



# How healthcare organisations can act as institutional entrepreneurs in a context of change

Institutional entrepreneurs

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## Abstract

**Purpose** – The aim of this paper is to illustrate and discuss how healthcare organisations can act as institutional entrepreneurs in a context of change.

**Design/methodology/approach** – The authors conducted an in-depth longitudinal case study (2005-2008) of a healthcare organisation in the province of Quebec, Canada. Data collection consisted of real-time observations of senior managers ( $n = 87$ ), interviews ( $n = 24$ ) with decision-makers and secondary data analysis of documents.

**Findings** – The paper reports on the extent to which entrepreneurial healthcare organisations can be a driving force in the creation of a new practice. The authors analyse the development of a diabetes reference centre by a healthcare organisation acting as an institutional entrepreneur that illustrates the conceptualisation of an innovation and the mobilisation of resources to implement it and to influence other actors in the field. The authors discuss the case in reference to three stages of change: emergence, implementation and diffusion. The results illustrate the different strategies used by managers to advance their proposed projects.

**Research limitations/implications** – This study helps to better understand the dynamics of mandated change in a mature field such as healthcare and the roles played by organisations in this process. By adopting a proactive strategy, a healthcare organisation can play an active role and strongly influence the evolution of its field.

**Originality/value** – This paper is one of only a few to analyse strategies used by healthcare organisations in the context of mandated change.

**Keywords** Canada, Healthcare, Management strategy, Organisational theory, Leaders, Change process

**Paper type** Research paper



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## 1. Introduction

Institutional theory is one of the most prominent approaches used for understanding organisational phenomena (Battilana *et al.*, 2009; Greenwood *et al.*, 2008; Scott, 2000). Whereas early institutional studies (*c.* 1950) were interested in actors' agency, later studies focused much of their attention on how environmental context influenced actors (DiMaggio and Powell, 1983; Tolbert and Zucker, 1983). Following DiMaggio's (1988) suggestion that institutional theory should reincorporate an "agency" concept, scholars have become increasingly interested in understanding how organisations also shape their environment. In seeking to understand better how innovative behaviours emerge, how individuals and organisations behave strategically, and how they influence change in institutionalised environments, scholars have developed the concept of institutional entrepreneurship (Beckert, 1999; Oliver, 1991). Institutional entrepreneurs, whether organisations or individuals, are described as actors who put forward ideas that diverge from dominant models (Battilana *et al.*, 2009) and thereby introduce change in established routine practices.

The objective of this paper is to illustrate and discuss how healthcare organisations can act as institutional entrepreneurs in a context of change. First, we present the institutional theory concepts on which our work is based, followed by our methodology and our research setting. We then present a summary of our longitudinal case study. We analyse the process of institutional change advanced by a healthcare organisation through the emergence, implementation and diffusion of an innovation in the organisational field. Based on this empirical case, we discuss how healthcare organisations can act as institutional entrepreneurs and become driving forces in de-institutionalising and re-institutionalising a field's practices. We conclude with a discussion of the implications of our findings for research and practice.

## 2. Theoretical background: institutional theory

Several authors have sought to understand not only how environment exerts a determining influence on organisations, but also how organisations in turn influence their environment. This concept, known as the "paradox of embedded agency" (Seo and Creed, 2002), reflects the tensions that exist between institutional determinism and agency with respect to specific action (Battilana *et al.*, 2009; Greenwood and Suddaby, 2006). This paradox combines the key characteristics of neo-institutionalism (environmental pressures) and earlier work on agency (Haveman and David, 2008). Thus, a central challenge for institutional theory is to show how and why embedded actors become motivated and able to envision new practices and then subsequently get others to adopt them (Greenwood and Suddaby, 2006). In this section, we briefly describe the environmental pressures that influence organisational behaviour. Then we present the concept of institutional entrepreneurs. Finally, we introduce a conceptual model that can help in understanding the process of institutional change, by seeking to bridge what have come to be termed "old" and "new" institutionalisms in organisational analysis.

### 2.1 Environmental pressures

According to scholars of neo-institutionalism, the environment exerts a determining influence on organisations that inclines them toward a certain degree of homogeneity within an organisational field. This homogeneity, or the sharing of common norms and values, is called isomorphism (Greenwood *et al.*, 2008; Meyer and Rowan, 1991).

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Isomorphism is a process by which organisations try to conform to environmental pressures to gain legitimacy. DiMaggio and Powell (1983) define three types of environmental pressures that influence actors' behaviours:

- (1) coercive;
- (2) normative; and
- (3) mimetic.

Coercive pressures are imposed by laws, regulations and state policies. Normative pressures refer to recognised standards that dictate what behaviours are acceptable in various sectors of activity, such as the values and norms held by professional associations. Finally, mimetic (or cognitive) pressures emerge from organisations considered as examples by others that tend to imitate them.

Environmental pressures influence actors' behaviours to varying degrees of intensity by providing them with motivations to adopt those behaviours (Greenwood *et al.*, 2008). These motivations come from various sources. Organisations are motivated toward coercive isomorphism when they seek to avoid sanctions from influential institutional actors; toward normative isomorphism by their desire to respect social expectations; and toward mimetic isomorphism by their interest in replicating other organisations' successful behavioural patterns. Scholars of neo-institutionalism have been able to offer more insight into the processes that explain institutional stability than into those that explain institutional change (Oliver, 1991; Seo and Creed, 2002). This has been due, in part, to the greater emphasis on how environmental pressures force organisations to adopt similar practices to gain legitimacy and support (DiMaggio and Powell, 1983). Thus, it is widely acknowledged that organisational behaviour occurs within a web of socially constructed, tacitly accepted prescriptions of appropriate conduct (Scott, 2000). Organisations are clusters in organisational fields where identities and interactions are defined and stabilised by shared institutional logics.

Although organisations within an organisational field tend to converge to some form of isomorphism, they do not react uniformly to these environmental pressures (Scott, 2000). Recent studies have examined the variety of strategic behaviours that different actors may adopt when subjected to environmental pressures. Oliver (1991) was one of the first authors to propose a typology of all the alternative strategic responses available to organisations dealing with highly institutionalised environments. The typology presents a diversified spectrum of strategic organisational responses, ranging from passive conformity to active manipulation. Actors' responses to environmental pressures have variable influence on the evolution of organisational fields. Some actors – called institutional entrepreneurs – try to change certain institutionalised practices through their ideas and actions, in order to move the organisational field forward (De Holan and Phillips, 2002). Institutional entrepreneurship is therefore a concept that reintroduces agency, interests and power into institutional analyses of organisations (Garud *et al.*, 2007).

## 2.2 Institutional entrepreneurs

According to Battilana *et al.* (2009, p. 72):

Institutional entrepreneurs, whether organisations or individuals, are agents who initiate, and actively participate in the implementation of, changes that diverge from existing institutions,

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independent of whether the initial intent was to change the institutional environment and whether the changes were successfully implemented.

They are agents of change who initiate divergent actions that shake up institutionalised practices and who actively participate in mobilising resources to implement this change. Thus, the notion of institutional entrepreneurship runs against the tacitly accepted thesis of neo-institutional theory (Greenwood and Suddaby, 2006). The concept of institutional entrepreneurship tends to emphasise how organisational processes are shaped by creative entrepreneurs who bring about change by envisioning an alternative future (Seo and Creed, 2002). Institutional entrepreneurship offers considerable promise for understanding how and why certain new organisational solutions come into existence and become well-established over time (Garud *et al.*, 2007). In the literature, a few studies have analysed the concept of institutional entrepreneurship (Maguire *et al.*, 2004), such as, for example, in the introduction by government of business plans in museums and other cultural organisations (Oakes *et al.*, 1998), moves by professional associations to persuade members to standardise new practices (Greenwood *et al.*, 2002), and software manufacturers' sponsoring of new technological standards (Garud *et al.*, 2007).

In summary, institutional entrepreneurs, by their strategic action, try to modify practices that have been institutionalised. In the following brief overview of the literature on institutional change, we present the concepts that structure our discussion on how healthcare organisations can act as institutional entrepreneurs.

### *2.3 Institutional change*

Hinings *et al.* (2004) argued that institutional theory provides an excellent platform for analysing change, first by providing a convincing definition of radical change and, second, by pointing out the contextual dynamics that create the need for organisational adaptation. In their dynamic framework, they used insights from the new institutionalism to explain the normative contextual pressures that constrain organisational change and insights from the old institutionalism to explain the intra-organisational political dynamics that produce change. Hinings *et al.* (2004) incorporated the two institutionalisms into their model while conceptualising them as separate processes, the first of which involves normative pressures operating in the institutional context and influencing the second process, which is agents' political action within organisations. They define institutional change as a bi-directional phenomenon that presupposes, on one hand, the de-institutionalisation of established practices, and on the other, a re-institutionalisation of practices that incorporate the proposed change (Greenwood *et al.*, 2002; Hinings *et al.*, 2004). Hinings *et al.* (2004) propose five stages of change at the institutional-field level:

- (1) pressures for change;
- (2) sources of new practices;
- (3) processes of de- and re-institutionalisation;
- (4) dynamics of de- and re-institutionalisation; and
- (5) re-institutionalisation.

This model describes how certain institutionalised practices fade away and are replaced by new ones that become legitimised and disseminated within the

organisational field. The different phases of the institutional change are spread over shorter or longer time frames, depending on the cases analysed.

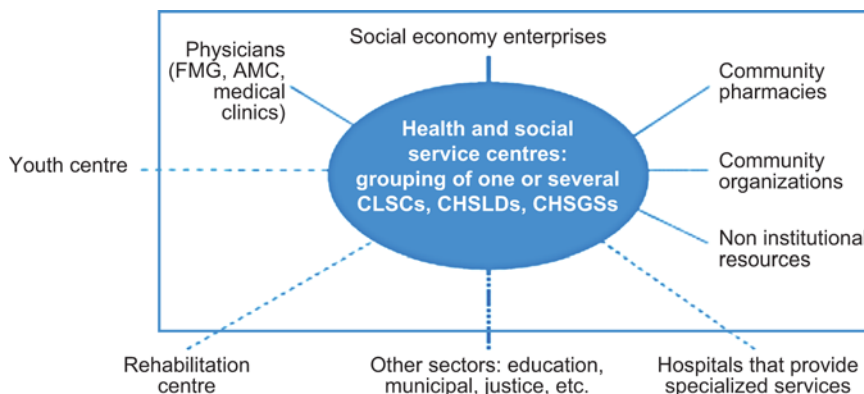
In this article, we base our analysis on Hinings *et al.*'s (2004) model of institutional change, which we summarise as evolving from emergence to implementation and finally to diffusion as the change becomes taken for granted in the field. Drawing upon these concepts, we discuss the different roles healthcare organisations can play as institutional entrepreneurs in these three phases of institutional change.

### 3. Methodology

#### 3.1 Research setting

We analysed the actions taken by four healthcare organisations in the province of Quebec, Canada, in response to mandated reform. Quebec is a province of over eight million residents, covered by a tax-based system providing universal access to medical services. Institutions such as hospitals and community health services are funded directly by the Ministry of Health, and physicians are reimbursed for services predominantly on a fee-for-service basis. While nearly all family physicians are individually remunerated by public funds, most primary care organisations are private enterprises, neither owned nor governed by the state. Several other government agencies and non-governmental organisations also offer health services to the population.

In 2004, the Quebec government initiated a large-scale redesign of its healthcare structure that focused on implementing integrated local health services networks across the province to ensure accessibility, quality and continuity of care. At the heart of the mandated local health services networks is a new organisational structure, the Health and Social Services Centre (Centre de santé et des services sociaux; – CSSS), shown at the centre of the Figure 1. CSSSs were formed by merging several healthcare organisations operating within a geographic territory: community health services centres offering home care and social services, long-term care facilities, and, in most cases, a general acute-care hospital. These major processes of merger were carried out by CSSSs in line with a new mandate, called “population-based responsibility”, to



**Figure 1.**  
Schematic representation  
of the local network of  
CSSSs

**Source:** Québec, Agence de développement de réseaux locaux de services de santé et de services sociaux, 2004, p.6. The Population Approach: New Vision and Action for Health. Information Kit, p.6, Québec : Government of Québec

improve the health and well-being of a geographically defined population. The objective was to give CSSSs responsibility for developing services adapted to the needs of their population. They were mandated to develop collaborative or contractual arrangements with other providers inside their territory that offered services needed by the local population (e.g. community pharmacies, community organisations and medical clinics, depicted by solid lines in Figure 1) as well as supra-regional entities (depicted by dashed lines in Figure 1).

This new orientation represented an ideological shift from a “services-based” to a “population-based” logic. The new CSSSs were expected not only to provide services to those who requested them (services-based), but more broadly to assume responsibility for the health status and needs of the population in their geographical territory (population-based). This was a radical change in focus whose origins lie in broader institutional trends that have permeated thinking around healthcare reform (Denis *et al.*, 2009). Table I illustrates the various tensions between services-based logic and population-based logic.

Many actors in Quebec’s healthcare system concluded that the CSSSs’ population-based responsibility called for services to be tailored to the needs of the population in their territory. The shift toward population-based responsibility created an openness to innovations aligned with this new vision. A consensus emerged around the idea of formalising different health services networks targeting specific clientele. Thus, the new mandate had the potential to produce many changes in practices because managers were required to broaden their organisation’s target clientele to include the whole population residing in their territory (Breton *et al.*, 2010). CSSSs were expected to develop new ways of organising healthcare and to coordinate local health services networks with other organisations in their territory.

In summary, the CSSSs were expected to take the lead in developing actions to carry out their mandate. They were called upon to develop an offer of services geared toward the health needs of the people living in their territory. They had to take on their new responsibility in a mature field. A mature field consists of relatively well-structured configurations of actors who see themselves as being involved in a common enterprise, and among whom there are identifiable patterns of interaction such as domination, subordination, conflict, and co-operation (Greenwood and Suddaby, 2006; Maguire *et al.*, 2004).

Population-based logic	Delivery	Services-based logic
Population in the territory that uses or does not use the services	Target	Individuals who use the services
Improve the health of the population of the territory, over the medium and long terms	Objectives	Improve the health of individuals who use care, at the time when they need it
Focus on prevention, promotion and protection	Services offered	Focus on diagnostic and curative services
Public health professionals and various intersectoral stakeholders	Stakeholders concerned	Healthcare professionals and administrators
Forward-looking, anticipates problems	Temporality	Corrects the past, reacts to problems

**Source:** Breton *et al.* (2010), adaptation of Derose and Petitti (2003), Garr *et al.* (1999)

**Table I.**  
Various tensions between population-based logic and services-based logic

3.2 *Research approach*

This article is based on our three-year (2005-2008) study entitled “Governing Change and Changing Governance in Healthcare Systems and Organisations”. Here we present an analysis of one of the four cases we studied. We selected this case because it is an informative example of the creativity and innovation that can be shown by healthcare organisations acting as institutional entrepreneurs in a context of change. Our research is based on case study analysis, which is particularly suited to the analysis of change processes (Langley, 1999; Patton, 2002; Yin, 1989). We conducted a longitudinal study because this is the best approach for gaining a rich understanding of the change process. The case analysed in this article is located in an urban region. Table II presents the characteristics of the CSSS in this case. In our study, we had the rare opportunity to gather rich process data during the early stages of institutional change in a project that appeared to be legitimising new practices. The case we present is that of an organisation that successfully implemented an innovative project and played an active role at each step of institutional change. While this case is not representative of all the projects proposed by CSSSs, it serves as a tracer for discerning the influence of healthcare organisations as institutional entrepreneurs. It reflects a new business model guiding the organisation’s activities and represents a shift toward the new population-based mandate. We also analysed the regional environment in which the healthcare organisation operated, focusing particularly on the Regional Health and Social Services Agency, whose mandate is to allocate resources among the territory’s organisations and to support them in developing local health services networks.

3.3 *Data collection*

For this case, we collected three types of data over a three-year period (2005-2008) from three sources:

- (1) semi-structured interviews;
- (2) observations of meetings; and
- (3) archival documents.

The interviews and meeting observations were our major data sets, and the archival data were used to further validate findings and identify key events. We carried out 24 semi-structured interviews with CSSS senior managers in French at two points in time, i.e. 14 interviews at the start of the study and ten interviews approximately 18 months later. We attended 87 meetings of strategic committees at the local and regional levels. Locally, we observed committee meetings of senior management within the CSSS as

	CSSS
CSSS: institutions merged	One hospital, three local community health centres, five long-term care facilities
Population	132,779
Employees	3,810
General practitioners	102
Budget (2005-2006) (\$CDN, millions)	170

**Source:** Regional Health and Social Services Agency, Montreal (2007)

**Table II.**  
Characteristics of the CSSS under study in this article

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well as strategic committees related to the development of local health services networks. At the regional level, we observed the committee in which senior managers of the Regional Agency met with the CEOs of the 12 Montreal-region CSSSs. Signed consent was obtained from participants for all observations and interviews, which were audio-recorded. The archival data consisted of empirical materials generated from a systematic review of archival materials (i.e. formal agreements, media articles, government reports, and other documents).

### 3.4 Data analysis

As a data analysis strategy for qualitative analysis, we used a deductive-inductive thematic analysis (Locke, 2001). We focused in particular on discerning actors' strategies for fulfilling their population-based responsibility. As is typical with interpretative research based on qualitative data, throughout our analyses we moved iteratively between the different data sources and between the data and themes generated (Reay *et al.*, 2006). To analyse the data, we used a number of techniques and analytical categories suggested by the literature, such as environmental pressures and actors' strategies. The contents of the interview transcripts, observations and documents were first analysed to develop a chronology of the process of responding to a mandated change. We used a process theory strategy to analyse the data in order to understand how events took place over time and why they unfolded as they did (Langley, 1999; Miles and Huberman, 1994). Defining the process theory involved developing a detailed case history to obtain a clear picture of the main processes involved in the implementation and to identify key actors within the organisation and its environment (Denis *et al.*, 2009). We wrote a chronological narrative of the case based on the three stages of change identified by Hinings *et al.* (2004):

- (1) emergence;
- (2) implementation; and
- (3) diffusion.

We distinguished patterns in the sequence of events that led to results. We then validated the case history with members of the participating organisation. In this article, our description of the case focuses on key activities and their evolution through time.

## 4. Empirical findings

As mentioned, the mandated reform was based on an ideological shift from a services-based to a population-based logic. The new CSSSs were expected not only to provide services to those who requested them (services-based), but more broadly to assume responsibility for the health status and needs of the population in their geographical territory (population-based). This shift generated ambiguity by destabilising long-standing practices and, by opening minds, created a window of opportunity to create new practices in the field.

Managers of CSSSs had begun questioning certain practices that were taken for granted, and over time this led to re-visioning health services organisation through a population-based lens. Many new practices were developed simultaneously across the field. The field gradually transformed to reflect the philosophy underlying the delivery of services and transcended the CSSS's organisational boundaries as managers began to support and help other organisations on their territory. As one manager said, "For



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me, the CSSS is becoming a network. It should be viewed as a whole. There should not be a separation between various organisations of the CSSS; we really are all together". We observed several examples of managers investing time and effort in carrying out a population-based responsibility. For instance, we observed CSSS managers negotiating with hospitals to obtain privileged access to high-tech support for primary care organisations, arranging referrals to family physicians for vulnerable patients who had none, supporting medical clinics (family medicine groups) undergoing their accreditation process, and formalising integrated health services networks for specific clientele such as seniors and mental health patients. Managers tried to develop contractual agreements and alliances (virtual integration) with different partners, including private primary care organisations, to improve the delivery and integration of services offered to the population of their territory. One manager exclaimed, "The public/private partnerships with physicians on our territories are the reform!". This effort represented a significant development of managers' practices, since public and private primary care organisations have historically evolved in separate silos (Breton *et al.*, 2010). A number of managers seemed to agree that the most important gains to date were in the CSSS's commitment to improve the overall supply of primary care services, whether these were provided in private or public settings. Another manager said, "Five years ago, we didn't talk about that, we didn't know private clinics. Now, they're really our partners. It's a major step".

In accordance with their population-based responsibility, managers of CSSSs have gradually expanded the areas of activity targeted by CSSSs, and their thinking about services organisation has been strongly influenced by public health issues. The many areas in which they can develop have opened up opportunities for CSSSs to establish themselves as new institutional entrepreneurs by taking the lead in developing innovations based on the new logic. Windows of opportunity are being created for institutional entrepreneurs to propose and implement new ways of organising health care.

Of the several possible strategies that could be developed in this new context, one was to set up integrated services networks based on disease or population target groups (Provost *et al.*, 2011). In this section, we describe a successful project for a diabetes reference centre developed by one of the CSSSs in our study to show how it was able to act as an institutional entrepreneur in the field. The discussion is structured around the three consecutive phases of institutional change: emergence, implementation and diffusion.

#### 4.1 Emergence

One of the first actions taken by the CSSS under study to address its new mandate and incorporate the new logic into its activities was hiring a director of program development. The organisation's CEO formally appointed a director with the mandate to design and develop the new clinical plan in line with the population-based logic. The new director of program development had extensive prior experience in public health, which was at the heart of the new logic, and thus had already integrated the new logic into her thinking. She began her mandate by compiling a portrait of the local population's health status. This information helped identify the population's greatest problems and needs. Among these, one of the most significant was diabetes:

Among our priorities, we know that the current epidemic is the epidemic of obesity and its corollary, diabetes. It is definitely a catastrophe at the population level. We have a population

of diabetics [...] of 10 per cent or 12 per cent [...] around 13,000 or 14,000 people. There are 6,000 who are diabetic, the others don't know it yet. It's pretty catastrophic.

The director put forward a first version of the clinical plan that had been developed within her department with two staff members and then submitted to broad consultation. The CEO also played a crucial role in the process by working with the managers in charge of specific clinical programs to ensure that a broad vision was developed and shared. Also, the CSSS's chairman of the board of directors was very active in the local field to promote the clinical plan. This plan presented 23 priorities for the CSSS over the next five years. One priority was to treat 50 per cent of patients with diabetes in accordance with Canadian guidelines. By demonstrating the important need for diabetes services in the territory, the director of program development helped establish the legitimacy of this development initiative. Through sustained efforts, she created a window of opportunity for this innovative intervention to take shape within the new population-based logic. The director of program development undertook the challenge of conceptualising a new way of organising diabetes centres. The diabetes reference centre was seen as an innovative intervention because it was among the first initiatives to foster the integration of services for a target group of patients with a specific chronic illness within geographic boundaries for which the CSSS had a mandated responsibility. The project was innovative compared to institutionalised practices in the field because it proposed a new way to care for diabetics by coordinating a wide range of integrated services in the local territory, even in private practices. In this way, through the forcefulness of its idea, the CSSS exerted cognitive pressure on the field. Before that innovation, diabetes services had generally been delivered in a services-based silo model, organised in hospitals by specialised services with no formal links to primary care organisations. The CSSS's innovation translated the population-based logic into a new way of organising health services for these clients.

Creating the diabetes centre was a priority for the CSSS, and a broad consultation among different actors across the local field supported the project. It was one of the first CSSSs in Quebec to pursue the creation of a diabetes reference centre based on a network of different community-based organisations. The vision proposed by the director of program development was then conceptualised by a project committee that included a physician specialised in internal medicine who was recognised in the field for his leadership and involvement in the community. The committee included the CSSS's director of family medicine and director of professional services. Many meetings were held to develop the project. Their vision was that the diabetes reference centre would offer a continuum of services provided by specialists and professionals based at the CSSS's hospital, working in collaboration with family physicians in the community. The centre offered physicians in the territory support and follow-up services for their diabetic patients.

According to one of the directors of this CSSS:

The doctor who is alone in his office cannot monitor changes in lifestyle habits, exercise, instruction about insulin, etc. [...] The CSSS's approach is interesting. We're going to offer to help them in these relatively time-consuming activities. We'll manage their more complicated patients [...] at the diabetes reference centre. So, the doctor no longer has this responsibility, it's a support to the doctor. For the population, it's a big support, it's definitely an improvement, because no doctor, no matter how competent or how devoted, can do as much as can be done in one session, even a session of three hours, or if absolutely necessary, a session of three days.

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#### 4.2 Implementation

Having developed and articulated a vision, the CSSS, acting as an institutional entrepreneur, had to convince different constituencies embedded in the field to accept the change and to rally behind it. To implement the diabetes project inside the organisation, the CSSS mobilised a variety of actors. Considerable effort went into promoting the new project among different audiences. The organisation's employees were aware of and supported the diabetes project. The physicians involved in designing the innovation collaborated actively and successfully in enlisting the support of medical practitioners across the territory. In this regard, several people we encountered acknowledged the central role played by one medical specialist's involvement in the project's development. As one manager told us, "I recognise the advantage of working with a specialist who is proactive and shows leadership". This physician helped to strengthen the project's legitimacy and to get medical specialists involved in it. The director of program development and this specialist physician leader visited every medical clinic in the CSSS's territory to present the diabetes project personally to family physicians in the community. According to the director of program development, "This is a project to support the practice of family physicians. Without the doctors on board, it won't work".

The project was also strongly supported by the CEO and chairman of the board. Both used the diabetes centre as a concrete example of how the organisation was moving toward the new logic. They exerted a great deal of political influence, both internally and externally, to promote the diabetes centre. As well, the director of program development was very active at the Regional Agency, participating in panels and public events with members of the RA's management team. This director was well connected with leaders in the field and was very active in developing links with partners. Thus, through their various involvements, these three leaders actively influenced the normative and cognitive pressures of the field.

During the same period, a research group studying chronic diseases, funded by the pharmaceutical industry and working in collaboration with the Regional Agency, had put out a call for projects on the management of chronic diseases in primary care. The CSSS rapidly seized this opportunity by proposing their project, already conceptualised and in the early stage of implementation. The CSSS's diabetes centre was a clear choice as one of the projects to study. This alliance with the scientific community allowed it to benefit from rich expertise to further conceptualise the project (theorisation) as well as to obtain additional resources for implementation.

We have more money for this [...] This allows us to spread the word [...] The concern about diabetes was there for a long time [...] But now, we have highlighted it and given it an official position. We have invested.

Also, the CSSS succeeded in persuading the Regional Agency to appoint representatives to several of its working committees to develop the diabetes centre. The endorsement of such high-status actors increased the project's legitimacy and helped mobilise other actors behind it (Battilana *et al.*, 2009), gradually building a network of actors around the project. This result converged with the observation of Leblebic *et al.* (1991) that legitimation occurs when an innovation made by fringe players is adopted by established actors.

With strong agreement and support, the innovation then moved into the implementation stage. The first diabetes reference centre in the region, implemented in

the summer of 2007, was the result of concerted efforts of multiple actors at different levels in the field. It consisted of two programs:

- (1) a lifestyle-change program; and
- (2) a teaching and treatment program.

Regarding the first program, one manager told us:

The lifestyle-change program is designed to restore normal biological indicators and to prevent complications in people newly diagnosed with diabetes. In individual and group meetings with a kinesiologist, a nurse and a nutritionist, the patient will focus on improving his quality of life through exercise, diet and a better understanding of his illness, always remaining connected to his family physician.

The second program included a three-day course and was designed for patients with more advanced disease and suffering from complications or side effects. According to a specialist:

Basically, many of these patients are under the care of a family physician who previously tried a few combination therapies without success. Thus, in groups of six or seven, patients are supported by a multidisciplinary team made up of a doctor, a social worker, a community pharmacist, a nurse, etc. With the help of this team, patients can get a clear picture of the disease and equip themselves to deal with it.

The CSSS was proud of its innovation, as one manager pointed out:

I am pleased this project could be implemented so quickly. The CSSS's structure, with three local community services centres and a hospital, has facilitated the coordination of resources that previously worked separately on the same problems. Basically, the diabetes reference centre is a project to realign services to better serve the diabetic population referred mainly by family physicians. This shift represents a challenge that is at the heart of the CSSS's population-based responsibility.

Several actors pointed out that the special feature of the diabetes references centre was networking. According to one clinician:

We are connected with several of the CSSS's organisations, including family medicine groups, the integrated services network and the community pharmacy. We have also recently hired a community organiser who will work on chronic disease prevention in the field by verifying the needs of the community and reaching out to people who don't necessarily go to the hospital or medical clinics.

The innovation was appreciated by clinicians and patients. Over time, the volume of patients followed by the diabetes centre increased significantly. On average, 80 per cent of the medical clinics in the community referred patients to the diabetes centre during its first year of implementation. This helped strengthen its legitimacy by convincing other actors in the field of the value of the innovation, thereby establishing new norms that corresponded to the characteristics of the project proposed by the CSSS.

#### *4.3 Diffusion*

The picture we have presented thus far deals primarily with what happened at the organisational level, where the innovation was initiated (considering the organisation to include its territory of responsibility). From there, the extent to which a project

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penetrates into the field depends on several factors, and particularly on the network of actors involved in its promotion and their social position.

Nearly a year and a half after the implementation of the diabetes references centre, the CSSS organised a press conference to recognise this innovative project, with numerous personalities in attendance, including the Minister of Health, provincial and federal elected politicians, the CEO of the Regional Agency and the CEO of Diabetes Quebec. By means of this highly publicised event, the innovation was disseminated through different levels of the field, even province-wide. This event positioned the CSSS as a leader and entrepreneur in the field for advancing successful new services for the diabetic clientele. Also, the project was reported in several newspapers and professional journals such as *Le Médecin du Québec (The Quebec Physician)*. The diffusion of this innovation throughout the field, based on its demonstrated added value, created stronger mimetic and normative pressures in the field. Testifying to its success and productivity, approximately 650 patients have been seen every year since the project began in 2007. One manager exclaimed that “Collaboration with physicians in the community is excellent; 87 per cent of them have referred patient with diabetes. It’s wonderful!”.

From the beginning of the project’s conceptualisation, the Regional Agency believed strongly in its potential to improve services to the population and promoted it at several forums as a promising model, exerting even stronger cognitive and normative pressures on the other CSSSs. Building on these positive results, the Regional Agency asked the region’s 11 other CSSSs to implement a similar project. It thus became a model for several other actors that attempted to reproduce this project in their own organisation. According to a consultant physician for the Regional Agency:

The Agency designed some common tools, such as forms for referring patients to the teaching centre. Also, in collaboration with the CSSSs, it developed a clinical process for all the centres. At the request of the CSSSs, it also organised round table discussions for kinesiologists, nutritionists, and nurses, to ensure they share a common approach.

Currently, 11 of the region’s 12 CSSSs have expanded their service offer to include a diabetes reference centre, thereby putting even stronger normative pressure on the last CSSS of the region without a diabetes reference centre, as well as on CSSSs in other regions. According to the Regional Agency’s CEO:

The diabetes teaching centres are the concrete result of the fact that the region has made the management of chronic illness a priority. The benefits to patients are enormous. The goal is for diabetic patients to be able to manage their own illness more effectively, understand it and control it better. With these new centres for people with diabetes, Montreal’s healthcare network now offers the same primary care services to everyone on the Island.

After broadening its service offer to respond better to the needs of its diabetes population, the CSSS targeted another chronic disease, cardiovascular illness. Based on its previous success, and because these two diseases are closely related and have the same risk factors, the CSSS decided to expand the range of services offered at the diabetes centre and subsequently renamed it the chronic disease action centre. Once again, the CSSS was a leader in the field and succeeded in influencing five others CSSSs of the region to follow its initiative and expand their diabetes reference centres to include cardiovascular care. The CSSS persuaded the Regional Agency to support this project. Moreover, the CSSS, along with the five others that implemented a chronic disease action

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centre, and working in collaboration with a research team, recently obtained major funding to evaluate this intervention and its impact on population health outcomes.

## 5. Research and practice implications

### 5.1 *Research implications*

This study aimed to better understand how a healthcare organisation in a mature field can be an institutional entrepreneur in a context of mandated reform. Previous studies have focused more on institutional entrepreneurship arising from actors on the fringes or outside an organisational field (Greenwood *et al.*, 2008 Maguire *et al.*, 2004). We analysed the evolution of a central organisation in the field. We used the three stages of institutional change defined by Hinings *et al.* (2004) as a theoretical framework to explore the process of change in which healthcare organisations act as institutional entrepreneurs. In our discussion, we return to these three stage of change and discuss them in light of our results and other work that sheds light on our findings.

Here, the conceptualisation of an innovation was preceded by a change in context. The reform deliberately created pressure for change by formally mandating a shift from a services-based logic to a more population-based logic. This regulatory change stimulated the intellectual climate of ideas (Davis *et al.*, 1994), which disturbed the stability of the field by raising awareness of existing and alternative logics, opening these up to the possibility of change. This shift in logic opened the way to questioning practices that had been taken for granted. However, this mandated change occurred in a context in which the vision of healthcare had been gradually transforming from a more curative care approach towards a broader vision of the continuum of care in a public health logic (population-based). The reform was situated in the broader context of a field already in transition, moving away from existing norms and practices toward the justification of new norms and practices based on vision or pragmatic considerations. The mandated reform accelerated this de-institutionalisation of the field, thereby exposing organisations to different institutional logics and confronting them with new ideas and an awareness of alternative possibilities. Institutional structures do not necessarily constrain agency, but rather, may also serve as the fabric for the development of entrepreneurial activities (Garud *et al.*, 2007).

In the case analysed here, the institutional field was destabilised by the formal introduction of a new population-based responsibility. Fligstein (1997) called this phenomenon a “field in crisis”, in which shocks disrupt the meaning of existing institutions and the stability of the field. This leads to de-institutionalisation, a process in which the legitimacy of an institutionalised practice gradually erodes at the field level. Organisations are likely to engage in criticism of current practices and to search for alternatives. In explaining institutional change, Barley and Tolbert (1997) propose, first, that a critical number of actors must make a collective, conscious choice before they can depart from established patterns of social reproduction, and second, that a larger contextual change, such as this mandated reform, may be necessary before actors make a collective choice. Organisations recognise the need, the opportunities, and the appropriate courses for collective action to change existing institutional arrangements. This new environment creates opportunities for institutional entrepreneurs to introduce innovations, opening the way for creativity. This change at the institutional level corresponds to the environmental jolts described by Hinings *et al.* (2004) in their institutional change model. The case analysed shows that a

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state-mandated reform may provide the opening for innovation by an institutional entrepreneur.

We have presented the case of a healthcare organisation that, by proposing a new service offer based on a network of actors in the community, successfully conceptualised an innovative alternative practice that diverged from established practice. This divergent project proposed by the CSSS was more aligned with the new alternative logics of the field. The CSSS was the first in the field to intentionally design such a project, aligning its vision with its new population-based responsibility. It seized the opportunity created by the mandated reform to position itself as a leader in the field by proposing a project aligned with the new logic. The process of creation involved collective leadership at early stage. The project was led by both clinical and management expertise and involved key actors inside and outside the organisation. This collective leadership helped to legitimise the project and engage allies in the local field. This conclusion is convergent with the findings of Battilana *et al.* (2009), who described the key activities organisations engage in when implementing a divergent change, which include articulating a vision of change and mobilising allies around the vision.

Our observations highlight the crucial need, during the implementation stage, to set in motion collective action with influential actors in the field to gain sufficient legitimacy and resources to make the project a reality. For this, institutional entrepreneurs must be skilled actors (Perkmann and Spicer, 2007). This may even be more important in a mature field. The case presented here illustrates that mobilising change involves three sets of resources:

- (1) organisational;
- (2) financial; and
- (3) political.

The CSSS positioned the innovation as one of its top strategic priorities. The innovation was strongly supported by the organisation's CEO and chairman of the board. The organisation set up a structure to facilitate innovation by formally appointing a director in charge of developing innovations aligned with the new logic. This director's management skill and record of success helped rally key actors to participate in conceptualising and implementing the innovation. Employees at different levels of the organisation and partners in the local field were also involved in its conceptualisation and implementation. Also, by associating their project with a research team, the CSSS successfully seized an opportunity to obtain additional funding from outside the organisation to implement their project. Finally, the Regional Agency's involvement was crucial in conferring legitimacy in the field. These connections in the political arena strengthened the new cognitive and normative pressures and ultimately influenced the behaviour of other organisations in the field. Thus, a key to success is the way in which institutional entrepreneurs connect their change project to the activities and interests of other actors in the field; they have to narrate and theorise change in ways that give other social groups reasons to co-operate (Garud *et al.*, 2007; Greenwood *et al.*, 2002). It is not surprising, therefore, that institutional entrepreneurship is viewed as an intensely political process (Fligstein, 1997; Garud *et al.*, 2002; Seo and Creed, 2002).

Once a particular institutional project has won the political campaign and has been legitimised and ratified, the diffusion phase may best explain the dynamics of de- and

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re-institutionalisation of the field. This step emphasises the snowball effect on actors in the organisation's field. The mimetic movement set in motion contributes to the process of institutionalising the new practice in the field. The adoption of new practices becomes widespread as they become connected to routines and values at the organisational field level. Why, when and how organisations adopt a new practice will depend on their internal dynamics (Hinings *et al.*, 2004). The more organisations adopt the new practices, the more pressure there is on the other actors to adopt them as well. Tolbert and Zucker (1983) hypothesise that the first organisations to adopt a new practice are motivated by rational decisions, whereas organisations that adopt the practice later are more motivated by gaining social legitimacy. We suggest that the last organisations to adopt the practice do so when it has become increasingly difficult to resist the collective feedback mechanism. In Dorado's (2005) view, the late-adopters of the new institutionalised practices are also acting as institutional entrepreneurs, in that they are opposing and resisting a dominant model of the field.

In summary, both the institutional entrepreneur's role and environmental pressures are modified during the process of change. The emergence and implementation phases emphasise strategic agency, while the diffusion phase has more to do with environmental pressures that shape the structure and action of organisational actors. Institutional entrepreneurs play an active role not only in designing the innovation, but also in the implementation process. This study highlighted an important contrast between institutional entrepreneurship as an individual phenomenon at the organisation level versus the wider collective phenomenon. Our results showed that, while the leadership was more individual at the conceptualisation phase, it rapidly evolved into collective action through relations with other organisations in the field and particularly with actors in high-status positions. Many studies are still required to understand better the mechanisms at work in the process of implementing change in highly institutionalised contexts. Such studies will provide opportunities to identify more clearly the roles of institutional entrepreneurs in this change process, particularly in terms of proactive communication, negotiation and persuasion.

### *5.2 Practice implications*

In describing the detailed implementation of a new practice put forward by a healthcare organisation in the context of a mandated reform, this article illustrates strategic actions that managers may undertake to influence the course of events. Organisations can take advantage of instability in the field and seize opportunities for local action. To realise these actions, they have to clearly demonstrate the need for an innovation in the field in order to establish legitimacy for the project, particularly among clinicians. This insight related to practice is congruent with the literature on change in professional organisations, which emphasises the important role of professionals in implementing change (Lamothe, 2007; McNulty and Ferlie, 2004; Buchanan *et al.*, 2008; Sylvain and Lamothe, 2012). Also, organisations need managers with leadership skills and good knowledge of the power dynamics at play in order to rally different allies, especially those with high status in the field. Managers need to create a dynamic of change by mobilising a network of actors who will be actively involved in the process. This underscores the need for managers to "orchestrate" the change process (May *et al.*, 2007). The leaders of the innovation must represent the diversity of actors in the field.



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The organisation's managers need to attend to the innovation's sequential development through the stages of emergence, implementation and diffusion. During the innovation's development, by articulating a vision, communicating proactively at the local field, negotiating resources and persuading and mobilising allies, they actively influence and generate pressures that shape other actors' behaviour in the field at each stage. According to Oliver (1991), managers in organisations may act as leaders by using more active strategies to participate in the field's evolution. To successfully institutionalise the practice in the field and to be recognised as an institutional entrepreneur, an organisation needs support from other actors in the field, and its managers must play a central role by mobilising, organising and coordinating a large network of allies.

Also, the article presents practical implication for policy-makers, those who think and introduce reforms in health systems. The results show that a mandated reform destabilises the field and creates opportunities for change. There might be a practical implication to conduct reforms that are less prescriptive and top-down in nature. Mandated reforms should change the vision and initiate a change in mindsets and let the actors in the field define practical implications. Thus, all level of decision-making (including clinicians) become involved in the definition and development of the change. Policy-makers had to define the orientation of change and support entrepreneurs who emerge.

In summary, this case study offers lessons for both managers and policy-makers. This study suggests that aspiring institutional entrepreneurs need specific skills and resources. Their positions must have broad legitimacy to attract allies. They must have the ability to promote the innovation as a top priority for action among disparate actors and to create coalitions. Finally, they must have in-depth understanding of field's key actors in order to gain the support of a wide array of actors across the field.

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