied to solve these problems while others are rejected. Other questions involve looking at who is speaking, from which position, with what authority, and to whom.

Third, I analyze the selected documents more thoroughly in order to explore the existence and use of legitimizing strategies in the municipal translation process. After coding each text chronologically, I coded strings of text according to the categorization of strategies: normalization, authorization, rationalization, moralization and narrativization (Vaara, Tienari and Laurila (2006). Next, I coded the text strings' embeddedness in the patient discourse and the healthy citizen discourse. This analysis of the development of discursive strategies within a municipality facilitated an assessment of how the patient and health citizen discourses are conceptualized at the local level, and whether the use of discursive strategies has an impact on the domination of discourse.

Finally, I analyze the archival data in order to investigate the practice level. It was particularly relevant to analyze which activities the health care center developed, i.e. whether it targeted patients or citizens. In this way the analysis includes the relationship between the practice level and the patient and healthy citizen discourses.

CASE ANALYSIS

In this section, I explore how the patient and the healthy citizen discourses became more or less dominant as part of organizational actors' use of discursive legitimizing strategies. The strategies were used as part of a local translation process constructing an emerging health care center and its legitimacy. The analysis identifies which organizational actors are privileged by different discourses in the development process, how the discursive legitimizing strategies link to these discourses and pave the way for different constructions of organizational legitimacy and, finally, how the discourses and the level of practice interrelate. The analysis shows that the patient discourse was shrinking, in contrast to the healthy citizen discourse, which was blossoming.

Before analyzing the progress of the two discourses, I first outline the design of the organizational setting, which illustrates who was formally included in the development process, but also constitutes a platform for both the patient and the healthy citizen discourses. The organizational setting indicates that the municipality was experimental in the establishment of a health care center, but also that the centre could be legitimated by both the patient and the healthy citizen discourses.

The organizational setting

In January 2005, the municipality forwarded an application to the Ministry of the Interior and Health to apply for state funding for a health care center. On August 31, 2005, the municipality was selected by the ministry to be financially supported. The formal application indicates that the initial goal of the center was broad, including the rehabilitation of patients as well as the promotion of healthy lifestyles. The organization was not to be located in a particular building, but tasks were to be managed in collaboration with the municipality's staff in existing training facilities, school kitchens, gyms, etc.

A steering committee for the health care center project was then established, which signaled that the project was high priority. The committee was chaired by the Department of Health and Prevention and included the municipal chief executive as well as senior managers from other departments such as the Children and Youth Department and the Social Welfare Department. The committee's task was

to secure the project's development and organizational integration, make the overall decisions and follow the project's finances. The committee held meetings regularly once a month during 2006 and 2007.

The center officially opened on February 1, 2006, when a manager was hired for the center. The project was scheduled to run for two years until the co-financing ran out on February 1, 2008 and a decision to either close down or continue the center as a permanent service was made. The center manager was a nurse with a master' degree in public health as well as hospital work experience. On April 1, 2006, a project coordinator was hired by the center manager. Trained as a food scientist, the project manager had been managing health promotion projects for children and youth in a patient organization. The center manager emphasized in interviews that the differences in their professional backgrounds were intentional in order to develop both rehabilitation activities and promote lifestyle changes. Additional staff included a nutritious food consultant, a physical therapist, a social welfare consultant, a partnership manager, two physical education instructors, and one administrative employee. Three physical therapists, a nurse, a general practitioner and a smoking cessation instructor were also affiliated with the center.

In April 2006, an expert monitoring group was constituted. The group's tasks involved defining and giving advice about particular activities, following the center's development, contributing to the collaboration with partners and making the center visible to the public. Surprisingly, the invited board members were senior managers from national organizations, not their representatives from local departments, which also indicates that developing this new type of organization was a prime concern. Furthermore, the broad range of members covered both rehabilitation and the promotion of a healthy lifestyle. The members included the municipal senior manager of the Division of Health and Prevention (chair), the center manager, three patient organizations (cardio, rheumatism and cancer), a representative of handicap organizations, a local general practitioner, a doctor in social medicine, a local sports organization, three research institutes (health sector, health promotion and social welfare), the local board representing elderly citizens and a representative from the region. Four meetings were held in 2006, three in 2007 and one January 16, 2008, which was the board's last meeting.

The broad range of services and the presence of both the patient and healthy citizen discourses were evident in the first status report forwarded by the center to the

steering committee and expert monitoring group in July 2006. The description states that the center's goals were to provide:

> … a flexible organizational framework for municipal provision of prevention, health promotion and rehabilitation, a systematic, documented and experience-based platform for the development of a new health policy targeting both citizens and patients, and practical experience in the management of coherent flows to be used in the following collaboration with other municipalities, the region and general practitioners, etc. (Fredensborg Municipality, July 12, 2006*).*

It was further emphasized in the report that the center's focus would be on services for citizens, including 1) supporting people in making lifestyle changes with a focus on smoking, food and exercise, 2) activities for children in daycare and schools, 3) activities for patients with orthopedic-surgery, rheumatic diseases and apoplexy, 4) management of patient flows in relation to surgery, and 5) activities for recipients of sickness benefits and unemployed citizens receiving cash benefits.

A project group was established in order to support the center manager in the development of the center, to define and give advice about particular activities, coordinate task solutions, develop collaboration with partners and make the center visible to the public. All members came from within the municipality. The project group split into two – with one group focusing on patients and the other one focusing on children and youth.

Combined, the initial application, the formal goals, and the design of the organizational setting show that initially the organizational actors intended to draw on both the patient and the healthy citizen discourses, translating the health care center concept into an organizational model that was legitimized by rehabilitation and health promotion activities. However, this changed as the organizational actors were not equally successful in their development of activities and the establishment of the two discourses.

The patient discourse died out

As described earlier, the patient discourse defines the growth in number of pa-

tients with chronic diseases as a problem, stating that these patients are in poor health and often require hospitalization (Ministry of Health, 1999; Dahlager, 2001). This is costly for society. Furthermore, chronic diseases keep patient from carrying out daily physical tasks and enjoying social contact.

Organizational actors involved

Building on a medical approach and scientific knowledge, the patient discourse enables especially the voices of traditional health professionals to be heard, for example, physicians, nurses, physical therapists, etc. However, only a few traditional health professionals became members of the established project group that focused on patients which left them unable to employ the patient discourse. The group included a physical therapy manager for the elderly, a pediatrician, a consultant in prevention, a general practitioner, two representatives from the social welfare authorities, the center coordinator and the center manager. The municipal actors invited hospital representatives into the group, but none of them ultimately became members.

The aim of the group was to develop rehabilitation services and to integrate them into the established health sector. This included management of patient flows, professional cooperation and the referral of patients from general practitioners and hospitals to the new municipal health care center. The group was to develop services for hip and knee surgery patients, patients with acute or chronic back pain, rheumatism, and apoplexy. In addition, the group intended to make a concerted effort for the unemployed and people receiving sickness benefits.

The group emphasized that the provision of activities should be based on medical evidence. Thus, the group planned to seek existing evidence-based knowledge and clarify the content and procedures before any activities were started. Analysis of the status reports, however, indicates that this proved to be difficult.

Discursive legitimizing strategies embedded in the patient discourse

In the early stages of the translation process, the legitimate organizational model within the patient discourse was conceptualized as based on medical science, targeting individual patients with chronic diseases and collaborating with the established health care field. The patient discourse was particularly present in the docu-

ments developed in the early process. The weight of the rehabilitation activities was noticeable in the center's first status report forwarded to the steering committee and expert monitoring group in July 2006 (Fredensborg Municipality, July 12, 2006). The report included a three-year budget in which patient activities cost 30-50% more than activities for average citizens.

In this case, the actors sought to legitimize the rehabilitation activities using an authorization strategy by linking them to authoritative entities such as general practitioners, the mandatory collaboration between the municipalities and regions on patients, the use of medical clinical guidelines, evidence-based knowledge evaluations, and quality monitoring of services. For example, in the first status report forwarded in July 2006, the health care center wrote that a general practitioner had been hired two hours a week to facilitate the execution of patient services and the center's collaboration with the other general practitioners in the municipality. (Fredensborg Municipality, July 12, 2006).

A discursive rationalization strategy was used to emphasize how rehabilitation activities would help patients through illness and improve the management of patient services. For example, the status report forwarded in January 2007 describes how the services targeting knee and hip surgery patients was now organized as a coherent combination involving patient surgery and preventative activities for people with muscle pain and illness (Fredensborg Municipality, January 7, 2007).

The narrativization strategy was visible when the actors' conceptualization of specific obstacles for the rehabilitation activities was highlighted. Accordingly, the early documents stated that although the center had not yet received referrals from general practitioners, this was expected to happen. Yet, it was later emphasized that the general practitioners were reluctant to refer patients to the center despite the centre's efforts to inform and engage the physicians. In June 2009, I noted this narrative when I observed an internal meeting in the health care center. The staff discussed the challenge of recruiting patients for an educational program, and general practitioners were selected as a specific target for improved communication and collaboration.

During the process being studied, the patient discourse did not appear to a large extent in later documents. Although the later documents still highlighted the provision of rehabilitation, the level of service became limited compared to the initial aims. In January 2007, a third status report was forwarded to the steering committee and expert monitoring group. (Fredensborg Municipality, January 7, 2007).

This report departed from former presentations by using the label "citizen" instead of "patient" as the center's target. Furthermore, although many of the listed activities focused on health promotion, i.e. physical exercise and activities for children and youth, the two patient activities were now grouped into one project. And this project was limited to providing patient counseling before hip and knee surgery, while rehabilitation after surgery was left out. In this way, the patient discourse was showing signs of decline as part of the center's development and being conceptualized more and more in the direction of the healthy citizen discourse.

Finally, in June 2007 three models were presented to the steering committee, expert monitoring group and the political Social and Health Board in order to decide the future of the center (Fredensborg Municipality, June 19, 2007). Interestingly, patients were now fully excluded as a target group, including the management of patient flows and the rehabilitation of patients in relation to surgery. Instead, the document noted that additional patient services were to be expected in the future and that making decisions on patient services therefore should await a clarification of the new responsibilities placed with the municipality.

The practice level

The rehabilitation services got under way in March 2007. The center developed a pre-surgery service for people scheduled for knee and hip surgery. The service included physical therapy and counseling about smoking, a nutritious diet, alcohol and the surgery. All in all, twenty-four people took advantage of this service in 2007.

In October 2007, the implementation of "patient education" was under way. The program was developed at Stanford University and licensed by the Danish National Board of Health to be used by Danish municipalities. The program consists of six modules totaling fifteen hours of education. The target group included people with various chronic illnesses and their relatives. The objective was to empower people and to strengthen their ability to actively take care of themselves and tackle their daily lives with a chronic illness, including any physical or mental problems. The program established social networks, was managed by trained patients and offered information about chronic illnesses, how to tackle pain, how to communicate with the established health care system, etc. In 2007, thirteen people attended the newly started program.

Additionally, the data, i.e. the interviews conducted with key decision makers, show that one of the largest obstacles for establishing rehabilitation activities in practice was how to incorporate them in the flexible nature of the organization. The actors emphasized that it would have been a major advantage if the center could have administered its own facilities. This would have facilitated the provision of continuous programs for patients with chronic illnesses who needed physical therapy and individual counseling.

In other words, the patient discourse became limited and was mostly present in the early translation process. A few discursive legitimization strategies were embedded in the discourse, including the authorization strategy, the rationalization strategy, and to a minor extent, the narrativization strategy. The discourse constitutes health professionals as powerful, but only a few became involved in the organizational development with the prospect of cultivating the discourse. And local general practitioners who potentially could have offered support came across as hesitant in their collaboration with the new organization. At the outset, the patient discourse established the center as an organizational model that derives legitimacy from activities based on medical scientific knowledge, targeting individual patients needing rehabilitation, collaborating with the established health care field and succeeding in reducing patient hospitalizations. One project group strived to find evidence based knowledge before developing rehabilitation activities as advocated by the medical regime. However, this turned out to be an obstacle as little scientific knowledge exists within rehabilitation service. Thus, the rehabilitation service was not provided until March 2007 and then in a very limited version oriented more towards counseling about healthy lifestyles than rehabilitation of patients with medical diagnoses. This indicates that the patient discourse was not manifested in practice, and that rehabilitation activities were even translated into the direction of the healthy citizen discourse. The strategies embedded in the patient discourse became less about explaining what the center actually did, and more about how this particular center would be able to manage the expected rise in future rehabilitation demands while still remaining focused on the promotion of a healthy lifestyle.

The healthy citizen discourse blossoms

The healthy citizen discourse seizes on people's increasingly unhealthy lifestyles, which lead to illness and cause an increase in public expenditures (Ministry of Health, 1999; Højlund and Thorpe Larsen, 2001). Good health is not defined solely in terms of the absence of disease; it is tied to a proper way of living, including physical exercise, nutritious food and not smoking. Antagonistically, some social groups, i.e. the uneducated and unemployed, are pictured as having particularly unhealthy and dangerous lifestyles that result in health problems.

Organizational actors involved

The healthy citizen discourse broadens the scope so that more actors can have a say in how to promote health and actually provide this service (Højlund and Thorpe Larsen, 2001). Instead of medical scientific knowledge, this discourse endorses knowledge from a broad range of fields, including social services, education and psychology. More than just health professionals are involved and constituted as powerful; politicians, social welfare professionals, teachers, nutrition consultants, educational sports instructors, as well as public institutions, volunteer organizations, private companies, etc. are also part of the picture. Hence, the new health care center created a network that facilitated collaboration with various actors.

The organization established a project group that developed services for children and youth in daycare and schools. This group included a pediatrician, an administrative school nurse, a public dental care manager, an exercise and leisure consultant, an educational consultant, a consultant on prevention, and the center coordinator. The aim of the group targeting children and youth was to implement various activities, including a survey of the health profile of the youth in the municipality, physical activities and nutritious food in schools, a Get Moving campaign developed by the National Board of Health, physical activities in daycare, and the Health Sign, which sets minimum standards for health in municipal institutions. Already by July 2006 relationships were built with local organizations and a formal organizational network providing health promotion activities was emerging in practice.

Discursive legitimating strategies embedded in the healthy citizen discourse

In contrast to the patient discourse, the healthy citizen discourse appears throughout the whole translation process, and is linked to several discursive legitimating strategies.

The organizational actors produced various documents in which the authorization strategy contextualized the healthy citizen discourse. Thus, the documents refer to a broad range of authoritative individuals or organizations within health promotion activities such as patient organizations, producers of organic food, and even a famous chef. Concepts such as the national Health Sign, the national Get Moving campaign and the municipal Health Week were also employed. Furthermore, a scientific aspect was also included in the shape of municipal knowledge and information about certain health risks or habits that cause disease or early death, for example, smoking, drinking, a lack of exercise, etc.). Especially one piece of authoritative scientific information was often used in documents to legitimize the local health promotion activities: a general profile of people's health. Initiated by the center, the profile appeared in the second status report forwarded by the center to the steering committee and expert monitoring group in October, 2006. The formal aim of the survey was:

> … to gain knowledge about people's living conditions, lifestyle, health and diseases in order to obtain a platform for the municipal (center's) planning of prevention and health promotion, as well as a later evaluation of the municipal effort (Fredensborg Municipality, October 31, 2006).

Based on a survey standard developed by the National Institute of Public Health, an external party drew up the health profile. The profile emphasized specific additional areas of concern, for example: 1) social inequality and geographical differences in health as especially the poorly educated, unemployed and people living in public housing areas faced numerous health problems; 2) lifestyle related problems due to smoking, obesity, consumption of alcohol and level of physical exercise; 3) people's relatively low level of self-evaluated health; 4) the major diseases people suffer from; and 5) the use of health care services.

The rationalization strategy further emphasizes that the health profile revealed a need for local health promotion activities such as physical exercise, which would increase people's average life expectancy and quality of life. The strategy also emphasized that specific health promotion activities were designed to capture

people's interest, facilitate dialog and promote participation. Apart from promoting healthy living as fun, the health promotion activities would conform to people's expectations about being treated as individuals in a local context. Moreover, the documents emphasize that, for example, health promotion activities would implement political goals as formulated in the municipal health policy and create visible health care services. In March 2008, the municipal evaluation of the health care center emphasized that:

> The project contributed actively to developing a municipal health policy, creating new knowledge about health and prevention, sharing knowledge within the organization, developing and implementing the new municipal responsibilities within health care services, and especially to establishing fruitful collaboration that will last far longer than the project period … The project has successfully carried out its aims (Fredensborg Municipality, March, 2008*).*

The organizational actors used the narrative strategy to construct the center as dynamic, visionary, strategizing, developing services, and utilizing resources, etc. The actors highlighted the organization of the center as flexible, enabling the center to run a complex development process and establish relations with a broad range of partners. The center was constructed as the obvious nexus for municipal health tasks which an organizational diagram from July 2006 signals (Fredensborg Municipality, July 12, 2006). There were also challenges. The center's resources were limited due to the concurrent merger of municipalities and a lack of will to be involved in health projects from other departments within the municipality. However, the center positioned itself as a driver in the development process and as being able to defeat those challenges. The narrative strategy also emphasized that health promotion activities indicated that the center was receiving external recognition and that it possessed certain competences. In addition, the strategy highlighted that the center had been invited to participate in projects to develop new health promotion activities and methods for encouraging people to participate.

Finally, the moralization strategy appears in relation to the healthy citizen discourse. The strategy problematizes health in the population: children were becoming too fat, young people smoked and drank too much, adults were too overweight, health issues were inequitably distributed among social groups, etc. The solution was to change people's behavior and way of life by enabling them to make healthy

decisions and maintain their own health, for instance, by exercising more, eating nutritious food, developing an active family life, etc. The health care center's role was to support this strategy based on how it provided services, including by offering the unemployed active support instead of passive financial support. Obviously, this strategy was intended to produce specific behavior in people. During a speech held at the opening of a new mobile Health Bus, the speaker, a politician, stated:

> We've placed people's health on the agenda for a long time in Fredensborg – and created good, educational activities, which motivate our children, youth and adults to live a healthier life. Just take a look at the pictures by the bus, which were taken at several events held by the health care center. They testify to the fact that health is fun: it's exercise, it's the pleasure of good food and especially social activities with others … The closeness and visibility of the Health Bus in town will make it an extension of the municipality's borders, allowing people and staff to have more contact with one another. The activities have, so to speak, been moved from the city hall and public institutions to the street. And not just to one street, but to every street where people live and to every street where people shop, visit the library and move about as part of their daily lives (Fredensborg Municipality, November 27, 2008).

In June 2007 when the center presented a policy document with three possible organizational models for the steering committee, expert monitoring group and the political Social and Health Board (Fredensborg Municipality, June 19, 2007) the centre emphasized that the recent reform of the public sector and the national law on health gave the municipality responsibility for developing an organizational framework for healthy living and for establishing health promotion and preventative activities. The introduction in the policy document emphasized further that the main target of the center was healthy people, people with the risk of developing illnesses, and people with chronic diseases who do not require hospital treatment. Consequently, the focus was that the center's target group was people in general and not patients. The municipal board decided to continue the center on a permanent basis.

The level of practice

One of the center's main health promotion tasks was to establish organizational collaborations with a number of local organizations. For instance, the center in-

itiated a formal partnership between the center, a national forest organization and a local sports organization. This partnership developed activities for the health care center's target group that were to be carried out by the other two collaborating partners, such as hikes in the forest for the unemployed.

At the strategic level, the center developed different initiatives focusing on health promotion. This included a proposal for a municipal health policy and a survey of people's general health profile.

The center developed and implemented a broad range of activities that were set in motion in 2006. The activities included individual and team-based smoking cessation courses, the implementation of the Health Sign in municipal institutions, the provision of health promotion activities and physical therapy for staff in nursing homes and day care centers in order to strengthen employee health, provide physical therapy and give the unemployed the opportunity to be out in nature. Other activities included, for example, gardening with children and their grandparents and providing advice for staff in after-school programs about children's physique, fun activities, games, etc. In 2007, nearly 1,000 people were involved in different health promotion activities.

In summary, the healthy citizen discourse appeared throughout the translation process, took up space in documents and was linked to four discursive legitimizing strategies. The discourse enabled a broad range of actors to become involved in the development of the new organization. Traditional health professionals were included, but so were local politicians and other professionals working in the municipality, such as social welfare professionals, teachers, nutrition consultants, and educational sports instructors, etc. Applying the healthy citizen discourse implies the translation of the center into an organizational model that derives its legitimacy by involving a broad range of professionals, creating a network of collaboration between municipal, volunteer and private organizations, basing activities on knowledge from several fields, providing services that target everyone as well as specific groups of marginalized people, and by reducing the level of lifestyle related diseases and the social inequities present in health care. The legitimizing strategies emphasized the importance of health promotion activities. Interestingly, the center developed a general profile of people's health in the municipality which was used as scientific documentation to prove the necessity of promoting healthy activities. Moreover, the organizational actors were able to place the healthy citizen discourse

in the context of a politically governed organization that monitored people's health and stressed the possibility of guaranteeing that people would participate and that could provide customized services as well as implement political goals. These aspects are highly relevant for politicians. Furthermore, in addition to establishing the center as dynamic and strategizing, a narrative was constructed providing evidence that the center was an attractive, competent collaborator for outside projects. Finally, the documents moralized about people's way of living and emphasized the importance of healthy behavior, which is at the heart of governmentality and the exercise of power.

CONCLUSION AND DISCUSSION

This case study analyzes the translation of an organizational concept into a local context and the simultaneous local construction of what counts as a legitimate organization. I explore the organizational actors' use of discursive legitimizing strategies and their embeddedness in overarching societal discourses providing actors with power and competing senses of legitimation. The organizational concept was a new public health organization – a municipal health care center. From the outset, the municipality drew on two available discourses – a patient discourse and a healthy citizen discourse. However, the analysis of the legitimizing strategies shows that throughout the development process, the healthy citizen discourse ended up being the dominant one, while the patient discourse died out. I find that it is relevant to make three points here.

The first point concerns the actors' involvement in the translation process. The design of the organizational setting indicates that many actors gave high political priority to the development of this new type of organization. The process even involved the participation of national actors. However, the two discourses position different actors as powerful. The healthy citizen discourse involves not only health professionals, but also a broad range of professionals, private companies, volunteer organizations, and, importantly, municipal politicians. In this way, many actors were able to contribute to the stabilization of the discourse. In contrast, the patient discourse, which built on a medical knowledge regime, constrained the agency of health care professionals, some of whom were not even interested in supporting the center. In this way, the study is not an analysis of competing professions with dif-

ferent interests drawing on competing logics or discourses. Rather, it shows that because discourses position certain organizational actors with agency and power, then these actors will later influence the outcome of translation. Certain actors are granted the opportunity to participate in the development process, while others are not, and this contributes to the construction of a specific notion of organizational legitimacy and the domination of a particular translation.

The second point is that the use of discursive legitimizing strategies facilitated the healthy citizen discourse in becoming increasingly dominant. The strategies were more successful at linking the healthy citizen discourse to the particular political context than the patient discourse. For example, when the authorization strategy was embedded in the patient discourse, the text referred only to general authoritative entities such as general practitioners, the use of medical clinical guidelines, and mandatory collaboration with the region about patients. Where the authorization strategy was embedded in the healthy citizen discourse, in contrast, the text was linked to the specific, local municipal context, including local public-private collaborations, the innovative municipal idea of having a Health Week, and the general health profile, which was often used to legitimize the center's focus on health promotion activities. Likewise, when the rationalization strategy was embedded in the patient discourse, the text explained how rehabilitation activities in general would help patients. When the rationalization strategy was embedded in the healthy citizen discourse, in contrast, the text was linked to the local context by stressing that the municipal health profile documented a need for local health promotion activities. Notably, the documents emphasized that the health promotion activities would implement the political goals as formulated in the municipal health policy, capture people's interest, facilitate dialog and participation, and conform to people's expectations concerning individual treatment. All of these aspects are highly relevant for a politically governed organization.

Furthermore, the analysis of the narrativization strategies also reveals differences. A negative narrative embedded in the patient discourse highlighted that general practitioners were reluctant to refer patients to the center despite the center's effort to provide information and engage the physicians. In contrast, a much more positive narrative embedded in the healthy citizen discourse constructed the health promotion activities as dynamic, visionary, utilizing resources, etc. This flexible organization enabled the management of complex processes, including relationships with a broad range of local partners. The center positioned itself as a driver in the development process and as able to handle any hesitation from poten-

tial collaborating partners. The center's health promotion competences had even managed to gain external recognition for the organization. Again, the discursive strategy embedded in the healthy citizen discourse was able to legitimize the organization by constructing a positive narrative about an organization providing health promotion.

The fact that discourses have social consequences becomes especially clear when studying the moralization strategy. Although the strategy appeared less often, it was clearly linked to the healthy citizen discourse. The strategy problematized people's unhealthy habits and the rise in obesity, alcohol abuse, lack of physical exercise, etc. Thus, the aim of the center was to change people's behavior (as objects) by enabling them to make healthy decisions (as subjects). The centre would do this by providing, for instance, individual counseling and by activating young people, families and the unemployed. Obviously, this strategy was intended to produce specific behavior in people and can be understood from a "governmentality" perspective. Michel Foucault focuses on how power has productive aspects and constitutes individuals as subjects and objects. Foucault defines power as the "conduct of conduct" – a disciplinary power regulating actions by means of shaping the identities, capacities, and relations of the subordination of the social actors (1970, 1972). In line with this, governmentality concerns the whole range of practices and activities that are undertaken by various agencies and authorities in order to shape the conduct of citizens and subjects (Foucault, 1973; Rose, O'Malley and Valverde, 2006; Dean, 2006). Thus, the healthy citizen discourse paved the way for the stigmatization of particular habits as improper, but also of particular citizens as misinformed or irresponsible (Mik-Meyer and Villadsen, 2007:167). As mentioned, the health profile survey spelled out that especially people with lower levels of education, the unemployed and people living in public housing areas faced health problems. However, the health care center targeted only the 'wrong' habits of these groups, instead of perhaps focusing on the root of this social inequality such as education and employment.

Thus, wrapping up my second point, I emphasize that the use of discursive legitimizing strategies has an impact on the domination of a particular discourse. In this case, the actors put effort into contextualizing the healthy citizen discourse by monitoring the local health profile and then claiming a need for local health promotion activities. Furthermore, the actors adapted the healthy citizen discourse to a specific political context by stressing that health promotion activities would implement the municipal health policy, as well as mobilize support from local citi-

zens to public service and political initiatives. Also, only the healthy citizen discourse was used in the narrativization strategy and the moralization strategy. Perhaps this demonstrates that the use of these particular strategies indicates when a discourse is becoming dominant. However, more research is needed to make such a conclusion. The normalization strategy never appeared at all in any of the documents. This was not surprising due to the health care center being a fairly new organizational form that limited the actors' options for referring to similar organizations as standardized ways of providing service. In an interview late in the process, the health care center manager also made it clear that this was indeed part of a conscious strategy to position the health care center as a distinctively unique organization. Thus, the center needed to appear as a new organizational solution within prevention and rehabilitation – as proposed in the reform of the public sector – in order to derive legitimacy.

Finally, my third point is about the relationship between the level of practice and the discursive legitimizing strategies. I include the level of practice in order to explore how the organizational concept of a health care center was not only discursively legitimated, but also translated into practice. The analysis shows that when the level of practice is included, i.e. the type of activities and their provision to patients or people in general, then a close link between the discursive strategies and the level of practice occurs. The relatively few rehabilitation activities relate to the weak domination of the patient discourse, whereas the many health promotion activities relate to the increasingly dominant healthy citizen discourse. It is easy to anticipate that the center's activities would develop on the basis of an intended formal strategy drawing particularly on the healthy citizen discourse. However, it could also be that the discursive strategies were developed in a particular way and then used to legitimize the activities the centre was able to provide; as it was more difficult to create rehabilitation activities than health promotion activities, the legitimation of the center did not draw upon the patient discourse, but on the healthy citizen discourse. The analysis of the organizational setting and specific strategy documents support this as the initial aim was to create a flexible organization and to experiment in the development of health services. No fixed and formal strategy was planned, and even though the organizational actors at the beginning intended to provide both rehabilitation and health promotion, this changed throughout the translation process.

The combination of institutional translation theory and critical discourse analysis prove to be a comprehensive framework for studying micro-level actors'

co-construction of the legitimacy of an organization that was granted financial support for an experimental, vaguely defined project. Although the discourse on patient rehabilitation was used as a strong argument for decentralizing health responsibilities to the municipal level, another discourse on healthy citizens became dominant.

10. CONCLUDING REMARKS

In this dissertation I explore the actors' creation of meaning, and specifically their construction of accounts and use of discursive strategies to legitimize an emerging organization, namely a health care center. The combination of more theories and concepts, including institutional translation, multiple institutional logics and critical discourse analysis, contribute to the analysis of the development of health care centers with an explorative and coherent theoretical framework. Using an agentive conception of power as my basis, I explore how some actors are able to participate in local processes of translation, which institutional logics and discourses they draw upon, and how they use accounts and discursive strategies as a means in their translation. I examine the process of translation as it unfolded. In this section, I highlight which theoretical contributions the dissertation makes, how the analyses are also relevant for practitioners, what the limits of my study are and what I could have done differently, and finally, I make some suggestions concerning future research.

a. Theoretical contribution

This dissertation advances our understanding of emerging organizational forms. Although it is increasingly recognized within translation theory that the adoption of a new organizational concept requires the organizational actors to make sense of the concept and translate it into an organizational form within their local context, we also need to explore how the heterogeneous institutional context has an impact on the translation. Particularly, I emphasize three main points.

First, problems that at first glance seem to be constructed within a specific local context, resulting in a specific local organizational form, turn out to have much in common with problems in other contexts. These similarities turn up when the downsizing of a local hospital, for example, leads to situating a health care center at a particular hospital, or when the construction of a municipal identity leads to the provision of health services in a new, visible building. The analysis of which accounts the municipalities constructed to legitimize the emerging health care centers serves as an illustration. The municipalities constructed accounts that addressed the same logics, albeit in different ways. I confirm the existence of three institutional logics (quality, equal access and efficiency) embedded at the national

level. I also discovered two institutional logics: the logic of organizational identity and the logic of economic sustainability, which are both embedded at the local municipal level. Interestingly, the local logics turned out to have a more significant impact upon the organizational forms than the national logics. The national logics served, perhaps, as an inescapable source to legitimate the local translation, but it was the various interpretations of the logic of economic sustainability that created differences in the emerging organizational forms. Particularly, the way the legitimizing accounts emphasized that the municipality needed to utilize resources, prevent expenses and maintain jobs, and that the municipality had the opportunity not to, gave rise to different physical locations for the health care center. The centers were pictured as being located in former nursing homes, in downsized hospitals, as virtual networks, or in suitable new buildings. This finding concerning the impact of local logics emphasizes that it is important to explore logics at several analytical levels, as well as translations across more contexts. Furthermore, if I had only explored the logics embedded at the national level or had limited myself to how the health care center concept was adopted within one context, I would not have been able to observe that an emerging organizational form is in fact not just the articulation of one logic. It is the actors' interpretations and combinations of multilevel institutional logics that give rise to the organizational forms.

The second point is that the cultural-cognitive values of local actors shape the organizational focus. In the analysis, which investigated the municipalities as local jurisdictions, I show how the organizational focus is influenced by the local actors' relationship to an external institutional context. The analysis explores how actors draw upon the two logics that underpin the focus of health care provision – a rehabilitation logic and a lifestyle logic. Members of local political parties adopted and implemented the ideological position of the national party. Accordingly, social democrats prefer the rehabilitation logic, while conservatives prefer the lifestyle logic. This resonates with two different ideological orientations that emphasize that the responsibility to improve people's health lies mainly with the individual or with the public system. Similarly, professionals employed locally exhibit and push the normative code of their profession. Traditional medical professions prefer the rehabilitation logic, while social welfare professions prefer the lifestyle logic. The general picture is that the geographically bounded community is an important source of variation as local factors determine which party is in power, and thus also determine what choice will be made between particular logics. I find, however, that the choice is the same across municipalities controlled by politicians and profes-

sionals of the same persuasion. This combination shows little evidence of a distinctly local translation and more emphasis on the actors' relationship with an institutional context. Yet, it should not be neglected that various political and professional orientations interact in the process of translation, and the analytical conceptualization of the municipality as a political jurisdiction helps to explain who is able to translate based on which political party is in power and which professional groups are working within the municipality.

Following the question of who can participate in the local process of translation and act as 'carriers' of specific institutional logics is my third point, which emphasizes that beyond providing legitimacy to an emerging organization, discourses in the institutional context have an impact on who can become translators. I illustrate this in the analysis that explores the translation process within a single municipality. Two discourses provided the local actors with heterogeneous access to power. The healthy citizen discourse involves not only health professionals, but also a broad range of professionals, private companies, volunteer organizations, and, importantly, municipal politicians. In this way, many actors were able to contribute to the stabilization of the discourse and to gain support for their specific translation of a health care center concept. This allows for a more dynamic approach to understanding agency. The actors not only become translators due to a specific discourse, but they also utilize this discourse to legitimize their translation. In contrast, the patient discourse building on a medical knowledge regime constrains the agency of health professionals, some of whom were not even interested in supporting the center. Thus, the study shows that discourses position organizational actors with heterogeneous agency and power. Specific actors are granted the opportunity to participate in the development process, while others are not. This inclusion of translators contributes again to the construction of a particular organizational legitimacy.

Combining neo-institutional theory on translation with critical discourse analysis helps to explain which specific actors are positioned as powerful and become involved in the translation process, and why specific organizational forms are particularly legitimate.

This dissertation contributes to the translation approach in neo-institutional theory by emphasizing that the heterogeneous institutional context has an impact on the interpretive work of actors at the micro level. When a new management concept initiated as part of a national reform is translated into local communities

then these actors create a specific, localized social meaning that draws on multiple institutional logics embedded at the national and local levels. However, it is the actors' interpretation of these logics, i.e. their consideration of local issues and logics, that give rise to particular organizational forms. And further, the translating actors are part of the broader institutional contexts that they bring into their translation. A jurisdiction then becomes an important site, because it constitutes which actors – politicians and professionals – can participate in the translation. And finally, some actors are – more than others – granted the opportunity to participate in the process of translation due to the dominance of a specific discourse. These actors use discursive legitimizing strategies when they translate, thus reaffirming the discourse.

This study is also relevant for other contexts. In countries like Finland, England, France, Norway, Canada and the United States, various types of health care centers already exist. The organizational form of a health care center, including the focus and structure, might differ, but the local actors' responses to a national reform might follow similar mechanisms, and the processes of translation might be defined by the same inclusion mechanisms of translators as well as the use of legitimizing accounts and discursive strategies. This makes the results of this dissertation interesting and applicable outside of Denmark. The findings might also be relevant for areas other than health care, especially in fields that are highly decentralized such as environmental planning, business development, social services and culture, or, more generally, in countries where actors at the local level more often play a major role in decision making.

b. Relevance for practitioners

This dissertation is highly relevant for practitioners who work at the national or local level in the public sector.

The analyses provide knowledge for national politicians and public administrators as to how governance by soft regulation and audits affects the development of the public sector. If the national objective is to create local innovation processes and experiments to improve public services, then my analyses are disappointing. I find little evidence that the municipalities were guided primarily by the problems defined at the national level, including improving quality, efficiency and equal access. Not that these elements were not important. However, the municipalities

did not design the health care centers in order to meet the aims of the national reform. Rather, the local organizational innovations built primarily upon a local logic of improving municipal economic sustainability. The analyses indicate that the municipalities took into account how to utilize a former nursing home or how to maintain services at the local hospital, as well as how they constructed accounts that legitimized these solutions. Thus, the municipalities might best be understood as local enterprises that – inspired by New Public Management development – are to manage services efficiently and treat people as customers who they must work to satisfy. Perhaps this tendency was reinforced in this case because of the option of applying for funding for a health care center was limited. The municipalities had only one month to develop a whole new project for a health care center, which is why they probably drew upon what they had already established or what they had planned to develop. The short submission deadline for proposals provided no opportunity to clarify specific local health problems.

Also, the analyses show that local innovation processes are driven more by who the actors are – politicians and professionals – than what the local problems are. One of the analyses suggests that the local actors' interpretations of which services should be prioritized are important, but that this is influenced by their relationship with a wider institutional infrastructure. Thus, members of local political parties adopt and implement the ideological position of the national party. Similarly, professionals employed locally exhibit and push the normative code of their profession. Thus, this does not indicate that local innovation processes are built upon specific local problems. Yet, health policy is a particularly salient arena for politicians as well as for conflicting professions and may be especially related to national rather than local interests and influence. Less politically sensitive policy arenas might show more independent local innovations.

The dissertation is also relevant for politicians and public administrators who work in municipalities. Not surprisingly, the analyses show that there is a close link between the strategies, which are developed to legitimize an emerging organization, and the specific activities that are developed in practice. This is often explained by referring to innovation processes as developed on the basis of an intended formal strategy. However, the findings in one of my analyses indicate that the strategies were developed in a particular way, because they were intended to legitimize the activities the municipality was able to develop. Particularly, the strategy process indicates that although the initial aim was to create a flexible organization and provide both health promotion and rehabilitation without a fixed

and formal strategy, the legitimizing strategies began increasingly emphasizing health promotion activities. As creating health promotion activities was easier than for rehabilitation, the strategies also tended to legitimize the center by emphasizing the importance of promoting people's health.

The analysis of the municipal discursive strategies is particularly relevant for practitioners working with health care provision. Although it was not at the core of my analysis, I explore how a particular moralizing strategy problematized the people's unhealthy habits and the rise in obesity, alcohol abuse, lack of physical exercise, etc. A local health profile survey spelled out that especially people with lower levels of education, the unemployed and people living in public housing areas faced health problems. Accordingly, the aim of a health care center should be directed at changing people's behavior and enabling them to make healthy decisions. The center could provide, for instance, individual counseling and activities for young people, families and the unemployed. Obviously, this strategy was intended to produce specific behavior in people. However, practitioners should keep in mind that – although this strategy means well, it also paves the way for the stigmatization of particular habits as improper, and also of particular citizens as misinformed or irresponsible. In addition, practitioners should consider focusing on the root of social inequality with regard to the level of one's health, such as the option of helping people complete their education or get a job instead of targeting only the 'wrong' habits of these groups.

c. Limitations of the study and what I could have done

By mid 2008, forty-two percent of all Danish municipalities were developing health care center and another twenty percent planned to do so (Ramboel Management, 2008). Far from all of these centers were co-financed by the ministry. It would have contributed to the validity of this study if I had included every single Danish municipality in an attempt to uncover possibly different accounts for developing a health care center. However, I did not include these municipalities because, first of all, their development of a health care center started later than this dissertation, and second, it would have been very time consuming to involve ninety-eight different settings in a primarily qualitative study. In addition, the access to data would have been constrained and unstructured as they were not part of the initial mandatory evaluation conducted by the National Institute of Public Health.

Yet, before designing this project, I compared each of the initial sixty-three municipal applications for financial support sent to the Ministry of the Interior and Health. It turns out that the variety in the design of the eighteen health care centers' organizational forms included in this study was strikingly similar to the variety in the design that was found in the total sample. Thus, the eighteen centers might in fact be representative of other Danish health care centers, but, more importantly, they serve to provide insight into the range of variation in emerging health care centers' organizational forms. Hence, I anticipate that the design of the study provides valuable and trustworthy knowledge illustrated by how the health care center developments that occurred under the various circumstances in the different settings (Stake, 2000).

I could have also used more interview data. Because I was collaborating with the National Institute of Public Health, I was able to collect and have access to a large amount of interviews. Yet, in the three analyses, I drew particularly on the data from the interviews we conducted in 2006 as they particularly suited my analytical questions. I used the interviews from 2008 as relevant background information. However, it would have been fruitful to use all of the interviews from 2006 and 2008 to explore how the actors in the eighteen municipalities conceptualized their simultaneous development processes.

I focus on each municipality as a whole or on specific groups of politicians and professionals. It would have been interesting to move to the individual level and analyze the subjective interpretations of each actor. In this way, I would have been able to explore the actors' struggles, negotiations and coalitions within a municipal setting and within a specific political party or profession. Furthermore, I would have been able to note whether the actors changed their interpretations of a health care center over time or not. However, as I moved along in my research, I decided to focus on the municipality as a whole and to take advantage of the possibility of comparing eighteen different settings.

d. Suggestions for further research

It would be relevant to continue this study and explore the later development of health care centers. Such a longitudinal study would reveal much more about the process of institutionalization, including the complex mechanisms in actors' interpretation of a new concept and of what happens at different stages. So far, I do not

even know whether the case of a health care center is a case of institutionalization. Perhaps it later turns out to be a case of institutional failure, and it will be interesting to explore why this was the end result. Yet, I believe that the National Board of Health will become a more dominant actor in the emerging municipal health care field. This has not been the case so far. But perhaps the board will provide the field with standards for managing municipal health care, including constituting certain health care centers as legitimate. Some of my interviewees pointed to a growing national focus on patient rehabilitation, the management of patient flows, and more debates on how to prevent public health costs. Thus, although I identify a local development towards prioritizing health promotion, the national focus might force municipalities towards rehabilitation. Particularly, it would be interesting to explore why a specific translation becomes more dominant than another one within an organizational field, and whether the interaction between local and national translating actors has an impact on this selection.

It would also be interesting to compare the health care center concept examined here with other cases of organizational concepts that are more fixed and detailed than the health care center concept. The translation processes might follow other mechanisms and it would be interesting to explore the space for local interpretation and the inclusion of local logics. Likewise, it would be interesting to study whether translation processes in the public sector in other countries is less decentralized and as open for local interpretation and variation as in this case.

Also, it would be interesting to explore the inclusion mechanism of translators in other cases and countries. This implies investigating how jurisdictions constitute specific translators as powerful in translation, and whether these translators, including politicians and professionals, are also embedded in external institutional contexts. Furthermore, it would be interesting to explore how discourses position specific actors as powerful, and whether it becomes possible to predict the outcome of translation due to the domination of a specific discourse. Comparing the case of health care centers in Denmark with other cases and countries might reveal interesting similarities and differences in the positioning of specific powerful translators.

Finally, this study points to the relevance of further exploring how translators use discursive legitimizing strategies in translation. The analysis of the process in one municipality shows that when the legitimizing strategies make a discourse resonate in the local context, in this case a political context, then the discourse and specific translation become dominant. Furthermore, the analysis indicates that

when a discourse is present beyond the authorization and rationalization strategies, then the discourse becomes more dominant. However, much more work is needed to explore this. In addition, it would be interesting to explore other cases and contexts to challenge my finding that a discourse becomes dominant when it facilities the inclusion of a broad range of actors in translations. The inclusion of specific types of actors, such as powerful politicians, might perhaps be what makes the difference for the stabilization of discourse.

11. SUMMARY

a. English

In this dissertation I focus on a national reform of the Danish public sector, which in January 2007 facilitated the development of new municipal health care centers in order to meet specific local demands and to improve primary health care. However, this new organizational concept was not presented as a mandatory and detailed legislative reform. The municipalities therefore developed centers focusing in different ways on health promotion and rehabilitation and with great variation in their structure. Specifically, I find it intriguing how specific actors at the local level, such as politicians, medical professions, and social welfare professionals, were able to participate in local developments, and how they constructed specific organizational forms as local manifestations of the new national policy. Particularly, I am interested in exploring *how the heterogeneous institutional context influences local actors' translation of an abstract organizational concept into specific organizational forms.*

The reform provided an opportunity to examine two institutional dynamics that have so far been treated separately in the literature: local processes of translation (Czarniawska and Sevon, 1996; Sahlin-Andersson, 1996) and the existence of multiple institutional logics (Friedland and Alford, 1991; Thornton, 2004). First, I draw on a tradition of neo-institutional research that treats the diffusion of new organizational ideas as a process of translation. Organizational actors translate ideas into solutions that fit their locally constructed problems. However, not much attention has been specifically paid to how the heterogeneous institutional context influences the local actors' translation. I conceptualize the institutional context both as an emerging municipal health care field (DiMaggio and Powell, 1983), and as local jurisdictions that are geographically bounded communities (Greenwood, Diaz, Li and Lorente, 2009; Guthrie and Roth, 1999a: 1999b; Guthrie, Arum, Raksa and Damaske, 2008; Marquis, Glynn and Davis, 2007; Marquis, 2003; Marquis and Lounsbury, 2007). These contexts contain institutional logics and discourses that are socially constructed systems providing meaning to the local actors. On the one hand, they guide and constrain the actors' agency; on the other hand, they are legitimizing tools that can be utilized. I employ critical discursive analysis (Fairclough,

1992, 1995; Wodak and Meyer, 2002, Phillips and Hardy, 2002; Vaara, Tienari and Laurila, 2006) to investigate how actors use legitimizing texts and documents as part of their translation, as well as examine how discourses provide different sources of legitimacy to organizational forms and provide actors with heterogeneous access to power.

The analytical strategy for this study was an open bottom-up policy analysis (Sabatier, 1986; Hjern and Hull, 1987; Bogason and Sorensen, 1998; Reff Pedersen, 1999; Gjelstrup and Sorensen, 2007) focusing on the micro-level actors' subjective interpretations and construction of social meaning within a local context. Primarily, I employ qualitative methods supplemented with a quantitative analysis.

In the first analysis I explore which legitimizing accounts (Scott and Lyman, 1968; Strang and Meyer, 1993; Elsbach, 1994; Creed, Scully and Austin, 2002; Suddaby and Greenwood, 2005) the eighteen municipalities constructed and to which multiple national and local institutional logics they linked. I assemble these accounts into four groups of translations which correspond to four specific organizational forms with a similar focus and structure. Particularly, I analyze interviews completed in 2006 in order to facilitate maximum case variation and then combined these interviews with the emerging organizational forms as monitored in 2007.

In the second analysis, I narrow down my investigation to explore why an organization is constructed with a specific focus targeting either citizens or patients. In other words, I investigate how the socio-economic variables and the institutional context of the local actors influence the construction of an organizational focus. I use qualitative methods to analyze the differences in focus, the local ideological values, and the participation of professions in the development of the centers. Additionally, I used quantitative methods to compare the eighteen sites in order to explore the impact of socio-economic variables and to find patterns across the municipalities.

Finally, in the third analysis, I continue to analyze the organizational focus but employ critical discourse analysis. This theoretical lens adds a novel view on how to understand the construction of organizational focus. I explore how a discourse positions specific organizational actors as powerful in the process of translation, and how these actors develop discursive strategies in order to legitimate their translation of a health care center by linking it to the discourse. Particularly, I focus on a single municipality as an extreme case and explore the development of a health

care center in a three-year longitudinal study. I draw on qualitative data, including texts, interviews and observation studies.

This dissertation contributes to translation theory by emphasizing that the heterogeneous institutional context has an impact in the interpretive work of actors. When a new national management concept is translated into local communities, then these actors create specific localized social meanings by drawing upon multiple institutional logics embedded at the national and local levels. It is the actors' interpretations of these multiple logics and their considerations of, i.e. local issues and logics, which give rise to particular organizational forms. And further, the translating actors are part of the broader institutional contexts that they bring into their translation. A political jurisdiction such as a municipality becomes an important site, because it influences which actors – politicians and professionals – can participate in the translation. And, finally, also the dominance of a specific discourse constitutes some actors more than others with the opportunity to participate in the process of translation. These actors use discursive legitimizing strategies when they translate, thus reaffirming the discourse.

b. Danish

I denne afhandling tager jeg udgangspunkt i kommunalreformen fra januar 2007, der gav kommunerne mulighed for at udvikle nye "sundhedscentre" med afsæt i særlige lokale behov og som lokale forsøg på at udvikle hele sundhedsområdet. Da dette organisatoriske koncept ikke blev præsenteret i form af en bindende og detaljerede lovgivning, gik kommunerne i gang med at udvikle mange forskellige former for sundhedscentre, herunder centre med et forskelligt fokus på sundhedsfremme og rehabilitering samt med en stor variation i de organisatoriske strukturer. Jeg synes især, at det er interessant, at særlige aktører i kommunerne, herunder politikere, sundhedsprofessionelle og socialrådgivere, får mulighed for at deltage i denne udvikling, og at de udvikler forskellige organisationsformer som udtryk for forskellige lokale fortolkninger af den nationale politik. Især er jeg interesseret i at undersøge *hvordan den heterogene institutionelle kontekst påvirker lokale aktørers oversættelse af et abstrakt organisatorisk begreb til specifikke organisationsformer.*

Reformen gav mulighed for at undersøge to institutionelle dynamikker, der indtil nu har været behandlet adskilt i litteraturen: lokale oversættelsesprocesser (Czarniawska and Sevon, 1996; Sahlin-Andersson, 1996) og eksistensen af flere institutionelle logikker (Friedland and Alford, 1991; Thornton, 2004). For det første så jeg trækker på en tradition af nyinstitutionel forskning, der behandler diffusionen af nye organisatoriske koncepter som en oversættelsesproces. Lokale aktører oversætter abstrakte organisatoriske koncepter, så de kommer til at passe som løsninger til lokalt konstruerede problemer. Men på trods af en udbredt erkendelse af at denne oversættelsesproces påvirkes af den institutionelle omverden, så har der dog indtil nu ikke været fokus herpå, især ikke på at den institutionelle omverden er heterogen. Jeg undersøger derfor den heterogene institutionelle omverdens indflydelse på de lokale oversættelses processer. Jeg begrebsliggør denne omverden som dels et voksende kommunalt sundhedsfelt (DiMaggio and Powell, 1983) og dels politisk og geografisk afgrænsede lokale communities (Greenwood, Diaz, Li and Lorente, 2009; Guthrie and Roth, 1999a: 1999b; Guthrie, Arum, Raksa and Damaske, 2008; Marquis, Glynn and Davis, 2007; Marquis, 2003; Marquis and Lounsbury, 2007). Den institutionelle omverden huser desuden forskellige institutionelle logikker og diskurser, der er socialt konstruerede systemer, som indgår i de enkelte aktører meningsdannelse. På den ene side så guider og begrænser de aktø-

rernes handlinger, og på den anden side så er de værktøjer, som aktørerne kan bru-
ge til f.eks. at legitimere deres oversættelse af sundhedscentrekonceptet til en be-
stemt organisatorisk form. Jeg anvender desuden kritisk diskursanalyse
(Fairclough, 1992, 1995; Wodak and Meyer, 2002, Phillips and Hardy, 2002; Vaa-
ra, Tienari and Laurila, 2006) til at undersøge, hvordan de lokale aktører udvikler
diskursive legitimerings strategier forankret i forskellige diskurser, samt hvordan
disse diskurser positionerer aktørerne med forskellig mulighed for at indgå i over-
sættelsesprocesserne.

Min analysestrategi var en åben bottom-up policy analyse (Sabatier 1986, Hjern
og Hull, 1987; Bogason og Sørensen, 1998; Reff Pedersen, 1999; Gjelstrup og Sø-
rensen, 2007) med fokus på lokale aktørers subjektive fortolkninger og konstrukti-
oner af social menig i en lokal kontekst. Jeg anvendte først og fremmest kvalitative
metoder og supplerede disse med en enkelt kvantitativ analyse.

I den første analyse udforskede jeg hvilke legitimerende 'accounts' (Scott og
Lyman, 1968; Strang og Meyer, 1993; Elsbach, 1994; Creed, Scully og Austin,
2002; Suddaby og Greenwood, 2005), som de atten kommuner skabte og relaterede
til flere nationale såvel som lokale institutionelle logikker. Jeg grupperede disse
accounts i fire forskellige former for oversættelser – hver svarende til en specifik
organisatorisk form med et særligt fokus og struktur. Jeg analyserede samtlige 96
interviews fra 2006 for at opnå en maksimal variation i min case og kombinerede
disse med centrenes fremstilling af deres organisationsformer i 2007.

I den anden analyse indsnævrede jeg mit fokus og undersøgte, hvorfor en or-
ganisation konstrueres med et særligt fokus rettet mod enten borgere eller patien-
ter. Jeg undersøgte, hvordan henholdsvis socioøkonomiske variabler og den institu-
tionelle kontekst påvirker den lokale bestemmelse af det organisatoriske fokus. Jeg
anvendte kvalitative metoder og data til at analysere forskelle i fokus, de lokale
ideologiske værdier, og deltagelsen af forskellige professioner i centrenes udvik-
ling. Derudover brugte jeg en kvantitativ metode og data til at sammenligne de at-
ten kommuner og undersøge påvirkningen fra socioøkonomiske variabler samt fin-
de mønstre på tværs af kommunerne.

Og endelig i den tredje analyse fortsatte jeg med at analysere konstruktionen af
det organisatoriske fokus men ved hjælp af kritisk diskursanalyse. Denne teoretiske
tilgang tilføjede et anderledes analytisk blik. Jeg undersøgte, hvordan forskellige
diskurser placerede specifikke aktører som særligt centrale i oversættelsesproces-

sen, og hvordan disse aktører så udviklede diskursive strategier for at legitime deres oversættelse af sundhedscentrekoncept. Jeg fokuserede på en enkelt kommune, som jeg anså for at være en ekstrem case, og undersøgte udviklingen af centret i et treårigt longitudinelt studie. Jeg trak på kvalitative data, herunder tekster, interviews og observation undersøgelser i analysen.

Samlet set så bidrager afhandlingen til teori om oversættelsesprocesser ved at vise, hvordan den heterogene institutionelle kontekst har en betydning for oversættelserne. Analyserne indikerer, at når et nationalt organisatorisk konceptet skal oversættes til det lokale niveau, så vil de lokale aktører danne nogle særlige lokale betydninger ved at fortolke og kombinere flere forskellige institutionelle logikker forankret på både nationalt og lokalt plan. Det er således aktørernes fortolkninger af disse mange logikker, og deres overvejelser om lokale problemer, som medfører at særlige organisationsformer opstår. Desuden så indgår de enkelte oversættende aktører i bredere institutionelle sammenhænge, hvorfra de henter mening til deres lokale oversættelse. En kommune bliver derefter en vigtig ramme, fordi den får indflydelse på, hvilke aktører - politikere og fagfolk, der kan deltage i oversættelsen. Og endelig får nogle aktører i højere grad end andre mulighed for at deltage i en oversættelsesproces på grund af en særlig dominerende diskurs. Disse aktører vil så igen udvikler diskursive legitimerende strategier, der bekræfter denne diskurs.

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