ISCTE Business School

Accounting Department

An institutional perspective of hospital accreditation:

A case study in a Portuguese hospital

Célia Maria Rodrigues da Cova Gomes Picoito

Thesis specially presented for the fulfillment of the degree of

Doctor in Management - Accounting

Supervisor:

PhD. Maria João Martins Ferreira Major, Professora Catedrática

ISCTE – IUL

Co-supervisor:

PhD. Luis Manuel Dias Martins, Assistant Professor

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Jury:

President: Helena Oliveira Isidro, Professora Catedrática - ISCTE-IUL

Members:

Paulo Sérgio Lima Pereira Afonso, Professor Auxiliar, Escola de Engenharia – Universidade do Minho;

Ana Cristina Mendes da Conceição, Capitão-Tenente de Administração Naval – Escola Naval

Ana Maria Dias Simões da Costa Ferreira, Professora Auxiliar, ISCTE-IUL

Maria João Martins Ferreira Major (supervisor), Professora Catedrática - ISCTE-IUL

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ABSTRACT

This thesis investigated the introduction of the new "bureaucratic-quality" logic in the health sector, where already two dominant logics existed: professional logic and business-like logic (since 2002). This new logic was introduced in the health field, in the beginning of 21st century, through hospital accreditation programs, as a result of a major societal movement that affected public administration – New Public Management. A qualitative approach based on a case study was chosen, as the research questions were according to this method. An interpretative perspective based on institutional theory was used to analyse the dynamics between the various levels: societal, field, organizational and individual. Throughout the study two actors were identified and studied regarding the institutional work they attempted in this process. This investigation demonstrated that the introduction of this new logic at the hospital generated minimal or no conflict. This is explained by the fact that (1) this new logic presented compatible, even intrinsic, goals with the two existing logics, (2) the hospital had unique characteristics that increased the compatibility between these logics, and (3) this new logic preserved the identity of physicians as accreditation programs do not interfere with clinical acts. Notwithstanding, the researcher points out that even with compatible logics, if physicians' identity had not been preserved, there would have been resistance to the introduction of the new logic. By choosing a cross-sectional analysis to study the process of introducing a new logic, the researcher responds to the numerous calls for investigation of cross-sectional analysis in institutional theory.

Key words:

Hospital accreditation, Institutional work, Institutional logics**,** New Public Management; Quality

JEL Classification:

M 41 Accounting

M 49 Other

RESUMO

Esta tese investigou a introdução de uma nova lógica "qualidade burocrática" (associada aos programas de acreditação hospitalar) no sector da saúde, que apresentava já duas lógicas dominantes: a lógica profissional e a lógica empresarial. Esta nova lógica foi introduzida no sector da saúde por via dos processos de acreditação hospitalar, como resultado de um movimento societal que afectou a administração pública – New Public Management. Foi escolhida uma abordagem qualitativa realizada através de um estudo de caso, uma vez que as questões de investigação se adequavam a esse método. Foi utilizada uma perspetiva interpretativa com o intuito de analisar as dinâmicas entre os diversos níveis societal, sectorial, organizacional e individual. Ao longo do estudo foram identificados e estudados dois actores tendo por base o trabalho institucional que intentaram neste processo. Esta investigação demonstrou que a introdução da nova lógica no hospital gerou conflito mínimo ou inexistente. Isso deveu-se ao facto de (1) esta nova lógica apresentar objectivos que eram compatíveis, ou mesmo intrínsecos, às duas lógicas existentes, (2) o hospital apresentar características únicas que aumentaram a compatibilidade entre essas lógicas e (3) esta nova lógica preservar a identidade dos médicos uma vez que os programas de acreditação não interferem com actos clínicos. Não obstante, a investigadora salienta que mesmo no caso de lógicas compatíveis, se a identidade dos médicos não tivesse sido preservada teria existido resistência à introdução da nova lógica. Ao escolher estudar este processo de introdução de uma nova lógica através de uma análise transversal, a investigadora responde às inúmeras solicitações de investigação de análises transversais na teoria institucional.

Palavras-chave:

Acreditação hospitalar, Trabalho institucional, Lógicas institucionais**,** New Public Management; Qualidade

JEL Classification:

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ABBREVIATIONS

ACSA	Agencia de Calidad Sanitaria de Andalucía
ACSS	Health System Central Administration
ADSE	Illness assistance for State Workers
ALPHA	Agenda for Leadership in Programs for Healthcare Accreditation
ANAES	National Agency for Accreditation and Evaluation in the Health Sector
ARS-LVT	Health Administration Regions - Lisboa and Tejo valley
CAC	Clinical Administration Committee
CAMQ	Accreditation and Quality Improvement Commission
CHKS	Caspe Healthcare Knowledge Systems
CHS	Setúbal's Hospital Centre
CJEU	Court of Justice of the European Union
CRES	Health Reflection Council
DGS	Directorate-General for Health
DL	Decree-Law
DRG	Diagnosis-related groups
DTT	Diagnostic and Therapeutic Technicians
DUQuE	Deepening our understanding of quality improvement in Europe
EA	European co-operation for Accreditation
EFQM	European Foundation for Quality Management
ENSP	Public Health National School
EPE	Business public entity
EQUIP	European Society for Quality and Safety in Family Practice
ERDF	European Regional Development Fund
ERS	Health Regulator Entity
ESF	European Social Fund
EU	European Union
EURO	WHO European Regional Office
EUROPEP	Questionnaire for patient's evaluation of general practice care
ExAC	ex ante conditionalities
ExPeRT	External Peer Review Techniques
GDP	Gross Domestic Product
HCO	Health Care Organization
HCQI	Health Care Quality Indicators
HOSO	Sant'iago do Outão's Orthopedic Hospital
HQPS	Health Quality Portuguese System
HSB	S.Bernardo's Hospital
HSPA	Health Systems Performance Assessments
IAQH	Hospital Quality Assessment Survey
IGIF	Health Informatics and Financial Management Institute
INEM	National Institute of Medical Emergency

INFARMED	National Authority of Medicines and Health Products, I.P.
IOM	Institute of Medicine
IQS	Health Quality Institute
ISO	International Organization for Standardization
ISQUA	International Society for Quality in Health Care
JCAHO	Joint Commission on the Accreditation of Hospitals Organization
JCI	Joint Commission International
KFHQS	King's Fund Health Quality Service
MARQuIS	Methods of Assessing Response to Quality Improvement Strategies
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NOC	Clinical guidance standard
NPM	New Public Management
OECD	Organisation for Economic Co-operation and Development
OPSS	Portuguese Observatory of Health Systems
PIDDAC	Central Administration Development Investment and Expenditure Program
PNAH	Hospital's National Accreditation Program
PPP	Public-Private Partnerships
PRACE	Restructuring Program of the Central State Administration
PT-ACS	Health Care Association for Portugal Telecom workers
QCA	Community Support Framework
RDP	Regional Development Programs
SA	Anonymous Society
SAMS	Medical and Social Assistance Services
SIMPatIE	Safety Improvements for Patients in Europe
SPA	Administrative Public Sector
TQC	Total Quality Control
TQM	Total Quality Management
WHO	World Health Organization
WONCA	World Organization of Family Doctors

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“Not everything that can be counted counts and not everything that counts can be counted”

Einstein

CHAPTER I – INTRODUCTION

1.1. Gaps in literature and purpose of the study

During 20th century, the health care field was dominated by the medical profession and "*nurses and pharmacists deferred to physicians*" (Besharov & Smith, 2014: 368). Consequently, the professional logic dominated the health field. Nevertheless, in the 80's, a societal movement known as New Public Management (NPM) emerged in Europe. It was the natural response to the failure of the social state that could not respond to the 1970's oil crisis, which exposed social state's fragilities, weight and bureaucracy. NPM defended less state, a regulator state. According to Meyer & Hammerschmid (2006), under the scope of NPM, the public sector was the target of a major public management reform. The legitimacy of public sector activities became to be judged on the basis of outputs, outcomes and efficiency contrariwise the adherence to bureaucratic rules that were the respected public administration focus until then (*ibid)*. Scott *et al*. describe these transformations as "*the ascendance of corporate forms and intrusion of managerial logics into even more arenas of social life*" (2000: 27). The Portuguese Observatory of Health Systems (OPSS) considered that "*the effect of NPM in our country [Portugal] is related to the relaunch of a hospital management reform program, under the responsibility of the state for the provision of health care established by the Constitution, which resulted in several innovative management experiences*" (2009: 86). In Portugal, these transformations were felt in health sector since 2002 when hospitals from the public administrative sector (SPA) were transformed in anonymous societies (SA). The aim was to change the management model without changing state responsibility for health care, which was a Constitutional imposition. This represented the introduction of a new management model, similar to corporate models. The need to achieve higher quality on health care and to enhance hospital's efficiency became a reality. As Donabedian endorsed, quality was something that was appreciated but it was not measured until the 1980's, when it turned into the opposite direction (Donabedian, 1988). Indeed, the benchmarking of hospital's performance raised the question of delivering high-quality care services and put on the agenda the question of quality in health services. Accreditation programs for hospitals started to disseminate and brought an associated logic: the "bureaucratic-quality" logic (Cf. Thornton *et al*., 2012).

In this study the main objective is to understand how a new institutional logic ("bureaucratic-quality"), that is inherent to a hospital accreditation program, emerged and developed in the Portuguese health care field, and how it co-existed with the pre-existent logics in the hospital studied. Institutional logics *"provide building blocks for focusing attention through the set of social identities, goals and schemas that are part of each logic"* (Thornton *et al.*, 2012: 91). For Hampel *et al.* (2017: 564) institutional logics "*are frames of reference through which actors make sense of the world, construct their identities and interact with the world around them*". Therefore, the researcher adopted an interpretative perspective based on Thornton *et al*.'s (2012) metatheory – Institutional logics Perspective. This perspective understands society as "*an interinstitutional system*" (*ibid*: 18) and assumes that institutions "*operate at multiple levels of analysis with potential for cross-level interaction effects*" (*ibid*: 14). In order to understand the dynamics between societal, field, organizational and individual levels the investigator incurred in a multilevel analysis which allowed her to understand the cross-level effects and the causal mechanisms, leading to more precise theory (Thornton *et al*., 2012). By doing this the researcher fills a gap on multiple logics studies in organizations. Most are one-level, neglecting that studying institutional logics presupposes cross-level analysis of relations between levels - individual, organizational and institutional (Thornton & Ocasio, 2008).

To accomplish the cross-level analyses the researcher investigated how environmental pressures at societal level introduced the NPM movement in Portuguese Public Administration in late 1980's (although business logic just entered in hospitals in 2002) and how the business-logic (that is inherent in this movement) entered smoothly in the health care field and led to the emergence of health quality concerns. According to Thornton *et al.* (2012) changes in field-level institutional logics may be transformational, when there is a radical change in symbolic representations and practices, or developmental, when most prevailing practices and symbolic representations remain while others change. In this field-level logic change the researcher identified a developmental change by assimilation, where "*the core elements of the original logics prevail, with the new practices and symbols made part of the prevalent logic*" (*ibid*: 165). The authors call for further theoretical elaboration on the difference between blending and assimilation. This study also contributes to this gap by demonstrating at multiple levels that it is a change by assimilation.

Following a top-down approach on field-levels, the researcher carried out a meso to micro cross-level analysis with the aim to understand why and how the new logic was

introduced in the hospital studied. When analyzing the dynamics between the Portuguese health sector (field-level) and the hospital studied (organizational- level) with the aim to explain the reasons and the way this new logic was introduced in the hospital, the researcher faced the necessity to introduce the institutional work theory (Lawrence & Suddaby, 2006) to frame the work entailed by the President of the board of directors and Dr. P, a physiatrist. This duo revealed to be crucial for the success of this process.

Thornton *et al.* (2012: 179) recognize that, "*while it is difficult to focus on field macro dynamics and individual dispositions and behavior within one scholarly paper"* they encourage *"cross-level research on individuals and practice to strive towards a more holistic understanding of social action*". Institutional work theory puts the spotlight on actors and on the role they play and the efforts they make to interact and influence institutions (Hampel *et al*., 2017). Lawrence & Suddaby defined institutional work as "*the purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions*" (2006: 215). By emphasizing the "*embeddedness of individuals in society and institutional fields*" through a theoretical architecture, this study also contributes to make knowledge more "visible" (Thornton *et al., 2012:* 180) and also contributes to the collective knowledge and understanding on field macrodynamics and enhances the research on institutional logics (*ibid*).

The last cross-level dynamics analysis - micro to individual level - was taken in order to study the dynamics associated with the introduction of the new logic at the intra-organizational level – studying the dynamics within the individuals and between individuals and the organization (hospital). In this analysis the researcher highlights the special features of the hospital studied and how those characteristics may have acted as an enabler factor for group cohesion and close relationships in the organization. When analyzing how this new logic interacted with the existing logics in the field, the researcher addresses logics multiplicity theory with the aim to understand if there was a conflict, hybridization or if another factor explains how logics interacted with each other (Besharov & Smith, 2009; Thornton *et al.*, 2012).

According to Besharov & Smith (2014) close relationships create motivation to face multiple logics in more compatible ways, even when logics may continue to be incompatible at the field level. It was also identified the importance of professional's identity preservation (mainly physicians) as a factor that may constrain or enable the introduction of a new logic

(cf. Reay & Hinings, 2009; Hoffman & Ocasio, 2001). This analysis contributes to literature on this issue, which is not consensual (Battilana & Dorado, 2010; Zilber, 2002; Mars & Lounsbury, 2009; Pache & Santos, 2010).

This study allows a connection between the intra-organizational and institutional levels of analysis by studying not only logic plurality within an organization, but also the organizational factors that can influence actor's reactions towards the tensions that the introduction of a new logic may originate (cf. Battilana & Dorado, 2010; Reay & Hinings, 2009). By taking a cross level analysis the researcher is able to analyze how institutions both enable and constrain action (Thornton *et al*., 2012); and by bridging these different levels of analysis the study responds to the numerous calls for cross-level research in institutional theory (Thornton *et al*., 2012; Powell & Colyvas, 2008).

This study also addresses a gap in the literature concerning the coexistence of multiple logics in organizations. Most of the existing studies expose coexistence of multiple logics in organizations as incompatible and emphasize the replacement of one logic by another (Greenwood *et al*., 2001; Thornton & Ocasio, 1999). Despite this dominant discourse more recent research emphasized blending, segregation and hybridization of logics (Besharov & Smith, 2014; Pache & Santos, 2010; Marquis & Lounsbury, 2007; Meyer & Hammerschmid, 2006; Reay & Hinings, 2005; Thornton *et al*., 2005) and long-term co-existence of multiple logics (Besharov & Smith, 2014; Thornton *et al.*, 2012; Reay & Hinings, 2009). As the reality observed did not indicate conflicts, the researcher aimed to contribute to a non-mainstream explanation.

Appendixes I and II (A3 format) present a global vison of theory used and all the levels studied and their cross-level interaction.

1.2. Research methods and methodology

This investigation aims to understand how the logic inherent to an accreditation program in a hospital related with the logics pre-existent in the organization. To accomplish this objective the researcher proposed two main research questions:

1. How a new institutional logic ("bureaucratic-quality") emerged and developed in the Portuguese public sector of health care?

2. Why and how was the new logic introduced in HOSO and what were the dynamics associated with the introduction of the new logic at the intra-organizational level?

Considering this main objective, the researcher followed a qualitative research design as Reay & Jones consider that qualitative methods "*hold great promise for investigating institutional logics*" (2016: 441). Qualitative research enables the knowledge of a particular phenomenon moving away from the goal of finding the general picture or the average (Mason, 2002). Research questions are the heart of qualitative research design and they should lead to an interactive process of research (Gaudet & Robert, 2018). Question words are extremely important in qualitative research questions and in the research design, and they usually are a 'how' question (ibid). "How" questions enable rich understandings and explanations. They also enable the understanding of social processes. Given the nature of the research questions, "how" and "why" questions, the researcher developed a case study as a research method. Case studies contribute to knowledge of individual, organizational, social and political phenomena, allowing the researcher to investigate the holistic and meaningful characteristics of real-live happenings (Yin, 2018). This case study is both explanatory and exploratory (Yin, 2018; Ryan *et al*., 2002). Explanatory because it tests explanations for why specific events have occurred drawing on institutional logics and institutional work perspectives. Exploratory because it aims to generate theoretical developments for the prevailing theory based on the specific practices observed.

The researcher followed Ryan *et al*. (2002) and Yin's (2018) steps to conduct this case study and they are: (1) developing a research design; (2) preparation; (3) collecting evidence; (4) assessing evidence; (5) identifying and explaining patterns and (6) thesis writing. With the aim to validate and triangulate data collected, the researcher relied on diversified sources of evidence: documentation, archival records, interviews and direct observations (Yin, 2018). Documentation and archival records were an extremely important and relevant source of evidence as this study dates back to the early 21st century.

As this study is a cross-level dynamic investigation, the researcher had to contact and gather evidence from sources other than just the hospital: a former Minister of Health (1999/2002), two presidents of the Health Quality Institute in the period of 2000/2006, the

English auditor from Caspe Healthcare Knowledge Systems (CHKS)[1], who is in charge now of HOSO's re-accreditation (the auditor who accompanied HOSO's accreditation program's implementation retired), the director of quality department in DGS in 2018, the coordinator of accreditation health model for NHS in 2018 and several other professionals retired (but who exerted functions at the moment of the implementation of the accreditation program in HOSO). Interview process was conducted in two parts: the pilot study and the main study. In the total of both studies, 32 interviews were conducted, totalizing 55.5 hours.

The researcher employed the pattern inductive technique to study institutional logics, which consists on "*the identification or capturing of logics based on ground-level data and a process of upward theory building*" (Reay & Jones, 2016). In order to ensure rigor and allow for the creation of reality-adjusted interpretations and present credible and defensible conclusions, the researcher used a Gioia model (Gioia, 2012) thesis and, in addition, ensured methodological consistency, theoretical sampling and adequacy of sampling as Morse *et al.* (2002) advocate.

1.3. Thesis organization

The remainder of this thesis is structured as follows: the next chapter, Chapter II, presents a literature review. It begins with institutional work theory, addresses institutional logics perspective (Thornton *et al.*, 2012); both have served as an inspiration and a theoretical framework tool for writing this study. Next it is presented an approach to the problem of institutional complexity and organization's responses to multiple institutional logics, highlighting the role of collaboration as a facilitator. After this, the theme of identity is presented as institutional theorists recognize that it plays a crucial role in institutional change process (Marquis & Lounsbury, 2007); the last section addresses the subject of the new public management (NPM) movement and its implications on public administration logics, mainly in hospitals.

In Chapter III, the methodology embraced by the researcher in this qualitative investigation is discussed. It begins by explaining the reasons to follow a qualitative research design and the choice of a case study as a method. Then it is explained the reason to use a pattern inductive technique to study institutional logics. After that, the steps taken on this

[1] The new designation for King's Fund company that provides hospital's benchmarking services and international accreditation programs

study are described. Next, the methods used are presented and the chapter ends with testing the quality of conclusions.

Chapter IV presents the evolution of quality concept in "lato sensu". The theme of quality related to health care is addressed and focus on the evolution of the concept of quality through time, presenting the Donabedian model, explaining the developments at societal level and how it influences the Europeanization of health policy. Then the transformations at field level generated by societal developments are addressed and the chapter continues with the theme of accreditation in health care. The last section is dedicated to the particular case of Portugal. The history and development of national health care system is analyzed. Then it is presented the evolution of NHS, since 1976, framed by the political cycles, which are influenced by societal pressures and influence health sector, justifying the use of cross level analysis (Thornton *et al*., 2012).

Chapter V presents the case study in the hospital. Firstly, the hospital is presented and, afterwards, the researcher enters in the King's Fund accreditation program. The implementation in HOSO is then approached regarding the beginning of the works, the accreditation manual, the mitigation of resistances and the first audit. Then evidences of the process are presented and the chapter ends with the accreditation process nowadays.

In Chapter VI, the researcher discusses the findings from the interviews, direct observations and documents that present a dynamic cross-level analysis. This chapter is divided in five main parts: the first part addresses the theme of cross-level dynamics. Then the researcher introduces the two main logics that were already coexisting in the hospital. The emergence of health quality concern is then discussed. After that there is a discussion on the institutional work observed and studied in the implementation of this accreditation program. The chapter finalizes presenting Institutional logics perspective to frame that implementation. It is analyzed if a change occurred in hospital's institutional logics and also the compatibility between logics.

The thesis is then brought to a close in Chapter VII, with the study's conclusions and theoretical and practical contributions, while additionally addressing the primary limitations of the study and suggestions for future research.

CHAPTER II - LITERATURE REVIEW

INSTITUTIONAL WORK THEORY, INSTITUTIONAL LOGICS PERSPECTIVE, IDENTITIES AND THE NEW PUBLIC MANAGEMENT MOVEMENT

This chapter aims to introduce the theoretical framework of this thesis.

In the first two sections it is provided an overview on institutional work theory and on institutional logics perspective. The next section addresses the problem of institutional complexity and organization's responses to conflicting institutional logics. The fourth section introduces the theme of identities in the modern world and the last section addresses the subject of the new public management (NPM) movement and its implications on public administration logics, mainly in hospitals.

2.1 Institutional Work Theory

Lawrence & Suddaby (2006) rooted their study on DiMaggio's (1988) and Oliver's (1991; 1992) research and began a new direction in institutional research: institutional work. They defined institutional work as *"the purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions*" (Lawrence & Suddaby, 2006: 215). Hampel *et al*. (2017) considered that institutional work differs from other Institutional approaches because it puts the spotlight on actors and the role they play and their efforts to interact and influence institutions.

The study of institutional work is funded in two key concepts: embedded agency and the idea of "practice".

The idea of embedded agency has become part of institutions' research. Nevertheless, for institutional work this idea is at the heart of this perspective and it is rooted on DiMaggio (1988) and Oliver's (1991) primary work that drew attention to the important role agency played on the relationships between institutions and organizations. Research on this area explored the results of actor's actions. Lawrence & Suddaby (2006) defend that from institutional work lens, institutions provide meaning and motivation to human actions, enabling the material and symbolic structures that lead to the beginning and to the definition of those actions, shaping every human facet. However, institutions are simultaneously, human creations that are maintained by people's willing, thoughts and behavior, most times in thoughtless and unintended ways but with the same frequency which demonstrates the institutional consciousness of people and their desires "*to affect institutional arrangements and the necessary skills and resources they marshal to achieve those desires*" (Hampel *et al*., 2017: 559). Ashforth & Mael (1989) argued that individual agency can have two interpretations: can be interpreted as the pursuit of self–interest and the satisfaction of individual needs; or it can be guided by individual's identity and identification, on the premise that such identification is a result of the "*perception of oneness with a group*" (*ibid*: 35). In congruence with this position, the understanding of agency offered by Abdelnour *et al*. (2017) embraces the idea that agency is exercised by actors in social stage, not by individuals. This position is generated in the idea that individuals as sole, rarely turn into social actor, contrariwise, "*individuals take part in social life as actors by assuming roles and the positions to which roles are usually tied*" and agency is the capacity of those social actors tied to those roles and social positions (Abdelnour *et al*., 2017: 19).

The idea of "practice" in social sciences highlights the work of actors, representing "*embodied, materially mediated arrays of human activity centrally organized around shared practical understanding*" (Schatzki *et al*., 2005:11). Hampel *et al*., believe that this extreme view brings the possibility for "*fantastic theoretical clarity*" (2017:560). Institutional work relies on the idea of practice as the inter-relationship between peoples' efforts (may they be intentional or not) and the institutions where those efforts are applied. It calls also attention to the practices that underlie the patterns, shifting the focus from the field-level pattern. By doing this, a new research avenue is opened to institutional and practice scholars that can benefit from the two approaches (Hampel *et al.*, 2017). The authors consider that institutional work evolved from a concept to a perspective. The aim in the beginning was to capture actions that institutional research described but now, institutional work focus relies on understanding the relationship between institutions and actors, mainly answering the questions how, why and when actors shape institutions, what factors can affect their ability to do so, and how people involved experience these efforts. When asking those three questions researchers must take into account that social reality is socially constructed, mutable and depends on the actions, thoughts and feelings of people and collective actors that act in ways that involve consciousness of their relation to institutions (*ibid*). Hampel *et al.*'s study concluded that institutional work focus on "middle-range" institutions (what), on actors that work alone or cooperate with similar partners (who) and gives prominence to symbolic and discursive strategies, as narratives and discourse (how). They also concluded that some topics and issues as legitimacy, emotions, identity, discourse, community, power and institutional logics, have been related to institutional work through the last decade.

Lawrence & Suddaby (2006) considered nine forms of institutional work associated with creating institutions (cf. Table 2.1.) that have been used "*as a framework for empirical examination of the relation between purposeful human action and institutions"* (Svensson *et al*., 2017: 4). Advocacy, defining and vesting are forms of institutional work that reflect the political work done by actors which (re)create rules, property rights and boundaries defining access to material resources. Constructing identities, changing normative associations and constructing normative networks are the second type of institutional work that concerns actions that reconfigure actor's belief systems. The last group of forms of institutional work used to create institutions considers mimicry, theorizing and educating and it regards the change in abstract categorizations

Advocacy, defining and vesting reflect political work and they focus on rules. These rule-based works depend on the ability of an actor to enforce compliance. In terms of creating institutions these forms have greater potential than the others and they refer to the regulative pillar of institutions but they presuppose actors with political skills (Lawrence & Suddaby, 2006). According to Campbell (2004) these skills are particularly concentrated in actors that are used to link groups with different interests such as politicians, trade unions, lobbyists, industry associations and advocacy organizations. Vesting and defining can easily and rapidly lead to the institutionalization of practices, rules and technologies.

Table 2.1: Forms of institutional work used for creating institutions

	Forms of institutional work	Definition
Political Work	*Advocacy*	The mobilization of political and regulatory support through direct and deliberate techniques of social suasion
	Defining	The construction of rule systems that confer status or identity, define boundaries of membership or create status hierarchies within a field
	Vesting	The creation of rule structures that confer property rights
Actions to alter abstract categorizations	*Mimicry*	Associating new practices with existing sets of taken-for-granted practices, technologies and rules in order to ease adoption
	Theorizing	The development and specification of abstract categories and the elaboration of chains of cause and effect
	Educating	The educating of actors in skills and knowledge necessary to support the new institution
Actor's belief systems are reconfigured	*Constructing Identities*	Defining the relationship between an actor and the field in which that actor operates
	Changing normative associations	Re-making the connections between sets of practices and the moral and cultural foundations for those practices
	Constructing normative networks	Constructing of interorganizational connections through which practices become normatively sanctioned and which form the relevant peer group with respect to compliance, monitoring and evaluation

Source: Adapted from Lawrence & Suddaby (2006: 221)

Advocacy relies on the mobilization of political support and, as a consequence, regulatory support through lobbying for resources, promotion of agendas and modifying legislation. The main objective of this institutional work is to create new institutional

structures and practices. Advocacy offers marginal actors the opportunity to acquire the legitimacy they aspire to create new institutions. Defining is related to the activity carried out by actors in order to construct rule systems. These rule systems will confer status or identity; define boundaries of membership or status hierarchies in fields. Accreditation processes, standards creation and certification processes are examples of Defining work. Defining work has no prohibitive nature; it is directed to the establishment of future parameters or institutional structures and practices. Accreditation processes engage actors in processes that (re)define boundaries and frameworks, creating new institutions. Vesting has the objective of creating rules structures that confer property rights. By changing the rules of market relations, the state creates conditions for the emergence of new actors and new field dynamics. Although the state has a major role in this type of institutional work, it is not the only actor with coercive or regulatory power. This political institutional work provides the social basis on which institutions are constructed but the models of how institutions function require technical work that can be pursue by mimicry, theorizing and educating (Perkmann & Spicer, 2008).

These forms of institutional work, connected to creation of institutions, focus on institution's cognitive side (beliefs, assumptions and frames – that provide meaningful and understandable interaction patterns to follow). Lawrence & Suddaby (2006) believe that creating institutions by changing abstract categories of meaning presupposes the involvement of powerful actors on the field but also can be an enormous opportunity for entrepreneurs that are less powerful actors. This work involves the association of new practices with existing institutions. Mimicry holds on existing practices, technologies and rules and articulates them in order to legitimate new ones. Scott (1995) explained that the idea beneath mimicry was that legitimated ideas were the ones that were adopted by exemplary ones and were thought to achieve economic benefits. Greenwood *et al*. (2002: 60) describe theorizing as "*the development and specification of abstract categories and the elaboration of chains of cause and effect*". For these authors theorizing is important because it is connected to the "*conferring of legitimacy*" (*ibid:* 61) and it is especially important in mature or highly structured settings (as highly professional settings) where boundaries and templates of appropriated organizational forms are defined. Lawrence & Suddaby (2006) highlight an important issue on theorizing: the naming. It is essential to name the new concepts and practices for them to become part of the "*cognitive map of the field*" (*ibid*: 226). Naming is crucial for latter theorizing. Kitchener (2002) describes how naming and theorizing can

impact an entire sector. The narrative component of theorizing might be done by several actors. Finally, it is necessary to educate actors in skills and knowledge essentials to support the new institution. Lawrence & Suddaby (2006) augment that while mimicry can provide means for new entrants, theorizing and educating are associated with powerful actors in field – the ones that possesses resources and legitimacy to educate relevant actors to organization, to demonstrate the cause-effect relations and give surrounding actors templates for action. Perkmann & Spicer (2008:8) indicate actors like "*social scientists, consultants, academics*", among professionals with technical, technocrat or expert competences to overcome this type of institutional work. This technical work attributes rigor to institutions but it is not effective on creating a relation between actors and institutions (Perkmann & Spicer, 2008).

This [relation between actors and institutions] can be achieved by the last three forms of institutional work: constructing identities, changing normative associations and constructing normative networks, related to the normative structure of institutions. These forms of institutional work perform changes in norms and belief systems. This normative work relies on cultural and moral force that is incorporated in communities of practice which implies the co-operation of those communities to bring to reality the intended new institutions. The construction of identities in institutional work started with the development of professions, and it became a central form of institutional work when studying the creation of institutions because it enhances the relation between the actor and the field in which he operates. Changing normative associations is another form of institutional work that creates institutions. This work has to do with the refresh of the connections between practices in use and its foundations (moral and cultural). The construction of normative networks_refers specifically to the creation of peer groups that provide basis for new institutions, lending an institution some cultural or moral force. This depends on actor's ability to establish and maintain co-operative ties. This type of institutional work requires cultural skills that are concentrated in specific groups that have influence on public opinion and perceptions, like journalists, social movements, public relations experts, advertising agencies and intellectuals (Campbell, 2004).

2.1.1. Discourse Analysis

Suddaby & Greenwood (2005) argue that changes in organizations need to be legitimized, and legitimacy implies the establishment of new legitimacy criteria. These authors believe that this is primarily achieved by the rhetoric used. According to Lawrence & Suddaby (2006), rhetoric is one form of organizational discourse, among other two: dialogue and narrative.

Therefore, discourse analysis is considered a source extremely important to the dynamics of institutional work because it offers an additional "*set of lenses for institutional scholars to try on in order to more clearly see and describe the dynamics of institutional work*" (Lawrence & Suddaby, 2006: 246). Discourse analysis refers to multiple methods and approaches when analyzing an organization that may have on "organizational discourse" its focus. Grant *et al*. (2004: 3) defined organizational discourse as "*structured collections of texts embodied in the practices of talking and writing (as well as a wide variety of visual representations and cultural artifacts) that bring organizationally related objects into being as these texts are produced, disseminated and consumed*". The authors also state that the discursive practices and the perception of reality (of what they believe to be) shape and influence the attitudes and behaviors of all organization members (*ibid*).

Dialogue (and conversation) has been defined as a "*set of interactions that are produced as part of the talk or message exchange between two or more people*" (Grant *et al*, 2004: 5). Studies on dialogue show that it leads to understanding; it also creates opportunities to critique and question, and conditions that can achieve convergence of different point of views. Hardy *et al*. (2003) considered that any change (may it be environmental, political or organizational) is a discursive object that can be re-used by other actors on broader discourses. For Lawrence & Suddaby (2006: 241) generative dialogue is a "*potentially powerful form of institutional work, creating mechanisms of social control and associating them with sets of interaction sequences to effect institutions*". Dialogue's distinguishing characteristic from other forms of discourse is the fact that it depends, and it is created, by multiple actors. Grant *et al.* (2004) mention an important aspect on the conversation forms used to initiate an organizational change. According to these authors, those forms identify the need for change, may it be an environmental turn, an organizational issue or a political agenda. Once that discourse is produced it becomes available to actors to use it to support or extend it.

Narrative is a particular form of discourse that is characterized by its structure: it presupposes a chain of temporal events that were undertaken by characters (Lawrence & Suddaby, 2006). They are part of the process of sense making in organizations (Grant *et al*., 2004). This process of sense making is defined by Maitilis & Christianson (2014) as "*the process through which individuals work to understand novel, unexpected, or confusing events*" (p: 58). Narratives can be used by actors to create, maintain or disrupt institutions, using persuasive or compelling stories. Czarniawska (2000) brought to discussion the "petrification" of narratives that, seen as the support of institutions, must be stabilized. These static narratives are a result of intense stabilizing work done by narrators. Kitchener's (2002) when studying changes that occurred in health care collided with similar narratives from different actors (popular business press, academic textbook writers and consultants) pointing merger as the solution for competitiveness and efficiency problems. Narrative analysis helps to understand and demystify the narrative strategies and objectives used by institutional actors when they are working on the creation of a new institution and on the connections with existing ones.

Lawrence & Suddaby (2006) consider rhetoric an important form of discourse that "*is distinguished by a very specific focus on suasion and influence*" (Suddaby & Greenwood, 2005:239). According to Mueller *et al*. (2003: 87) "*rhetorical strategy is a way of giving expression to an underlying interpretive scheme, while taking account of the situational context, as well as opposing views*". Mueller *et al*. (2003) studied in which forms the principles of the New Public Management were invoked in interactions, conversations, and argumentations in a professional health organization. The authors identified three rhetorical strategies: the argument that work arrangements in the hospital had to be compared with other hospitals in the country; the argument that questions of finance needed to be discussed on a broader political context; the argument that finance issues needed to be analyzed in a broader debate. Suddaby & Greenwood (2005) argue that changes in organizations need to be legitimized, and legitimacy implies the establishment of new legitimacy criteria. Authors believe that this is primarily achieved by the rhetoric used.

2.1.2. Institutional work theory focus

The main objective of institutional work has been field characteristics, rooted in DiMaggio & Powell's (1983) institutional theory. Field concept is not consensual. DiMaggio (1991) defined field as a group of organizations that constitutes a specific and recognized area of institution's arena. Scott (1995:56) defined 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 the field*". Hampel *et al*. (2017) believe that field actors are challenged both internally and externally. In an internal level, they need to decide the roles, practices and logics to apply in order to achieve the agreements they need to concretize the internal arrangements on the field (Jones & Massa, 2013; Zietsma & McKnight, 2009). In what concerns external work, actors need to preserve the support from their providers that are mainly and usually, external to the field (regulators, media, and investors). In order to ensure the maintenance of that support, actors need to preserve (or build) field's legitimacy, its boundaries and the relations to other fields. The most studied theme in institutional work, related to field-levels institutions, has been field-level practices (Hampel *et al*., 2017). During the last decade, researchers focused their attention on how actors affect the status of field-level practices. The attention has been centered on the creation and maintenance of practices rather than their disruption. Perkmann & Spicer (2008) identified three forms of institutional work, when they were studying the institutionalization of management fashions: political work, technical work and cultural work. They concluded that such fashions are more likely to get successfully implemented when their defenders increase the institutional work and when the actors involved have heterogeneous skills. Zietsma & McKnight's (2009) found that, in contested fields' context, actors often needed to work in partnership with their opponents in order to create a joint solution that protects them against external threats.

The second most studied field-level objects of institutional work are roles (Hampel *et al*., 2017). For institutional work, professions are seen as arenas of institutional change, and there is where relies the interest for professional roles as objects of institutional work (Greenwood *et al*, 2002). Kitchener & Mertz (2012) studied the institutional change processes in healthcare that emerged from the professionalization projects of occupations. Reay & Hinings (2005) consider that the fact that the fields of healthcare organizations can be transformed by the institutionalization of a new structural form that is underpinned by a distinctive belief system (logic) has made this a primary concern for researchers. These

investigations helped to answer the questions 'how' and 'why' professionals/actors work to execute or reject change.

The third most studied field-level object of institutional work is the organizational form (Hampel *et al*., 2017). Greenwood & Suddaby (2006: 30) define organizational form as the "*archetypal configuration of structures and practices given coherence by underlying values regarded as appropriate within an institutional context*". There are few studies in institutional work about the creation of organizational forms and none about disrupt or maintenance. The few that exist show that organizational forms require a special work to become legitimate, being also important cooperation between similar minded organizations (Hampel *et al*., 2017). David *et al*. (2013) studied the emergence of management consulting as a new organizational form. It was necessary a collective action from related firms and relationships with high profile actors (for example, prestigious universities). These researchers concluded that "*new organizational forms in emerging fields face particular challenges not present to the same degree in established fields*" (*ibid*: 373).

Standards are the fourth most studied field-level object of institutional work. Few studies examined the action of actors on standards and standards-setting processes. Slager *et al*. (2012) defined standards as mechanism of control that help coordination by defining the attributes of the standardized subject, rendering these aspects visible to external inspection and, possibly, sanctioning non-compliance. Despite the major role standards play in today's society, assumed by the generality of scholars and public, institutional work on their formation is almost inexistent. Standards offer a rich context to investigate institutional work due to the contestation and debates that usually rise around them, exposing different actions and strategies used by different actors (Hampel *et al.*, 2017).

Hampel *et al*. (2017) call out to the minor attention that field-level logics have had on institutional work, although logics have been broadly studied by scholars, and assumed that is very important to "*explore how logics can be shaped by institutional work*" (p.564). The authors argue that institutional logics "*are frames of reference through which actors make sense of the world, construct their identities and interact with the world around them*" (p.564). Collective knowledge and understanding on field macrodynamics can be enhanced by institutional work research, as well as the research on institutional logics (Thornton *et al*., 2012).

A study about how actors influence field-level logics was done by Gawer & Phillips (2013). They concluded that to change field-level logics might be necessary internal work, at an organizational level, changing local identities and practices and external work, at a field level, changing field spread practices and building legitimacy. Regarding legitimation processes, Jones & Massa (2013) consider two distinct forms: institutional evangelizing and adaptive emulation. Institutional evangelizing takes place when actors, focusing on logic of appropriateness, co-create, spread and support novel practices through a desire to express their unique identities (Suchman, 1995). Institutional evangelism is a process that entails not only collective entrepreneurship of multiple actors who co-create and support novel practices, but also cross-generational institutional maintenance that protects the novel practice. Thus, for a novel practice to become a consecrated exemplar, social actors must engage in institutional work of both creation and maintenance. As Jones & Massa describe, institutional evangelizing "*seeks to express what is distinctive and (in the process) creates novel practices, provokes criticism and then silence, but its novelty is more likely to trigger re-engagement and then attain lasting prominence*" (2013: 1125). Adaptive emulation emphasizes adopters who focus on logic of consequence, seeking to enhance their perceived efficiency and effectiveness by conforming to established practices of prestigious others. This type of legitimation process "*seeks prestige, gains immediate attention and acceptance because it builds on established solutions; yet the lack of originality undermines the profession's sustained attention and mitigates the adapted solution from gaining exemplary status"* (Jones & Massa, 2013: 1125). The authors reveal also that "*actors engaged in both institutional evangelism and adaptive emulation employing institutional work and leveraging ideas, materials and identities to effect, transform and maintain institutions*" (*ibid:* 1099).

2.2. Institutional logics perspective

Thornton *et al*. (2014: 2) present this new approach to institutional analysis as a "*meta-theory for integrating and augmenting a variety of social science theories to better understand the effects of cultural institutions on individuals, organizations and societies*". Lounsbury & Boxenbaum (2013) describe the emergence of institutional logics perspective as a response to the many critiques on DiMaggio & Powel's (1991) and Scott's (1995) neoinstitutional theory. They present the reasons to justify their opinion by highlighting the fact that institutional logics embrace a "*wider set of core foundations*", as constructivism and

a focus on culture and meaning contradicting "*those undergirding the initial neo-institutional project*", who emphasized isomorphism (Lounsbury & Boxenbaum, 2013: 5). Notwithstanding, institutional logics perspective has its origins on neoinstitutional theory, still it distinguishes from it by the "*capacity to theorize the duality of the material-practice-based aspects of institutions and their cultural-symbolic-based aspects*" (Thornton *et al*., 2012: 15). Institutional logics perspective was developed following a paper from Friedland & Alford (1991), in the "Orange Book" edited by DiMaggio & Powel, who invited the two authors to test the boundaries of conversations, which they did. In the paper of 1991, "*Bringing society back in: symbols, practices and institutional contradictions*", Friedland & Alford questioned the theorization of the role of broader social forces. They questioned rational choice approach that focused attention on instrumental behavior and rational action, as well as organization theories that considered organizations isolated from broader society context, or considered society as an abstract environment or an organizational field[2]. Friedland & Alford (1991: 240) conceived an institutional logics approach that provides "*a non-functionalist conception of society as a potentially contradictory interinstitutional system*". This interinstitutional system is composed by institutional orders as the family, religion, market and state, and each of these orders includes a set of symbolic meanings and material practices that constitutes its cultural belief system and organizing principles – its institutional content (Thornton *et al.*, 2014).

Friedland & Alford (1991) advocated that each institution has its own institutional logic that is available to organizations and individuals who use it to rationalize their actions and practices. Institutional logics are, therefore, the belief system at play in a social field (*ibid*). Following the same line of thinking, Scott *et al*. (2000: 171) consider that institutional logics "*provide the organizing principles that supply practice guidelines for field participants*". It is, in essence, the understanding of culture's role in institutional analysis, assuming by culture the social systems of beliefs, values, norms and symbols (Thornton *et al.*, 2014). Institutional theory has been described as a metatheory as it provides a theoretical architecture based on the view that individuals are embedded in society and institutional fields to study practice, and assumed the homogeneity of organizational fields (Thornton *et al*., 2012). Notwithstanding, institutional logics perspective neglects the "*homogeneity and isomorphism in organizational fields*" and assumes that any context is influenced by "*contending logics of different societal sectors*" (Thornton & Ocasio, 2008: 104), explaining

[2] DiMaggio and Powell (1983) defined organizational fields as being made up of organizations and key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products.

homogeneity and heterogeneity, becoming a metatheory of institutions that includes organizations influenced by Western world (Thornton *et al*., 2012).

Thornton & Ocasio (1999: 804) defined institutional logics as "*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*". Thus, the understanding of institutional logics perspective offered by Thornton *et al.* (2012: 180) embraces the idea that it contributes to a wider scholarly interest in practice due to the fact that it emphasizes the embeddedness of individuals in society and in institutional fields and also provides a theoretical architecture that contributes to a more visible knowledge. In congruence with Thornton & Ocasio (1999) the understanding of institutional logics offered by Meyer & Hammerschmid embraces the idea that it shapes worldviews *"by providing relevance structures and frames to construct issues, problems and solutions as well as script actions"* (2006: 1000). Following these definitions, Greenwood *et al.* (2011: 318), in a concise definition, consider that institutional logics "*provide guidelines on how to interpret and function in social situations*". On the other hand, the constraint's argument about institutional logics posits that" *institutional logics shape individual preferences, organizational interests, and the categories and repertoires of actions"* with the aim to accomplish their objectives (Thornton *et al.*, 2012: 77). Dominant institutional logics become taken for granted by defining principles for organizing activities and changing interests (Zucker, 1977). Still, institutional logics are not static (Thornton *et al*., 2012), contrariwise, by stimulating the exportation of logics on organizational forms and institutional fields, they encourage institutional change (DJelic & Ainamo, 2005; Smets *et al*., 2012).

2.2.1. The interinstitutional system on institutional logics perspective

In their approach to institutional logics perspective, Thornton *et al*. (2012) assume that institutions function at multiple levels and actors are nested in higher order levels: individual, organizational, field and societal. Thus, actors may be nested in more than one institutional order being exposed to compatible or conflicting symbols and practices that they may reinterpret, exploit, export and change (Thornton *et al.*, 2014). This interinstitutional system provides a framework that allows the understanding of a "*levels metatheory of institutions*" (Thornton *et al.*, 2012: 52) – cf. Table 2.2. This framework, based on Friedland & Alford's

(1991), is designed as a matrix where the X-axis represents institutional orders and Y-axis represents the elemental categories that compose an institutional order.

Societies are composed by several institutions that are organized by sub-systems which were termed as institutional orders (X-axis) by Friedland & Alford (1991). Therefore, the junction of all institutional orders constitutes the "*key cornerstone institutions of society*" (Thornton *et al.*, 2012: 53) and each one is representative of a different domain of institutions, including their cultural symbols and practices. Each order represents a governance system that, by providing a reference frame, pre-conditions actor's choices (*ibid*).

These institutional orders - family, community[3], religion, market, state, professions and the corporation - are used by individuals and organizations as justifications to rationalize their positions, legitimating their choices (Thornton *et al.*, 2014). Therefore, these sources of legitimacy can be understood as the motivation, which justifies that switching institutional orders implies different justifications for the same behavior (*ibid*).

As stated above, each institutional order is composed by the cultural symbols and material practices that are specific to each order, and that are referred as the vertical Y-axis in the framework. These "*building blocks*", as Thornton *et al.* (2012: 54) named cultural symbols and material practices, "*specify the organizing principles that shape individual and organizational preferences and interests and the repertoire of behaviors by which interests and preferences are attained within the sphere of influence of a specific order*" (Friedland & Alford, 1991: 232). Thornton *et al*. (2012) exemplify some of these building blocks of institutional content: sources of legitimacy, norms, values and practices that can be expressed in symbolic or material forms. Theoretically, Y-axis allows individuals and organizations, which are influenced by any institutional order, to understand their "*sense of self and identity*" (Thornton *et al.*, 2012: 54).

[3] Thornton (2004) justified, by a literature review, that the concept of community was an institutional order.

Table 2.2 – Inter-institutional system ideal types

Y-Axis **X-Axis: Institutional Orders [at a societal-level] and associated logics**

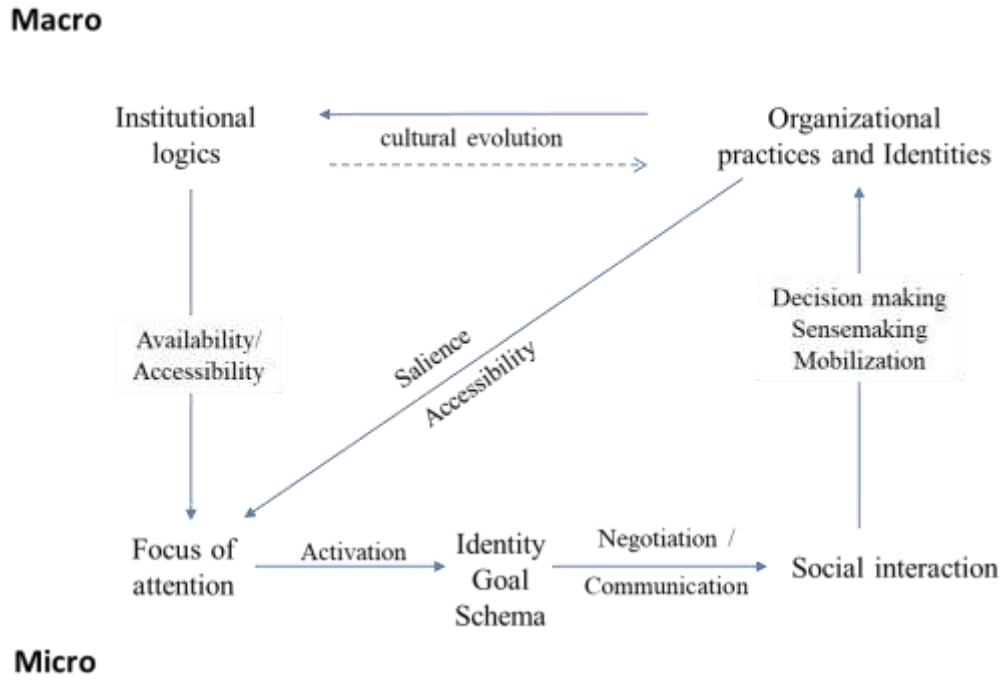
Categories	Family	Community	Religion	State	Market	Profession	Corporation
Root metaphor	Family as firm	Common boundary	Temple as bank	state as redistribution mechanism	Transaction	Profession as a relational network	Corporation as hierarchy
Sources of legitimacy	Unconditional loyalty	Unity of will Belief in trust and reciprocity	Importance of faith and sacredness in economy and society	Democratic participation	Share price	Personal expertise	Market position of firm
Sources of authority	Patriarchal domination	Commitment to community values and ideology	Priesthood charisma	Bureaucratic domination	Shareholder activism	Professional association	Board of directors Top management
Sources of identity	Family reputation	Emotional connection Ego satisfaction and reputation	Association with deities	Social and economic class	Faceless	Association with quality of craft Personal reputation	Bureaucratic roles
Basis of norms	Membership in household	Group membership	Membership in congregation	Citizenship in nation	Self-interest	Membership in guild and association	Employment in firm
Basis of attention	Status in household	Personal investment in group	Relation to supernatural	Status of interest group	Status in market	Status in profession	Status in hierarchy
Basis of strategy	Increase of family honor	Increase status and honor of members and practices	Increase religious symbolism of natural events	Increase community good	Increase efficiency profit	Increase personal reputation	Increase size and dimension of firm
Informal control mechanism	Family politics	Visibility of actions	Worship of calling	Backroom politics	Industry analysts	Celebrity professionals	Organization culture
Economic system	Family capitalism	Cooperative capitalism	Occidental capitalism	Welfare capitalism	Market capitalism	Personal capitalism	Managerial capitalism

Source: (Thornton *et al*, 2012: 73)

From an institutional logics perspective, the interpretation of the Y elements vary depending on the "*observational lens*", i.e., the X that is focused (Thornton *et al.,* 2014: 6). The authors defend that, in theory, there are no dominant logics and that multiple logics are not necessarily operative. They also draw attention to the fact that the degree of conflict and interdependence among institutional orders differs, on the norms and values each one appraises. The institutional orders family and market have norms and values that are likely more opposite than, for example, state and professions, and this will influence the way symbols are interpreted and actions are practiced (*ibid*).

The metatheory that is subjacent to institutional logics perspective is based on an interinstitutional system by assuming that institutions "*operate at multiple levels of analysis with potential for cross-level interaction effects*" (Thornton *et al.,* 2012: 14) – cf. Figure 2.1.

Figure 2.1. Cross level model of institutional logics combining Micro-Macro and Macro-Micro



Source: Thornton *et al.* (2012: 15).

The authors believe that, by taking a cross level analysis researchers are able to observe the mechanisms and how they work as well as the contradictory nature of institutional logics. Thornton *et al.*, in 2012, defended that this multi-level framework was essential to identify embedded agency problems and explain institutional arising and change. Notwithstanding, in 2014, they considered that *"the institutional content (what is in the cells of the table)"* in their model shouldn't be just macro to micro level, but macro to micro to macro (Thornton *et al*., 2014: 14). They consider that this 'X, Y' model does not capture this reality and admit that new methods are needed to enable the understanding of "*how institutional orders and their logics anchor in the inter-institutional system*" (*ibid*: 14). The inter-relation between interdependent but autonomous levels – society, fields, organizations and individuals – is emphasized by Friedland & Alford's perspective (1991). To Friedland & Alford, actors have the capacity to reconcile and take advantage of multiple contradictory institutional logics. This capacity enables institutional change and it is considered a solution to the problem of embedded agency in institutional theories. Drawing on the perspective of institutional logics, the authors demonstrated the institutional relations that exist between individuals, organizations and institutions defending that "*individual action can only be explained in a societal context, but that context can only be understood through individual consciousness and behavior"* (Friedland & Alford, 1991: 242). Institutional logics also provide social actors with willing and motivation for elaboration and development of the existing logic (Thornton *et al.*, 2012). By indicating the appropriateness of means, institutional logics legitimate activities. Moreover, institutional logics constrain action and behavior of organizations and individuals, but do not determine them. It is expected that organizations and individuals have the capacity to choose among logics, may they be contradictory, or not (Friedland & Alford, 1991). This relationship between individuals and institutional logics can be interpreted through two different points of view – one emphasizing opportunities, the other emphasizing constrains (Thornton *et al.*, 2012). The opportunity for individual agency is related to the exploration of contradictory institutional orders that occur in modern societies and it is inherent in the institutional logic perspective.

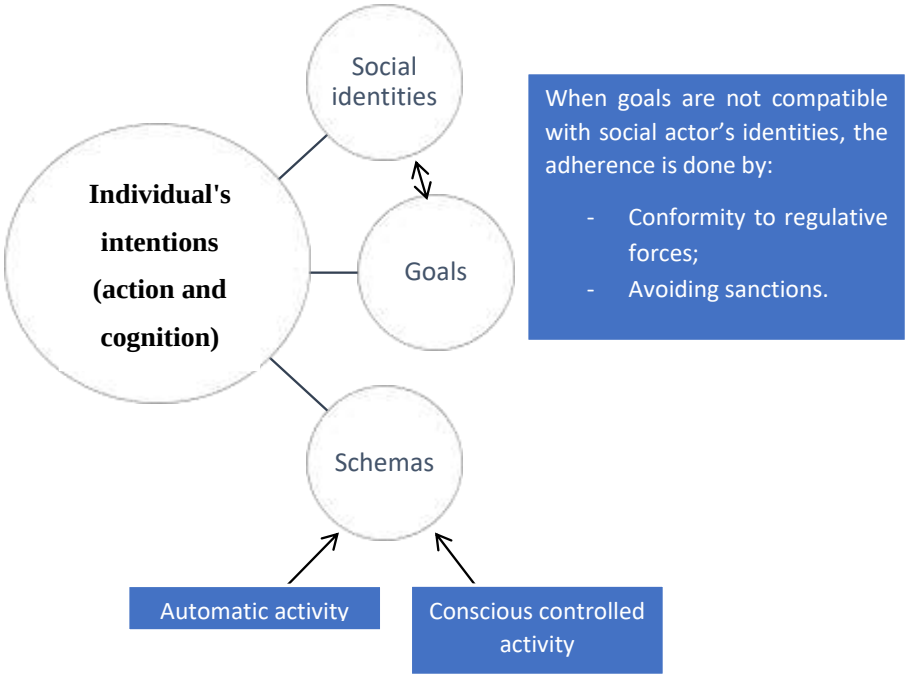
2.2.2. Embeddedness and agency concepts

The concept of embeddedness was developed by Granovetter (1985), who argued that rational theory provided an under-socialized view of human behavior, when assumed that rational, self-interested behavior was affected minimally by social relations. Simultaneously, Granovetter contested the other extreme, which he termed as embeddedness, that assumed that behavior and institutions were so constrained by ongoing social relations that provided an over-socialized view, with a limited role for individual agency. Granovetter avoided the extremes (1985: 504) arguing that "*most behavior is closely embedded in networks of interpersonal relations*". Granovetter suggested that individual choices and actions, while instrumental, are situationally constrained by the networks in which individuals are embedded. The theory of structural embeddedness was further developed by Zukin & DiMaggio (1990) who considered others types of embeddedness regarding economy: cognitive, cultural and political. According to Thornton *et al*. (2012) embedded behavior implies individual agency. However, individual agency can have two interpretations: can be interpreted as the pursuit of self–interest and the satisfaction of individual needs; or it can be guided by individual's identity and identification, on the premise that such identification is a result of the "*perception of oneness with a group*" (Ashforth & Mael, 1989: 35). In congruence with this position, the understanding of agency offered by Abdelnour *et al*. (2017) embraces the idea that agency is exercised by actors in social stage, not by individuals. This position is generated in the idea that individuals as sole, rarely turn into social actor, contrariwise, "*individuals take part in social life as actors by assuming roles and the positions to which roles are usually tied*" and agency is the capacity of those social actors tied to those roles and social positions (Abdelnour *et al*., 2017: 19). Furthermore, Scott *et al.* (2000) state that social actors have also the capacity to shape actions (of thirds) or rules that command those actions and they named it as social agency. Recognizing social agency decreases the influence of social structure, still social structure shapes social agency, as it does to all social behaviors. To Scott (2008) agency is related to the capacity that an individual has to create some effect in social reality, by changing rules, relationships or redistributing resources. Thornton *et al.* (2012: 79) used the concept of cultural embeddedness to consolidate the micro foundations of institutional logics – "*as the culture of social groups, of which individuals are members, provides individuals with symbolic structures to understand and construct their environments*". The concept of embedded agency (or social action that is culturally embedded in institutional logics),

allows for endogenous forms of change to occur and needs not to imply organizational or institutional inertia. The approach offered by Thornton *et al*. (2012: 77) embraces the idea that "*embedded agency and institutional contradictions are keys to the micro foundations of the institutional logics perspective*". Still they also defend that "*the role of social actors in shaping and being shaped by institutions requires a more developed theory of human behavior*" (Thornton *et al*., 2012: 80). They advocate that not only individual agency is culturally embedded in institutional logics, but also individual agency is involved in the reproduction and transformation of institutional logics. Seo & Creed (2002) defend that institutional contradictions can stimulate a shift in some actors' collective consciousness turning them into change agents. Creed *et al.* (2010) call attention to the fact that little is known about the micro processes that are underneath this reaction: institutional contradictions can trigger reflexive and critical actions by deeply embedded actors leading, in extreme case, to institutional change. Nonetheless, for actors to become change agents they also need to change their identity (Chung and Luo, 2008; Greenwood & Suddaby, 2006) and such changes can be difficult and involve emotions. This is where the reason lies. Not all institutional contradictions lead to a change-oriented agency by actors because they may not be prepared, or willing, to pass through an identity transformation process.

Individuals' intentions are guided by social identity (and individual interests) and goals that are bounded by cognitive limitations on human behavior and by *"internal contradictions between multiple goals and identities*" (p. 80). Thornton *et al*. (2012) highlight three main individuals' characteristics that affect cognition and action, namely social identities, goals and schemas – cf. Figure 2.2.

Figure 2.2. - Individuals' characteristics that affect cognition and action



Source: Based on Thornton *et al.* (2012: 84-90).

"Social identities are locations in social space; they position persons by virtue of placing them in power/dependency relations to other social categories of actors and associating with them a range of social expectations and capacities for appropriate actions" (Meyer & Hammerschmid, 2006: 1001). Social identities can be defined in terms of category or in terms of roles. The approach that looks at social identities in terms of group or category membership includes professional information, as occupation, profession, employer, department, but at the same time considers also affiliation in voluntary organizations and individual characteristics, such "*as race, gender, ethnicity, nationality and geography"* (Thornton *et al*., 2012: 85). In terms of roles within organizations there are several examples, as CEO, investor, manager, leader or volunteer, while outside organizations, the roles could be parent, wife, friend, and citizen, among other examples (*ibid*). In this sense, social identities are social constructs that vary and change with the logics that shape those identities (Meyer & Hammerschmid, 2006). Notwithstanding the fact that individuals exhibit multiple social identities and roles, not all identities are equitable accessible to individuals (Thornton *et al.*, 2012). The notion of identity verification corresponds to the validation of an actor's social identity with other social actor, in several contexts. The fact

that an identity is positively verified creates on social actors a stronger commitment to that identity (Burke & Stets, 1999). Stryker (2000) advocates that such commitments to identity influence the relations with actors with similar identities but it also potentiates conflicts and competition with actors committed to different identities. This concept of social identities has been used by institutional logics research to explain change or stability in organizations/ institutions (Meyer & Hammerschmid, 2006).

According to what institutional logics perspective posits, the understanding offered by Thornton *et al.* (2012) embraces the idea that, like social identities, goals are culturally embedded within alternative institutional logics and, as a result, identities and goals affect cognition and action. Several studies have been taken to demonstrate how a shift in logics creates a shift on goals (Mohr & Lee, 2000; Thornton, 2002; Townley, 2002). Nonetheless, an alternative approach is defended by March & Olsen (1989) who clearly distinguishes between identities (logic of appropriateness) and goals (logic of consequences) presenting both as alternative motivations for social actors. An important fact in the relation between identities and goals relies on the irrefutable evidence that not all goals fulfil or are compatible with social actor's identities (Thornton *et al.*, 2012). When such a situation occurs, social actors adhere to specific goals and behaviors either by conformity to regulative forces or by avoiding normative sanctions (Thornton *et al.*, 2012). A study taken by Jackall (1988) on how managers complied with institutional logic of patrimonial bureaucracy in U.S. corporations, concluded that it was a system of rewards and sanctions that steered manager's motivations, belittling the importance of social identification on their behavior.

Schemas are top-down knowledge structures generated by social actors in order to process information and guide decisions (Thornton, 2004). Schemas are usually theorized in organizational studies as of automatic use, but regarding an institutional logic perspective, the emphasis on a controlled use of schemas for reasoning and problem solving is considered more useful (Thornton *et al.* 2012). They are filters that allow managers to classify a situation, evaluate its consequences and ponder adequate actions (Thornton *et al.*, 2014). These schemas were termed as pragmatic reasoning schemas by Cheng & Holyoak (1985) and they represent general sets of rules applied to specific domains of action or classes of goals. Thornton *et al*. (2012) consider that, from an institutional logics perspective there is evidence that different logics have

different pragmatic reasoning schemas for decision-making and action. Pragmatic reasoning schemas generate three different types of behavior regulation according to the specific situation: permission schema, causation schema or obligation schema. A permission schema presupposes that to take action some preconditions must be satisfied. Causation schemas provide evidence for cause-and-effect relationships, as events and the problems they may generate. Social norms are examples of obligation schemas where a specific situation implies a subsequent action (*ibid*). Individuals form cognitive schemas based on different institutional logics (Glaser *et al.*, 2016). They do it by storing in their minds the institutional logics that are prominent in society, as schemas. When those schemas are embedded individuals will, more likely, adopt actions related to the logic and their behavior will be in line with those actions (*ibid*). Schemas help individuals to clarify doubts, draw conclusions and guide decisions, becoming a useful guide on behavior expectations (Thornton *et al*., 2012).

While individuals are surrounded by "*environmental stimuli and action responses*" (*ibid*: 89) their capacity to attend to all of them is limited. Norman & Shallice (1986) studied the role that attention has in the control of action. Their approach differentiated the way action is experienced in automatic activity and conscious controlled activity. Automatic activity does not need to activate individual´s scarce cognitive resources. Stimuli are the trigger to action. Stimuli that have an automatic attention-demanding characteristic activate a strong and direct schema. Schema selection in these cases does not require attentional activation from the supervisory system. Alternatively, when supervisory system produces attentional activation to select schemas, we are in presence of a conscious controlled activity (Norman & Shallice, 1986). Individual attention is, by natural cognitive restrained, selective. And selective attention is activated by external or internal (memories, goals, activities) stimuli. Being aware of this human's cognitive limitations, "*organizations create structures and processes in order to shape groups' and individuals' focus of attention*" (Thornton *et al.*, 2012: 90). Traditional neoinstitutional theory focused on automatic attentional processes; alternatively, institutional logics perspective highlights the "*controlled or willed attentional processes*" (Thornton *et al*., 2012: 90). Institutional logics guide the focus of individual's attention by highlighting the problems, issues and the solutions (schemas) that should be considered in decision-making process. Thornton *et al*. (2012) discuss how multiple conflicting logics may enable or constrain individual's and organization's focus of attention. The approach advocated by Thornton *et al.* (2012) explains how

the focus of attention is shaped simultaneously by top-down attentional perspectives and bottom-up environmental stimuli through the availability, accessibility and activation of identities, goals and schemas (cf. Table 2.3.).

Table 2.3. – The shape of individual's focus of attention

Focus of Attention	**Top-down Attentional perspectives**	Institutional logics and organizational practices
	Bottom-up environmental stimuli	"Salience" of stimulus is the K factor (novelty, events, unexpected action, attention control by other social actors)

Source: Based on Thornton *et al.* (2012: 89-92).

Top-down attentional perspectives shape the focus of attention through institutional logics and organizational practices: "*Institutional logics provide building blocks for focusing attention through the set of social identities, goals and schemas that are part of each logic* (Thornton *et al.*, 2012: 91). Additionally, individuals by participating in organizations and in their practices, create more specialized identities, goals and schemas that have a strong inductive flair on top-down attentional perspectives (Cho & Hambrick, 2006). In what concerns bottom-up environmental not all are attended. The crucial factor is the salience of the stimulus, that is to say, to what extend an environmental feature stands from the others. Salience may refer to unexpected actions, outcomes or events, novelty or attention control given by other social actors (Thornton *et al*., 2012). Nigam & Ocasio study (2010) demonstrated how a bottom-up process of environmental sense making can lead to a change in institutional logics. The authors studied the effects that Clinton's health care reform initiative had on public attention and how salient events can be the trigger for cognitive realignment and institutional logics transformation. In their study, Nigam & Ocasio (2010) found that the managed care logic was not just an adopted fashion. Instead, the authors

concluded that actors theorized[4] individual dimensions of the new logic that presupposed changes in the relations with other actors in the field. As the new logic gained space, individual dimensions became theorized and were assumed as an important part of the new managed care logic. The term "*managed care*", that was related to a specific organizational form became to symbolize the organizing principles for hospitals' relationships with other institutional actors (Nigam & Ocasio, 2010). Author's concluded that the interplay between theorization concept, representation (through exemplars and environmental features) and ongoing event attention can cause a change in institutional logics.

2.3. Institutional complexity and organization's responses to the existence of multiple institutional logics

2.3.1. Institutional complexity

"*Organizations face institutional complexity whenever they confront incompatible prescriptions from multiple institutional logics*" (Greenwood *et al*., 2011: 318). Institutional scholars acknowledge that organizations are often exposed to multiple, and sometimes conflicting, institutional logics. Scott (1995) defined institutional logics as pressures for conformity that are exerted by referents on organizations. It may be in the form of rules, regulations, normative prescriptions or social expectations. Organizations comply with logics because they provide means for organizations to understand the social world and to act confidently in it. But organizations also comply with logics to achieve the approval from important audiences (Greenwood *et al*., 2011).

Conflicting institutional logics occur in the presence of antagonist pressures exerted by institutional organizations (Kraatz & Block, 2008). This occurs when organizations activity covers various institutional spheres, becoming subject to multiple and contradictory regulatory regimes, normative orders and cultural logics. Greenwood *et al*. (2011) take the example of hospitals where different professions coexist, each one with cognitive and normative orders that bound their socialization – physicians, physiotherapists, psychiatrists, social workers, and nurses, among others. For these authors, some fields are portrayed as more predestined to present

[4] Theorization is "the development and specification of abstract categories and the elaboration of chains of cause and effect" (Greenwood *et al*., 2002: 60).

enduring competing logics. It is the case of health sector due to the great variety of occupations, each one conditioned by different logics. Hospitals are examples of complex organizations, either horizontally (with multiple institutional orders) and vertically (with multiple categories for each institutional order).

According to Greenwood *et al.* (2011) most of the empirical studies that address the subject of institutional complexity assume two restrictive assumptions: the existence of only two logics and the incompatibility among them. Notwithstanding, it is consensual that organizations experience more than two logics and some studies have showed that different logics interact and may, potentially, reinforce each other. Still, logics are usually assumed as incompatible and the implicit idea when analyzing logics shift is the replacement of an older logic for a new one due to their incompatibility (*ibid*). Despite this dominant discourse there are studies that show that potentially conflicting logics are combined and reconfigured and give rise to hybrid organizations, hybrid logics, hybrid practices and hybrid identities (Besharov & Smith, 2014; Pache & Santos, 2010; Meyer & Hammerschmid, 2006; Thornton *et al*., 2005). Therefore, the concept of incompatibility becomes dubious. Although incompatible, some logics can be "*relative compatible or can be tailored to be so*" (Greenwood *et al*., 2011: 332).

Given this inconsistency, two approaches help to clarify logics' incompatibilities: for Pache & Santos (2010) incompatibility can be assessed by looking at different logics' goals or means; Goodrick & Salancik (1996) stress logics' specificity to identify incompatibilities. Pache & Santos' approach highlight that incompatibility on goals is particular challenging for organizations and it may lead to jeopardize support from members. In Goodrick & Salancik's approach logic's specificity is connected with the concept of organizational discretion that depends on the ambiguity of goals and practices prescribed. The higher specified goals and practices are, the less they are ambiguous and organizational behavior and choice is much more constrained. This leads to a more problematic level of complexity. When logics (goals and practices) are ambiguous and less specified, organizations are more malleable and able to alleviate complexity tensions (*ibid*).

2.3.2. Organization's responses to conflicting institutional logics

Kraatz & Block (2008) identified four adaptation strategies that organizations tend to use in the presence of conflicting institutional logics. When confronted with conflicting logics organizations try to act on those logics eliminating the sources of the conflict (whenever possible) or compartmentalize and deal independently with each one. Organizations can also choose to maintain a domain (and try to balance all) or, finally, they can forge/create a new institutional order. Oliver (1991) developed a preliminary conceptual framework for predicting the occurrence of the alternative strategies: acquiesce, compromise, avoid, defy and manipulation. She suggested that organizational leaders that present an "*internal locus of control*" and a "*high need for autonomy*" may be more expected to employ resistant strategies (p.173). Furthermore, Oliver also observed that organizations that are highly cohesive and present a strong internal culture would be more likely to resist external expectations.

Although Kraatz & Block (2008) and Oliver (1991) theoretical models did not explore the conditions under which specific responses are mobilized, they outlined generic response strategies to conflicting institutional logics. Pache and Santos (2010) tried to go further than Oliver and explored the role that intra- organizational processes play in organizational decision-making. By doing that, they identified the conditions under which specific response strategies are used. The authors focused on agency and choice to understand the details in micro level – how actors, within organizations, experience, evaluate and manage conflictual institutional expectations. To understand how organizations respond to conflicting institutional logics it is necessary to understand if a conflict is expected to occur and how it is imposed. According to Pache & Santos (2010) there are two factors that influence the existence of conflicting institutional logics and they are the fragmentation of the field and the degree of centralization.

In order to understand how organizations, respond to conflicting institutional logics, Pache & Santos (2010) investigated institutional contexts' role. In this sense, they had to move away from the existing models' ways of looking at organizations as a unitary actor, as DiMaggio & Powell (1983) that considered organizations as a passive receptor (as a whole) and Oliver (1991) as an active resistor (as a whole also). Those views did not allow organizations to predict the strategies to face conflicting logics. Pache & Santos went further on those views and looked at organizations as entities that are composed by different groups, with different values, aims and

interests and, for that reason, they are complex organizations. They are shaped by pressures but they also shape those pressures – a boomerang effect. In addition, the researchers define organizations as filters of institutional logics. All these particularities of each organization justify that in, the presence of the same institutional conflict, organizations experience and react to it differently. Pache & Santos (2010: 472) highlight the fact that "*field's structures and power arrangements are not static*". They change with regulation, culture or introduction of new players. In these change processes it is likely to occur conflicting logics that are a result of the co-existence of two sets of logics (the old and the new one), during the transition phase. In these cases, the occurrence of conflict between institutional logics is limited in time once the rise and establishment of a new logic ultimately determinates the final of the old logic and its logics (*ibid*).

Pache & Santos rooted their work on Scott & Meyer's (1991) approach. According to Scott & Meyer, institutional theory considers the fragmentation of the field and the degree of centralization, as the two factors that allow us to compare different organizational fields. Fragmentation refers to the number of actors – regulators, competitors, professional associations – that usually have different institutional expectations from organization. Meyer *et al.* (1987: 4) considered that fragmentation "*refers to the extent to which decisions made at any given level in an environment are integrated or coordinated*". Centralization has to do with the way power is distributed by those external stakeholders (Klenk & Seyfried, 2016). Meyer *et al.* (1987: 4) considered centralization "*the extent to which decisions are made at higher rather than lower levels within the environment*".

Pache & Santos (2010) concluded that conflicting institutional logics are expected to occur in fragmented fields. In high fragmentation fields (e.g., educational sector), organizations experience multiple and uncoordinated constituents. The coexistence of multiple uncoordinated actors and their respective logics about what is effective or legitimate behavior increases the probability of conflicting institutional expectations. Thus, the form how these conflicting institutional logics are imposed on organizations (fragmented fields) depends on the ability of the competing actors to enforce their logics. This is, in itself, a function of the degree of the field's centralization (Scott & Meyer, 1991). Hence, centralization characterizes the field power structure and it is responsible for the presence of dominant actors that support and strengthen

dominant logics. These dominant actors include regulatory authorities that, by using their legal power, exert coercive pressure in organizations to behave in a certain way; major funders that use their resource dependence relationships to exert their dominance; educational organizations, that influence behaviors through normative socialization; and professional organizations that influence behaviors through accreditation processes (Greenwood *et al.*, 2002). The way the field is fragmented (or not) is crucial for the existence (or not) of conflicting institutional logics on organizations (Pache & Santos, 2010). On unified fields (the case of military field in most democratic countries) organizations depend on a few coordinated decision makers, whose authority is formalized and recognized. These actors have the legitimacy and authority to mediate conflicts that may occur between different players and, if necessary, impose coherent logics on organizations. In decentralized fields, there are no dominant actors with power to influence organizations' behavior. In such fragmented fields institutional pressures have no power and when they are contradictory organizations easily ignore or challenge them. Moderately centralized fields are the most complex fields for organizations. These fields are characterized by multiple and conflicting players that, although not dominant, have strength enough to impose their influence on organizations (*ibid*). Pache & Santos make a proposition based on previous theory: highly fragmented fields that are moderately centralized are more likely to impose conflicting institutional logics on organizations, than other fields. Health care organizations are an example of a field that is described as a moderately centralized field but with a dual authority structure, with long-lasting irreconcilable logics. While, on one hand, there is a funding authority exerted by public organisms that emphasize the concentration of the decision power and the formalization of procedures, on the other hand, there is also a programmatic authority exerted by healthcare professionals that historically had defended the delegation of decisions and the autonomy of their independency (Scott, 1983). However, not all organizations experience conflicting institutional logics in a given field, in a similar way.

Modern societies with modern organizations lead to the increasing of conflictual institutional logics due to multiple mechanisms. Pache & Santos (2010) highlight four mechanisms that reinforce this dynamic and they are the (1) globalization of practices and cultures, (2) the field fragmentation, (3) adoption of hybrid forms and the (4) diversity of workforce. The globalization of practices and cultures increases the number of institutional influences on organizations and, consequently, the probability that these pressures will conflict

with each other also increases. Modern societies are composed by a wide range of specialized organizations and, at the same time, state feels unpowered to control complex societies. These two realities explain the increasing fragmentation of the field and its decentralization. Thus, modern organizations are compelled to integrate conflicting logics, assuming hybrid forms. Hybrid organizations incorporate different institutional logics and are, by nature, arenas of contradiction (Pache & Santos, 2013). Thus, whenever organizations are confronted with multiple and conflicting institutional logics, organizations face institutional complexity (Greenwood *et al.,* 2011). The fact that nowadays an enormous job pallet exists introduces in organizations conflicting normative pressures. All these realities are mirrored in the huge increase of scholar empirical studies on conflicting institutional logics (Battilana & Dorado, 2010; Greenwood *et al*., 2011; Perkmann *et al*., 2018; Raynard, 2014; van de Broek *et al*., 2014).

2.3.3. Multiple logics existence

Besharov & Smith (2014: 374) concluded that the existing studies on multiple logics in organizations offer mainly "*conflicting perspectives on their consequences for organization and field-level processes and outcomes*" and are one-level studies, neglecting that studying institutional logics presupposes cross-level analysis of relations between levels - individual, organizational and institutional (Thornton & Ocasio, 2008). Therefore, Besharov & Smith (2014*:* 370) created a framework in order to "*understand heterogeneity in how multiple logics manifest in organizations*", considering the dimensions of compatibility and centrality of the logics. Framed on these two dimensions, they proposed four ideal types of organizations: contested, estranged, aligned and dominant, cf. Table 2.4.

Table 2.4 – Types of Logic Multiplicity within organizations

Degree of Centrality	**Degree of compatibility**	
	Low Logics provide contradictory prescriptions for action	**High** Logics provide compatible prescriptions for action
High Multiple logics are core to organizational functioning	**Contested** *Extensive Conflict*	**Aligned** *Minimal Conflict*
Low One logic is core to organizational functioning; other logics are peripheral	**Estranged** *Moderate Conflict*	**Dominant** *No Conflict*

Source: Besharov & Smith (2014: 371)

Compatibility concept refers to the consistency between two logics and how they reinforce the actions of the organization. This consistency is linked to the organization's goals; it is not related to the means organization uses to achieve them. The authors point three influences on the degree of logic's compatibility. The first one is the (1) quantity of professional groups within an institutional field and the relations between them. When multiple professional groups co-exist in a field and each group assumes its professional logic as unique, compatibility between logics decreases. Nonetheless, when one professional group is clearly dominant it enhances logic's compatibility. This is the case of health care field during 20th century: the medical profession dominated the field and "*nurses and pharmacists deferred to physicians*" (Besharov & Smith, 2014: 368). The second influence is related with (2) practices and characteristics of organization, and the authors highlight the role of hiring policy in this matter. Young organizations where professional groups are not yet well established and also the practice of a hiring policy that privileges individuals that do not carry one pre-stablished logic, increases logic's compatibility. Finally, the last influence has to do with the (3) characteristics of members, enhancing the ties that field actors establish with organization members. When organization

members have strong ties with field actors that are associated with the logics that members carry, logics are reinforced, while compatibility with other logics [present in organization] decreases. The opposite also happens, i.e., the fact that the members of the organization do not have strong ties to field actors allows them to deviate from the dominant logic and thus be able to reconcile other logics [present in organization], thereby increasing compatibility. Nonetheless, this factor can be counterbalanced with relationships and degree of interdependence between members (with one another). Close relationships and interdependency between members creates motivation to face multiple logics in more compatible ways, even when logics may continue to be incompatible at the field level (Besharov & Smith, 2014; Smets *et al.*, 2012).

Centrality dimension respects the fact of existing one or more logics that are core to the organization and can be influenced also by institutional fields, organizations and individual members. The structure of the field is particularly important for centrality. High fragmented fields are characterized by multiple logics exerting equal influence over member's behavior (whether all logics influence all members or each one influences a subgroup of members). Health field is an example of a fragmented field, where professional logic, emphasized by physicians and "*business-like*" logic, emphasized by the state and management professionals, became central within hospitals and health organizations. As both actors hold power in the field, both logics became central to the organization (Besharov & Smith, 2014). Another way to influence centrality is connected with organizational practices and characteristics. Organization's mission and strategies situates it in a concrete place on a field or in the interstices of multiple fields. Hospitals are, once again, an example of organizations that, due to its mission, congregate multiple areas of expertise which implies that they have to congregate the logics associated with each area of expertise, which, ultimately, increases centrality. When an organization changes its mission, centrality may increase as the organization becomes to be exposed to more and different field-actors, carrying different logics. The degree of dependence from a particular actor or group for critical resources affects also the centrality dimension. Depending on a particular actor or group for resources means that organization responds to the demands made by that actor or group, even when those demands are opposed to organization logics. Reducing the dominant players' dependence increases centrality as there is no dominant logic but a mix of non-dominant players' logics. Finally, at an individual level, members' adherence to logics also creates variation in centrality. When members adhere strongly to one logic and weakly to others

centrality decreases; the opposite happens, i.e., centrality increases when multiple logics exert the same influence in members' behavior (either all logics influence all members or each logic influences a sub-group of members). It is possible to conclude that centrality increases when multiple logics' players have equal power and decreases when there is one logics' player that dominates.

The four ideal types of organizations conceived in Besharov & Smith's framework are displayed in Table 2.4 and are a result of the combination between the two dimensions authors defined to understand how logics manifest in organizations. The first type, (1) the contested organization, is characterized by low compatibility and high centrality. This occurs when members are confronted with different goals, values and identities, and different ways to achieve them – generating low compatibility among logics- and the existence of multiple logics looking for dominance generates dispute – generating high centrality. Second type, (2) estranged organizations, present low compatibility and low centrality, which means that, as in contested organization, goals, values and identities, and the ways to achieve them are different – low compatibility – but in this case, there is a dominant logic that muffles the other logics, thereby controlling conflicts, limiting their escalation and intractability – the level of conflict is moderate (due to low compatibility). The third ideal type of organization is nominated as (3) aligned organizations and this happens when high compatibility – consistent organizational goals - and high centrality – multiple logics with strong influence on organizational functioning- exist. Conflict is minimal (due to high compatibility) and this type of organization [high compatibility and high centrality] creates potential for logic blending, combining multiple logics into a new one. The last type of ideal organization is (4) dominant organizations and it is characterized by high compatibility and low centrality, due to the fact that multiple logics are compatible in terms of goals for organization still there is a single dominant logic. The combination of high compatibility with low centrality results in the reinforcement of the prevailing logic by one or more existing logics. Ultimately it can appear that organizations embody a single logic. Notwithstanding when a second logic influences members, the high level of compatibility enables a pacific coexistence which can lead to the assimilation of the peripheral logic with the dominant logic. The authors call attention to the fact that blending (in aligned organizations) and assimilation (in dominant organizations) at the organizational level may lead to changes in logics at the field level (Besharov & Smith, 2014).

As referred previously, the way logics manifest in organizations can be altered by changes in the structure of the field, by organization-level practices and by member's characteristics. By considering these factors, that may affect the expected ways logics manifest in organizations, authors believe that they are connecting investigation on logics multiplicity in organizations with investigation on institutional theory that studies how agency and structure influence organizations. Nevertheless, this framework was created to analyze the compatibility and centrality between two logics only.

2.3.4. The role of collaboration in the coexistence of different and conflicting logics

Reay & Hinings (2009) presented us with a different perspective on the co-existence of multiple logics within an organization, for long periods of time. The understanding offered by prior research focused only on field-level actors and embraced the idea that multiple logics may coexist but one must be, inevitably, dominant (Scott, 2008; Thornton & Ocasio, 1999). Co-existence was presented as temporary, and solved by competition between logics and fields were seen as arenas of power relations were actors had different positions, some more advantageous than others. DiMaggio & Powel (1983) concluded that as fields were structured as it suited to the most powerful actors, and for that reason, the dominant logic of the field was the logic of those actors. Thus, accordingly to this approach, when a new logic gained space in a field, the conflict was temporary and was resolved when one side won (DiMaggio, 1983) or when a new logic (a hybrid version of the two logics in conflict) was chosen (Thornton *et al.*, 2005). This shift on logics was considered essential for an institutional change to occur. Prior studies (e.g., Kitchener, 2002; Greenwood & Suddaby, 2006) focused on field-level actors and their role on shifting logics, neglecting the role of micro-level actors in organizations. Studies that narrowed the lens from the field-level to micro-level (e.g., Townley, 2002; Khan *et al*., 2007) were able to perceive that although institutional logics had shifted, and apparently the new logics were accepted by individuals, the daily routines showed compliance with older logics.

Reay & Hinings (2009) based their work on previous conclusions but valued the importance of micro-level actors. They concluded that the coexistence between multiple (and conflicting) logics could last for long periods of time without one being the dominator; the key was collaboration among actors. Scott *et al.* (2000) also examined how health care organizational

field shifted from a dominant logic, the professional logic, to a new one with three logics co-existing (professional, government and managerial-market) and no one dominating. The approach of Reay & Hinings (2009) embraces the idea that collaboration is a key factor for resolving competing logics conflicts and for institutionalization, once institutional fields are a product of collaborative activities that create networks, structures and institutional rules. Identity is "*a concept of enduring sense of self*" (Reay & Hinings, 2009: 633) that is connected to values and beliefs (logics). For that reason, the authors concluded that it is important to consider identity when analyzing collaboration. In existing literature there are contradictory understanding concerning the relation among identity and collaboration. Some authors (e.g., Maguire & Hardy, 2009; Hardy *et al.*, 2005) consider that an effective collaboration requires the detachment (at least partial) from existing identity and an approach to a new identity that is created within the collaboration. Alternatively, others (e.g. Fiol *et al*., 2009; Borum, 1980) sustain that the maintenance of collaborator's strong and independent identities may avoid insurmountable conflicts. The results of Reay & Hinings's (2009) are in line with these latter referred investigations. They concluded that in collaborative relationships, collaborators (in this case, physicians and regional health administrations managers) found important to preserve their own, established, identity. Thus, the maintenance and protection of different identities did not threaten physicians with the loss of their established identity and independence. This attitude facilitated collaboration between the two groups. The purpose was to achieve collective goals but maintain the differences between groups. These conclusions, as referred previously, contrast with the idea that a new collaborative identity has to emerge from the group join (Hardy *et al*., 2005), but also contradicts the concept of new hybrid logics (e.g. Thornton *et al.*, 2005) where individual's multiple logics merge. Reay & Hinings (2009) justify these contradictory results with the studies mentioned above, with the nature of collaboration they studied and the identity of the collaborators – physicians. For this reason authors believe that these findings are relevant for collaborations where one part has a specific knowledge that is crucial to reach the objectives, holds strong identities and power to maintain their independence. In these types of collaborations, the maintenance of identities is essential for collaboration to happen. This conclusion highlights the importance of identity in institutional change (Reay & Hinings, 2009; Lawrence & Suddaby, 2006). Creed *et al*. (2010) also concluded that "*professional identity is a significant driver of action, especially when autonomy is threatened; it can be an important reason why actors resist*

institutional change" (p.1339). Reay & Hinings (2009) investigation also evidenced that micro-level action can result in macro-level change. For this to happen time, energy and perseverance are required. The cumulative effects create change and new institutional arrangements, with more than one logics guiding actors. By directing their attention to micro-level actors, Reay & Hinings (2009) discovered that actors maintained a stable and long co-existence in the presence of conflicting logics. Instead of a day-to-day conflict they experienced collaboration relations between the groups observed [physicians and health care managers].

Beech & Huxham (2003) studied how identities affect collaboration in organizations and how trust, essential for those collaborations, is mined or incited. The authors corroborated the approach made by Brown (2015) which states that identities are not static; they shift along the time. Beech & Huxham (2003: 28) went further and identified that, in some periods, some identities may become crystallized and that affects the "*nurturing that is the essence of productive collaborative practice*". Notwithstanding, Ferlie *et al*. (2005) call attention to the fact that hospitals present a highly compartmentalized structure, where labor is divided to respond to several institutional logics, in order to obtain multiple institutional approvals. Hospital's structure is highly compartmentalized with several "*cellular, self-sealing and institutionalized*" boundaries (*ibid*: 129). The problem of this compartmentalization is that it acts against collaboration. Such organizations need leaders that understand multiple logics – ambidextrous leaders. They understand different types of business; have the authority to implement incentives to minimize internal resistances; and skills to communicate in a clear and precise manner eliminating any skepticism.

Jarvis (2016) claims that the existing studies that relate identity with higher institutional processes are incomplete and presents three reasons to justify his opinion. At first place, Jarvis calls out attention to the fact that researchers have been neglecting the consequences that identity construction may have on institutional stability. Last two decades have been fertile in addressing identity construction to institutional change. Thus, and according to the researcher, this neglecting recalls the focus on salient occurrences, dismissing the day-to-day institutional processes, which was the gap that identity construction research aimed to correct. The existing identity construction literature focuses on individual-level neglecting collective identities. Nevertheless, individual experiences are lived within collectives (workgroups, organizations and

professions) "*which carry along with them salient identities imbued to members*" (Jarvis, 2016: 175).

2.4. Identity

Identity is "*crucial to how and what one values, thinks, feels and does in all social domains, including organizations*" (Albert *et al*., 2000: 14).

Identity is perceived as central for themes as meaning and motivation, commitment, loyalty, logics of action and decision making, stability and change, among several others (Sveningsson & Alvesson, 2003). Identity and identification are root concepts in organizational context (Albert *et al.*, 2000). Entities (organizations, groups or even a person) need to know who they are to interact with each other; they need a situated sense of an identity. To Brown (2015) identity is consensually regarded as the meanings that individuals attach reflexively to themselves, through processes of social interaction seeking to answer the question "*who am I*?". These meanings are constructed based on discourses, narratives, dialogues or other symbolic forms (Giddens, 1991). In congruence with Rao *et al.,* (2003) and Sahlin-Andersson (1996), Meyer & Hammerschmid (2006) embrace the idea that through the use of new vocabulary, categorizations, ideals, reference groups, and role models, identities shift and change in actual forms and practices start to occur. Thornton *et al.* (2012) highlight the importance of vocabulary and language for changes in organizational practices and institutional logics, in their model.

Vocabularies and language are vital to meaning and to link individual knowledge and social interactions to culture at the level of organizations and institutional field (Thornton *et al.*, 2012). Professionals adjust this new discourse through their pre-existing interpretative schemas. One of the powers that discourse presents is related to how it exposes the problem(s) for which it is the solution. Doolin (2002) deconstructs the type of enterprise discourse that was used in new public management era for hospitals and highlights that this type of discourse makes each individual aware of them as an object. In his investigation he studied how physicians were reluctant to accept enterprise spirit in health care public service and how the discourse was used with the aim to expose clinical management as a tool for their own empowerment. According to Sveningsson & Alvesson (2003), discourse is a tricky term, used in a variety of ways: "*a way of*

reasoning (form of logic), with certain truth effects through its impact on practice, anchored in a particular vocabulary that constitutes a particular version of the social world" (Sveningsson & Alvesson, 2003: 1172). Alvesson & Willmott (2002) analyzed the discourses of quality management and concluded that they promote "*passion, soul and charisma*" (p.622). They go further and consider that the employee is considered as an "*identity worker*", as he incorporates the managerial discourses into "*narratives of self-identity*" (*ibid*). Examples of these processed is the use of *We*, instead of *The company*. This is accomplished through processes of "*induction, training and corporate education*", using in-house magazines, posters, etc. (*ibid*).

Sveningsson & Alvesson (2003) approach defend that individuals do not have to choose between extreme visions when it comes to identity creation. Those extreme visions are related to, in one hand, progressive authors that defend an 'essentialist' position where identity is fixed and stable, alluding to the concept of being; and, on the other hand, authors that defend that identity is flexible, uncertain, radically decentered and the concept of being is replaced by becoming. This vision is corroborated by Brown (2015) that states that identities are not a sign of stability; they are connected to the now through language and action. Professional identity is affected by the present occupation as well as by the organization through social and relational influences. Professional roles are identified as prestigious and provide, in most cases, the professional with autonomy and with a degree of privilege (Slay & Smith, 2011). Employee's identities can be shaped by leaders, mainly their closest leader, once he plays an important role in their daily life in organizations (He & Brown, 2013). Institutional theorists recognized the important role that identity plays in a process of institutional change; it can affect the process or even block it (Creed *et al*., 2010; Meyer & Hammerschmid, 2006), especially when actor's autonomy is endanger (Marquis & Lounsbury, 2007).

Modern world, as a result of globalization, rapid-technological advancements and workforce diversity is characterized by dynamic and complex organizations that have little to do with the conventional organization forms (Sullivan & Baruch, 2009). Organizations have become less hierarchical, teamwork grew, and outsourcing of secondary competences turned into a reality and the same occurred with temporary employment. These transformations in organizational forms also had an impact on the institutional forms on which organizations perpetuated until now (*ibid*). As a consequence it became essential for organizations to define and internalize what the

organization stands for (who are we?) and where it intends to go (who do we want to become?). In other words, it is essential to organizations to define a clear sense of identity. Within these premises organizations "*must reside in the heads and hearts of its members*" (Albert *et al.*, 2000: 13). Narrowing the lens, becomes evident that with the increase of short-term contracts (that do not establish a stable relation with the employer) and with the growth of boundaryless careers[5] the notion of loyalty or identification with one employer is becoming less common (Sullivan & Baruch, 2009). As a result of all these "*turbulent times*" (Albert *et al.*, 2000: 14*)*, the authors considered that it was the *momentum* to revisit the concepts of individual identity and identification.

2.4.1. Medical profession identity cultures

Professional autonomy and clinical freedom have been important in the construction of subjectivity and identity of physicians, ever since (Doolin, 2002). Jarvis (2016: 180) identifies three "*relevant, interdependent institutionalized identity cultures that characterizes medical profession*": the culture of perfection, the culture of silence and the culture of autonomy. These three cultures provide physicians with scripts and schemas embodied in their collective identity which they construct in training years and will be reinforced through the years of profession. These three cultures are also relevant to a reality that is part of medical practice – the medical error – that leads to an emotion that accompanies physicians during their professional life (and sometimes further) – shame (Jarvis, 2016). The culture of perfection is something that is embodied in physicians; it starts at medical school, where they (re)build their collective identity and it is reinforced in each day of practice. This perception creates the idea that physicians are, somehow, trained to think binary: either they are excellent or they are a failure (Ofri, 2010). When errors occur, and they do occur, physicians, who have a perfection-based self-identity construction, inflict in their selves the punishment of guilt and shame. This extreme shame is impregnated in physicians since medical school; it develops and grows hand-in-hand with perfection culture. Therefore, physicians do not talk about errors. This is a direct consequence from culture of perfection: the culture of silence. This culture provides physicians with one, and only one, reaction towards medical error: silence. Physicians are constantly afraid to err because they know the consequences it will have on their own professional self-image. They also are

[5] Artur & Rosseau (1996) defined career opportunities beyond the boundary of a single employer. Individuals are independent rather than dependent (as usually happens on a traditional organizational career).

aware that arise from such a condition is not a hit-and-run process; contrariwise, it is a long and psychologically painful process. Voluntary reporting error, the assumption, by physicians, that reporting error seldom generates improvements and the extreme shame they experience, creates the genuine feeling that the correct attitude is to remain silent. This culture of silence is only possible due to physician's autonomy that has been a synonymous of supremacy and professional pride, mainly towards less qualified occupations. Physician's culture of autonomy is characterized by little, or non-existing, supervision and unquestionable decisions, allowing the silence that enfolds medical errors, creating a sort of black hole that swallows the facts to be silenced as if they have never happened (Jarvis, 2016). Professional autonomy is also the reason for physician's being considered the only source when a medical error occurs.

Medical autonomy is experienced at a collective level and at individual level. Collectively, medical professional autonomy has covered, until recently, three dimensions: political, related to the capacity to make policy decisions; economic, by setting their own remuneration; and technical, when they set their own standards and control performance (Doolin, 2002). Individually, medical professional autonomy/ clinical freedom derive from the fact that physicians hold exclusive skills to define illness, diagnose and prescribe treatments (Doolin, 2002). *"Individuals secure their sense of meaning and reality from participation in various discursive and disciplinary practices that constitute them as subjects, confirming an individualized sense of identity*" (Doolin, 2002: 374). This identity, with the emphasis on their exclusive right to decide treatments and have access to medical professional knowledge, explains the reactions from physicians towards the efforts to control their clinical practice and behavior.

2.5. New Public Management movement and public administration logic shift

In late 1980's and subsequent decades, under the scope of New Public Management, the public sector was the target of a major public management reform (Meyer & Hammerschmid, 2006). Common themes, that were new to public administration sector, became the center of changes that occurred in this period: "*greater financial accountability, the development of a range of measures of efficiency by which individuals, units and organizations are judged, marketization between service providers and within organizations, and the changing relationship between service providers and costumers*" (Thomas & Davies, 2005: 684). The legitimacy of

public sector activities became to be judged on the basis of outputs, outcomes and efficiency contrariwise the adherence to bureaucratic rules that were the respected public administration focus until then (Meyer & Hammerschmid, 2006). Furthermore, there was also the intention to "*erode the long-standing dominance of the biggest spenders within the National Health Service, the doctors*" (Dent, 1995: 881). Dent (1995) refers that 80 percent of all health costs were generated by medical decisions of physicians.

This profound institutional change is described by Scott *et al.* (2000: 27) like "*the ascendance of corporate forms and intrusion of managerial logics into even more arenas of social life*". When observing this major change process in society, the authors also differentiate incremental change from discontinuous change. Incremental change presupposes the evolution of organizational structures bounded by the existing patterns; on the opposite, discontinuous change reflects the addition of a new pattern or the substitution of the existing pattern for a new one. Scott *et al.* (2000: 26) consider this institutional change as a "*profound*" change with a discontinuous characteristic and multi-level. The authors consider a discontinuous "*profound*" change due to the radical change in actor's behavior (rather than a gradual or incremental one). And they consider this institutional change multi-level because it (1) affected from individual actor (new roles and new individual identities that affect behavior and attitudes) to organizations (assuming new characteristics and strategies); (2) altered the rules that led actor's behavior in the field, and the same occurred with governance structures, who suffered important and substantial modifications; (3) created new logics – by changing the aims pursued as well as the means used to achieve it and the justifications for action; (4) created new actors, individual and collective, that represent new combinations, hybrid existences or even new entrants – actors that already existed may have transformed their identities; (5) created new relations among actors, leading to new linkages and relational structures of fields altered; (6) created new meanings for actor's behavior and their effects – they may not have changed, they may still the same, but they are perceived in different ways; (7) changed boundaries that separated populations, organizations, activities and personal – they became thinner, less rigid, often diluted; (8) and finally, it also changed field boundaries – new activities and new legitimated actors imply new central and peripheral players which reduces, expands or realign field borders. Greenwood & Hinings (1996) highlight the fact that rapid change in a highly institutionalized sector does not usually come easily, unless in the presence of undermined or highly challenged structures; when that occurs

change can be profound and fast. This duality of structure and action is also emphasized by Giddens (1984) when he describes structures as the ongoing patterns that shape action but, at the same time, action creates and modifies structure.

At a macro level there has been much debate within literature, considering new public management movement. This theorization, at a macro level, has presented a deterministic vision of new public management, where individuals are passive agents who receive change discourses imposed by a "*given*" new public management and are classified as "*in compliance with*" or "*in resistance to*" (Thomas & Davies, 2005: 683). The introduction of management concepts gave birth to a new work role or social identity for employees, especially for executives, turning new public management into an *identity project* (Gay, 1996). Meyer & Hammerschmid (2006) described this phenomenon: "*from a servant of the state, its interests and its people*" to a "*manager of organizations and scarce resources*" (p.1001). Contrariwise, at micro level, little attention has been paid to the day-to-day experiences of public services professionals (Thomas & Davies, 2005). This confirms a critic that scholars have been made to institutional logics perspective and that refers to the fact that most of the institutional logics studies focus on macro-level processes, neglecting the effects of institutional logics on actor's daily routines and behaviors – micro level processes (Gadolin, 2017). This is also highlighted on Smets *et al.*'s (2012) work on institutional change, where they focus on micro level actions to explain institutional change at field and organization levels. By integrating the meso- and macro-levels, Thornton & Ocasio (1999) demonstrated the influence that institutional logics have on the attention that organizational actors present on defining a problem and recognizing a solution.

2.5.1. New public management movement, medical profession and the arising of new logics

In health sector, the hospital turned into a business, patients became costumers and hospital's administrators shifted to managers. The rational principles of planning and priorities, within an integrated service, vanished (Dent, 1995). This new system, described by Dent (1995: 882) is based on "*a separation of functions between the purchaser and provider of health services*". The purchaser is the health ministry who, on behalf of the citizenry, is in charge to obtain the 'best' price/quality health service from the provider, hospitals. This is done by

'contracting out' the service to different hospitals "*which are (formally at least) in competition with each other*" (ibid: 882), simulating a competing quasi-market.

As a result of these changes, medical professional's autonomy was affected, once their decisions started to be mediated. Physicians still detain control on operational decision making but allocative decisions are government and market's responsibilities. Neo-liberalistic political perspectives redefined state's roles and functions and boundaries of professional competences (Doolin, 2002). This shaping of clinical autonomy can be understood as a form of *governmentality* (Doolin, 2002: 375) that is related to "*socio-technologies of controlling, organizing and ordering*" regarding the shape of the self. This includes appropriate and responsible conducts for individuals and collectives (*ibid*). Individuals, as subjects, come to act towards government programs, pursuing government's objectives.

A duality of logics was installed in hospitals: physician's professional logics vs management's business-like logics (Llewellyn, 2001; Kitchener, 2002; Reay & Hinings, 2005; van den Broek *et al*., 2014; Besharov & Smith, 2014; Shaw *et al*., 2017). Business-like logic (or managerial logic) relates elements from market and bureaucracy that were introduced in public sector and nonprofit organizations by the new public management reforms. This logic's emphasis efficiency, hierarchy marked by line management, and economic and managerial control (Sirris, 2019).

According to Freidson (2001) professional logic is related to special knowledge, a knowledge that is specialized and that is acquired with effort, which makes it an elite knowledge and, for that, an instrument of power. Professional logic respects closed expert occupations and is characterized by "*autonomy, discretion, and trust*" and it is exclusive because of the long-term academic training and socialization that their members had gone through (Sirris, 2019: 1). The control of work and self-regulation, autonomy and independence, is what differentiates professionals from other workers (Freidson, 2001). Due to the previous reasons listed, professionals only accept guidance and supervision when it is from a respected peer. Physicians have been seen as the paragon professionals (Freidson, 1986; Abbot 1988), not only due to the control they have always had in their professional work but also due to the dominance that they have had and still do, among other occupations in medicine groups (nurses, laboratory technicians, X-ray technicians, etc.). Nevertheless nursing has passed through a

professionalization that brought them more autonomy still subordination of nurses to physicians is a reality in health services. These two different roles (dominant/subordinated) creates in these two classes a totally different predisposition for managerial approaches that may influence the control they have on their work. While nurses may not see that intervention as a threat to their (relative) autonomy, physicians are more likely to see it as illegitimate, which is a consequence of the strong identification to the professional logic (Gadolin, 2017).

As discussed previously, often organizations experience the existence of multiple and, sometimes, conflicting institutional logics (Pache & Santos, 2010). This institutional complexity, that occurs when multiple and incompatible logics arise from multiple institutional logics, became to characterize healthcare organizations after new public management reforms (Besharov & Smith, 2014). This occurred because healthcare organizations started to depend on a highly number of actors that defend different logics (Pache & Santos, 2010). Greenwood *et al*. (2011) consider that hospitals have become a hybrid structure because they can only be seen as legitimate if they host multiple professionals and balance professional and commercial goals, assuming, thus, a hybrid structure. As they state "*most are seen as legitimate and even expected to exhibit hybrid characteristics*" (*ibid,* 2011: 355). Hospitals also have to respect the norms of community logics both with patients and with the local communities where they are situated. This leads to a reality were hospitals, that have an institutional identity, see its legitimacy divided in subunits that depend on each other's legitimacy (*ibid*).

An accommodation relationship is how Dent (1995) defines previous relations between National Health Service and medical profession. When medical audits and contracts were introduced, expectations from managers and physicians changed but still remains to be the latter who determine the criteria that define quality of medical care. Dent (1995: 894) argues that physicians suffered a "*comfortable incorporation within the new system as senior managers*", withdrawing the ghosts of subordination, deprofessionalization or even proletarianization. Doolin (2002) concluded in his research that senior physician's reactions towards the new management logic can be categorized in three major groups. The first group, that had an easy adaptation, assumed hybrid roles as managers. Contrariwise, there was another group of physicians who resisted changing their professional identity, defending their role as medical professional providing services to the public. And the major group, constituted by physicians that had a part

time job in public hospitals, and their own private clinical business, who resisted firmly to the introduction of management and enterprise discourses in public health system. However, they adopted entirely and assumed enterprise behavior in private sector. The explanation for this dual behavior is related to their historical professional autonomy that is jeopardized by the new organizational control (*ibid*).

Llewellyn (2001) termed this new role of senior physicians (who assumed management responsibilities) as *two-way window* suggesting increased interchange between boundary roles. This *two-way window* expression is a metaphor that the author uses to "*theorize the understanding of clinicians who become medical managers*" (Llewellyn, 2001: 619). According to Llewellyn (2001), senior physicians assumed a *janusian* thinking (McCaskey, 1988), i.e. the capacity to join, in a constructive way, two opposite ideas, as they mediate medicine and management. Llewellyn defends that communicational transparency is a "*pivotal drive to progress*" (2001: 596) and in her study she describes the difficulty of transmitting a message, either from managers to physicians, or *vice-versa*. Both have different logics and work with different set of ideas and, thus, have different frames for sense making. This reality leads to situations where messages cannot be decoded by the receiver (*ibid*). The joining of two groups with different expertise tends to culminate in one of two different situations: or it creates an alignment (but where one of the parts is privileged) or it creates a new domain of expertise. In the particular case of clinical directors, they not only have access to management's set of ideas but they also control their interpretation and their dissemination through their colleagues. Contrariwise, management does not have access to clinical set of ideas nor does control those ideas. This process of joining expertise was described by Borum (1995) who assumed that alignment can take place but it can lead also to a privileged part. Llewellyn (2001) concludes that in the case of clinical directors and managers it is clear that clinical agenda is privileged, increasing the power of clinical directors.

CHAPTER III - METHODOLOGY

This chapter presents the methodology the researcher embraced in this qualitative investigation. This chapter is divided in four parts. In the first part the researcher justifies her choice for a qualitative research and the choice to the use of a case study as method. After the main research steps followed by researcher are reviewed and described. Third part presents the methods used in this investigation. Lastly the researcher provides explanations on the quality of conclusions.

"What makes a valid body of knowledge is not a simple choice of methods and data. It is the coherence, the rigor and the transparency of a chain of scientific decisions related to the object of study, the problem related to this object, the research questions, the possible answers, the methods of data collection and analysis, and the conclusion. The hard thinking in this decision-making process is the methodology. In other words, methodology is the 'analysis of the principles or procedures of inquiry in a particular field'."

(Gaudet & Robert, 2018: 6)

3.1. Qualitative study and the choice for a case study

This investigation aims to understand how the logic inherent to an accreditation program in a hospital related with the logics pre-existent in the organization. Considering this main objective, the researcher followed a qualitative research design as Reay & Jones consider that qualitative methods "*hold great promise for investigating institutional logics*" (2016: 441). Logics are intrinsically suited to qualitative investigation, data and methods, which require a profound dive in the phenomenon (*ibid*). Furthermore, when investigating this main research theme the researcher came across pertinent questions that made her extend the research to institutional work executed by specific actors who played a crucial role in the implementation of this new logic. Qualitative research provides the investigator with knowledge of "*how things work in particular contexts*", moving away from the goal of finding the general picture or the average (Mason, 2002: 1). It was unquestionable for the researcher that this investigation was qualitative and she opted for a case study as this method contributes to knowledge of individual, organizational, social and political phenomena, allowing the researcher to investigate the holistic and meaningful characteristics of real-live happenings (Yin, 2018).

"*The distinctive need for case studies arises out of the desire to understand complex social phenomena*" (Yin, 2018: 1)

Furthermore, the choice for this method was also confirmed by the research questions *how* or *why* drawn in this investigation, and that are addressed in this chapter, as well by a "*set of contemporary events that researcher has little or no control*" (cf. Figure 3.1) (Yin, 2018: 5). This case study is explanatory and exploratory (Yin, 2018; Ryan *et al*., 2002). Explanatory because it tests explanations for why specific events have occurred. Exploratory because it aims to generate theoretical developments based on the specific practices observed.

Figure 3.1 - Conditions that Define the Research Strategy to be Chosen

Conditions ---------- Strategy	Form of research question	Requires control of behavioral events?	Focuses on Contemporary events?
Experiment	how, why ?	Yes	Yes
Survey	who, what, where, how many, how much?	No	Yes
Archival analysis	who, what, where, how many, how much?	No	Yes/ No
History	how, why ?	No	No
Case Study	**how, why ?**	**No**	**Yes**

Source: Yin (2018: 5)

3.1.1 Capturing institutional logics – pattern inductive technique

Based on Reay & Jones (2016) approach the researcher employed the pattern inductive technique to study institutional logics. This presupposes that the analysis of data to capture logics is made bottom-up, using an inductive approach (Gaudet & Robert, 2018; Reay & Jones, 2016). Thus, the researcher captured logics by showing as much of the raw data as she could. In this technique, text is not convertible into numbers to be treated as variables nor is fitted in external framework. The raw materials with which the researcher worked were the text segments taken directly from interview transcripts, the notes that were taken from field observations and the documents that were grouped into categories that revealed patterns associated with certain logic. This way of capturing logics is based on the assumption that "*the only way to understand a particular social or cultural phenomenon is to look at it from the 'inside'*" (Myers, 2013: 38). The aim is to understand and interpret so it is possible to explain a localized reality (Gaudet & Robert, 2018). The three logics identified are summarized in Table 3.1.

Table 3.1. – Three ideal types of Institutional Logics in HOSO

	Professional logic (Physicians)	Business-like logic (Board of Directors)	Bureaucratic-quality logic (Accreditation Program assured by Quality Commission)
Sources of Legitimacy	Personal expertise	Market efficiency	Prestigious and globally recognized organization (CHKS)
Sources of Authority	Professional Association	Top management; Board of Directors	Top management; DGS (through a clause in the contract); CHKS
Sources of Identity	Personal reputation	Bureaucratic roles	Bureaucratic rules; organizational reputation
Central values	Autonomy, discretion, trust	Efficiency; competition and performance measurement	Quality; Best practices
Basis of strategy	Increase personal reputation	Increase productive capacity	Increase quality of services
Overall goal	Provide all "medically" necessary services	Provide effective and efficient services	Ensure the best safety conditions for the patient from the moment he enters until he leaves the hospital

Source: adapted from Thornton *et al.* (2012: 56, 73); Thornton (2002: 85)

Nevertheless, inductive research has been criticized for lacking scholar rigor. With the aim to create credible interpretations of data and present plausible and defensible conclusions, the researcher used an approach conceived by Gioia *et al.* (2012). This approach enables creative imagination and systematic rigor in qualitative grounded theory investigations (see sections 3.2.4

and 3.4. for a detailed description of how the approach was used to assist the researcher to analyze data).

3.2. Research steps

3.2.1. Research design

Traditionally organization researchers design and execute theory development work based on traditional scientific method. Gioia *et al.* (2012) believe that the construct elaboration is what focuses more researchers' attention, rooting advances in knowledge and delimiting what is possible to know. Nevertheless, the researcher followed Ryan *et al.* (2002) and Yin's (2018) steps to conduct this case study. According to the authors case study research encompasses several steps, which should be followed in an interactive manner according to the course of the investigation. They are: (1) developing a research design; (2) preparation; (3) collecting evidence; (4) assessing evidence; (5) identifying and explaining patterns and (6) thesis writing. Each of these steps is discussed from subsection 3.2.2 to subsection 3.2.5.

The researcher did not planed a research design until she went to the ground and began to take knowledge of what that accreditation program was and all the details that surrounded it. Just after having collected some data from the initial interviews, in the pilot study, the researcher was able to understand that the accreditation program in that hospital was the culmination of a new logic that had its origins in societal field; this helped the researcher to rearrange the initial ideas she had in mind, and to define research questions. Research questions are the heart of qualitative research design and they should lead to an interactive process of research (Gaudet & Robert, 2018). Question words are extremely important in qualitative research questions and in the research design and usually they are a 'how' question (*ibid*). *How* questions enable rich understandings and explanations. They also enable the understanding of social processes. Some questions may not have the *how* word but they engage in the idea of complex processes (cf. Table 3.2) (*ibid*).

Table 3.2 - Question words and research questions

Hypothetico-deductive and linear knowledge production	Inductive and iterative knowledge production
Which, what Who Why Where When	How Some why questions lead to interpretative and comprehensive knowledge

Source: Gaudet & Robert (2018: 11)

The research questions that were proposed by the researcher were as follows:

1. How a new institutional logic ["bureaucratic-quality"] emerged and developed in the Portuguese public sector of health care?

2. Why and how was the new logic introduced in HOSO and what were the dynamics associated with the introduction of the new logic at the intra-organizational level?

3.2.2. Preparation work before starting to collect data

The researcher prepared for starting the case study by understanding the pressures European Union exerted in accreditation programs. Therefore some literature review was done previously. The researcher began the process of approaching evidence by conducting a pilot study, accessing the hospital in order to understand its accreditation process history and identify signals of European pressures. First meetings occurred with Financial Director, who was the liaison to the hospital. From those meetings the researcher was able to understand this process history in Sant'iago do Outão's Orthopedic Hospital (HOSO) and she could also identify the field actors and organization actors that were central to contact in order to understand the big picture of this process.

3.2.3 Collecting and assessing evidence

Collecting data for case studies is furthermore complex than in other research strategies considering the challenges faced by researchers (Yin, 2018). A methodological versatility is required and, at the same time, quality control must be ensured during this step. In this case study and according to Yin (2018) the researcher relied on documentation, archival records, interviews and direct observations. "*Data sources are those places or phenomena from or through which you believe data can be generated*" (Mason, 2002: 51).

Documentation and archival records were an extremely important and relevant source of evidence as this study dates back to the early 21st century and, in order to gain a general idea of all NPM movement in Europe, it was necessary to go back until the late 1980's. For example, the researcher gathered original documents, such as the "*Quality Portuguese system in Health*" (Ministério da Saúde, no dated) that explained in detail the objectives of the quality program and how quality goals could be achieved. IQS's magazines are another example of precious archived sources that were made available to the researcher by the IQS's ex-director.

The researcher had to rely on these sources (together with interviews) in order to create the knowledge of what was happening in late 1990s and early 2000s in HOSO. Direct observations, whenever possible, were used to supplement these data sources and to testify the visible transformations HOSO went through.

The initial intent was to restrain the analysis to interviews in the hospital and some research in European Community websites. Notwithstanding, as interviews were taking place and the research on documents, legislation and academic papers on institutional logics were reviewed, the researcher began to feel necessity to expand the scope of her investigation so it was possible to justify the emergence of these accreditation programs in the health field and the emergence of the "bureaucratic-quality" logic. Therefore the study became a cross-level dynamic investigation. "*At the beginning of the process, qualitative researchers often do not know where they will land*" (Bansal & Corley, 2012: 512).

For that reason the list of interviewees was much diversified in terms of professional class and organizations. As this process took place in late 1990's, early 2000's, not all the actors of the process were still in HOSO and some were already retired. Despite this the researcher was able to contact with a former Minister of Health (1999/2002), the two presidents of the Health Quality Institute in the period of 2000/2006, the English auditor from Caspe Healthcare Knowledge Systems (CHKS) who is in charge now of HOSO's re-acreditation (the auditor who accompanied HOSO's accreditation program's implementation is retired), the director of quality department in DGS in 2018, the coordinator of accreditation health model for NHS in 2018 and several other professionals retired (but exerted functions at the moment of the implementation of the accreditation program in HOSO.

The use of multiple sources of data (generated by HOSO, DGS's quality department, IQS's directors, a researcher in this area from ENSP, a former Minister of Health, CHKS client manager, CHKS auditors) and multiple methods used (interviews, documents and direct observation) allowed the researcher "*to address a broader range of historical, attitudinal, and behavioral issues*" but the major advantage was the process of triangulation that it enabled (Yin, 2018: 98). It was possible to corroborate data and even narratives from interviewees and documentation from the period analyzed, leading to more convincing and accurate findings and conclusions (*ibid*).

3.2.4. Identifying and explaining patterns

"*The features that enhance qualitative rigor actually begin with our approach to analyses*" (Gioia *et al*., 2012: 20).

This step is described as *"the most difficult and challenging in case studies*" (Yin, 2018: 139). The way how to organize data is not simply a technical decision or an administrative decision; it is related with the practical orientation of the study and the practical shape of data and it is part of researcher's analytical strategy (Mason, 2002).

Before initiating the analysis process the researcher concluded interview transcriptions. Mason (2002) highlights the fact that transcriptions are always partial partly because they do not capture non-verbal aspects of the interactions and also because for some verbal

expressions there are no written translations. Therefore it is essential that researchers do capture their own observations, interpretations and experiences of the interview. Although taped recorded, the researcher always took written notes during the interviews and wrote a summary of each interview right after or in the subsequent day.

To initiate data analysis the researcher had to immerse in it, categorize text excerpts in order to discover the hidden meanings and then identify patterns of beliefs that are characteristic of particular logics. As the researcher followed Reay & Jones (2016) pattern inductive technique the objective was to identify or capture logics from ground–level data and engage in a process of upward theory building. To identify institutional logics underneath data text segments were clustered in meaningful categories that revealed actors behavior. The researcher used the word processor MS Word to undergo this process and used Gioia-type figure to show raw data and the categorization process (Reay & Jones, 2016).

It was possible to show how NPM began to be introduced in Government programs (by analyzing the narratives, rhetoric and "business-like" terms used) and how this implied major changes in health sector, leading to the development of a new logic in the field(cf. Appendix V).

The Gioia framework was used to analyze the data the researcher collected related with the institutional work undertaken to bring a new logic to the field and the hospital studied. The use of these frameworks and tables revealed to be extremely useful in the process of writing-up and helped the researcher to focus on all themes that were crucial in that process. Figure 3.2 originated Appendix II that evidences all the interactions among different levels and within the hospital.

During the process of collecting evidence some patterns began to emerge and initial explanations were produced. They were the result of researcher's linking findings with theory. In order to validate those first explanations feedback meetings took place and the researcher was able to understand if those explanations were meaningful to interviewees. Getting these feedbacks gave the researcher the guarantee that explanations were plausible and reinforced her work.

Nonetheless, *"…all explanations are partial and capable of development in the future"* (Ryan et al., 2002: 157).

3.2.5. Theory development and writing-up thesis

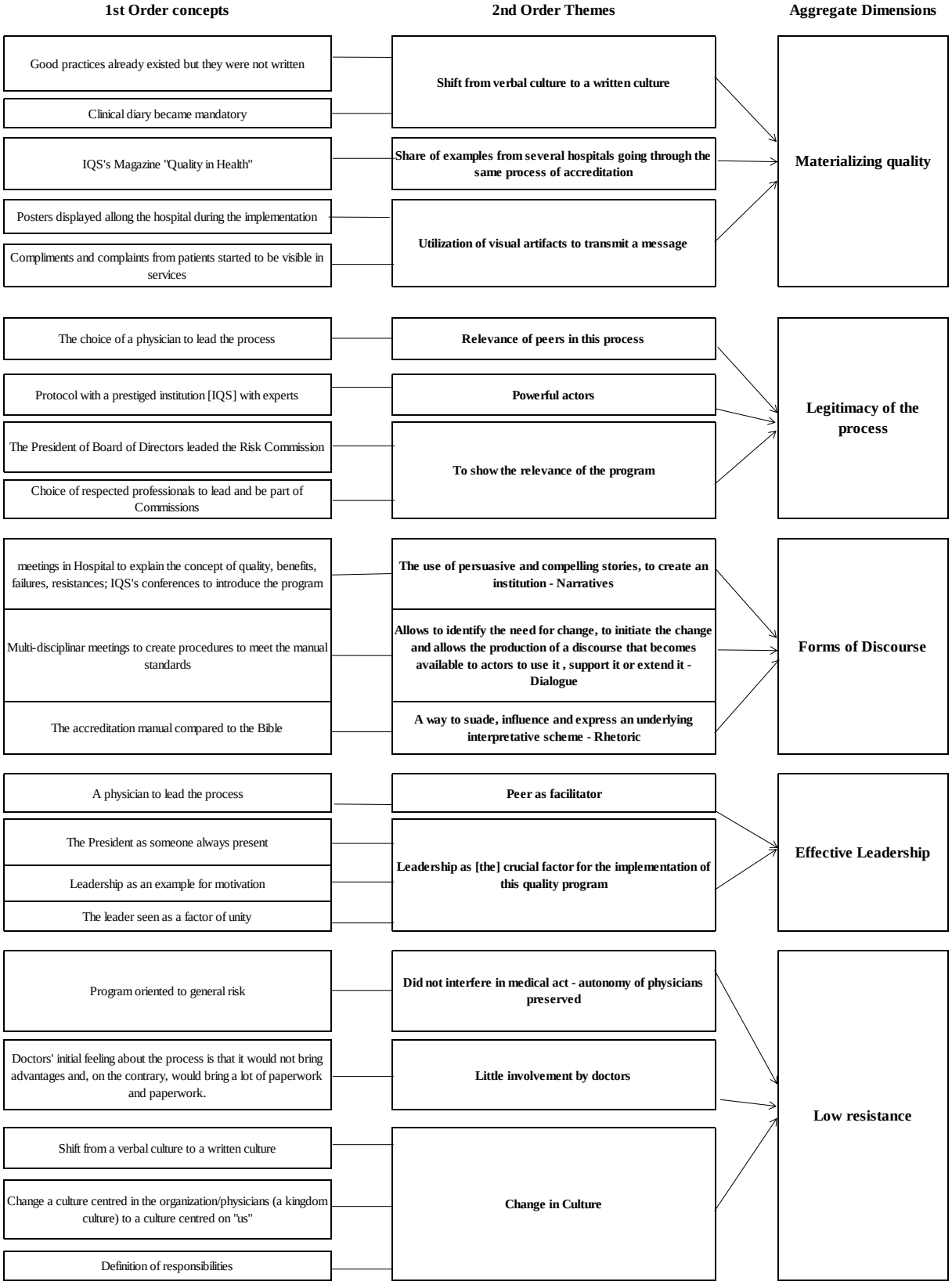
When working in case studies, *"we do not need general theories to explain, it is the pattern discovered in the case that does the explaining"* (Ryan *et al.*, 2002: 157).

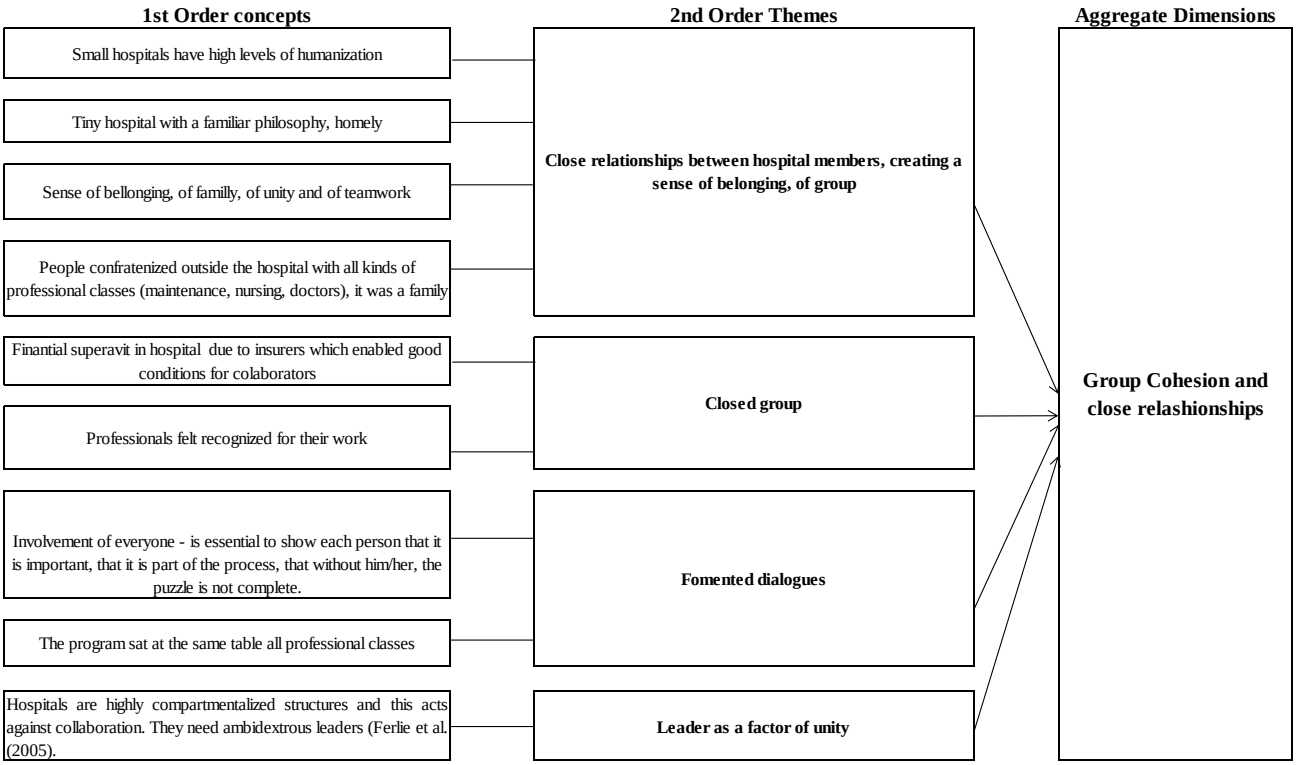
As this study was explanatory existing theory was used to explain the findings. At a first glance it seemed to the researcher that Reay & Hinings study (2009) captured what had happened in HOSO, explaining the coexistence of multiple logics by collaboration between specific actors. Nonetheless this presupposes a change in logics and the researcher concluded that it was not possible to assume that this new logic altered the existing ones.

This study was at the same time an exploratory case study as it allowed new insights for theory development.

"The writing-up stage involves the construction of the case study from what is likely to be a mountain of data, field notes, reports, etc., which have been collected during the fieldwork. This is a creative and literacy act, and, as such, the case researcher is the author-writer of the case study."(Ryan *et al*., 2002: 157).

Figure 3.2 - Gioia framework applied to this case study





Source: Adapted from Gioia *et al*. (2012:21)

3.3. Methods used in this investigation

In this investigation the researcher used a combination of three methods for generating qualitative data: semi-structured interviews, observation and documents.

This case study was conducted in a Portuguese hospital, a small and specialized hospital, located near Setúbal and Arrábida's mountain. The choice for this hospital is related to the fact that researcher had studied the same hospital but with another scope (cost accounting) for her master thesis. That work made her think that there was more to understand about that hospital that had special features: the ambiance; the size; the fact of being located far from everything and being a national reference in orthopedics. Having been welcome for the first time was also a point that was considered by the researcher as case studies rely on the openness and peoples' willing to share memories, thoughts and feelings with the investigator. "*Very often a case will be chosen simply because it allows access*" (Silverman, 2000: 102). As this hospital was one of the first to

volunteer for an accreditation program the researcher took the decision of embracing this new study in the same hospital.

Interview process was conducted in two parts: the pilot study, from March 2012 to December 2013. The main study initiated in November 2017 and lasted until June 2019. In the total of both studies, 32 interviews were conducted, totalizing 55.5 hours. The fact that it was possible to interview some actors that would be difficult to access at the outset, mainly because it was a theme that appealed to the memory of 20 years ago and because they are top management what implies lack of agenda, was an encouraging stimulus for the researcher. Appendix III resumes the interviews conducted in this research. Subsequently the methods used in this study will be detailed.

3.3.1. Interview techniques

Semi-structured interview is the heart of qualitative research because it enables to obtain "*both retrospective and real-time accounts by those people experiencing the phenomenon*" studied (Gioia *et al*, 2012: 19). Therefore, they are the most commonly used method in qualitative research (Mason, 2002, 2018; Yin, 2018). Extreme attention was deposited in the initial interview protocol, to ensure that it was focused in the research questions. As research progressed it was necessary to look back to the interview protocol. The researcher altered some scripts and re-interviewed some actors in order to triangulate information and delve into subjects that had not been addressed, or had not been much explored in a first interview (Gioia *et al.*, 2012). Interviews were semi-structured and because the interviewees were from different entities the researcher had an adapted script for each interview, moving away from "*one-fit-fits-all structured approach*" (Mason, 2002: 64), but always anchored in the same objective that was to answer the research questions.

"*Your approach to making analytical comparisons in your data set will certainly not depend upon having asked all interviewees the same questions. You will assume that in order to achieve data which are comparable in key ways, far from giving everyone standardized questions in a standardized form, you may well need to ask different questions of your different*

interviewees – precisely so that you can generate situated knowledge with all of your interviewees" (Mason, 2002: 65).

Although interview guides were the investigation line, the researcher was opened to explore themes and topics that might arise in the conversations. Contrary to what may seem, due to the informal and conversational style, to plan and carry out semi-structured interviews is much more complex and exhausting than, for example, to develop a structured questionnaire (Mason, 2002, 2018). Qualitative researchers have to develop and use specific intellectual and social skills.

In this interview process key informants were critical to the success of this investigation because they provided the researcher with insights in this particular subject and also they suggested sources that corroborated evidence provided – documents provided to the researcher and names and contacts of other key actors in this puzzle (Yin, 2018: 84). It is important to be cautious to not depend on a key informant, confirming data provided with other sources of evidence and search for possible contrary information (Yin, 2018). It was possible to triangulate information by comparing data from various interviews. However, the researcher had access to the collection of journals published by IQS from 2000 to 2006, on a quarterly basis, where various accreditation processes were presented as well as all the issues behind this process. Documentation was an extraordinary method for triangulating and validating the information that was obtained from the interviews.

3.3.2. Interviewees

Appendix III presents a summary of the interviewees. As referred previously the pilot study took place from March 2012 to December 2013. In this period of time the researcher carried out nine interviews, totalizing 14.5 hours. These were extremely important interviews as they gave the researcher the first knowledge of the process in HOSO. The first meeting took place in March 2012 with the Finance Director who introduced the researcher into the subject, and helped her to get a preliminary understanding of the process initiated the main changes occurred and the people's reaction. After having a preliminary understanding of what happened in HOSO, the researcher zoomed out and analyzed what was happening in Portugal at that time to

understand the reasons for the emergence of the accreditation programs. It was possible to interview a Professor from Public Health National School who investigated in this area and who introduced the researcher into some peripheral subjects that had a lot of influence on the subjects studied. This professor was a key informant for the researcher as she put the researcher in contact with the person who was always responsible for the hospital accreditation program at the Health Quality Institute, being its last director at the time of the interview (Yin, 2018). After this interview the researcher met again with the finance director. After these three interviews the researcher was able to start focusing on the key organization and field actors. The physician who introduced and led the process was interviewed twice in less than a month as the information conveyed was central to the study and further details were required. Finally, a former Minister of Health (July 2001-April 2002 and March 2005-January 2008)), Correia de Campos, was interviewed. This interview closed the pilot study and the researcher had been able to gain a reasonable knowledge of what was happening in HOSO and in the health sector at the beginning of the 21st century.

The main study began in 2017 as it was necessary to deepen the investigation and understand the intricacies of this whole process. With that aim key persons for HOSO accreditation program were interviewed, as the President of Board of Directors, a Chief-nurse and a member of quality commission back in the time of the implementation of the program. It was possible to interview, in Lisbon, CHKS's client manager, who works in London. Another meeting was then repeated with the last IQS's director (2005/2006). As the researcher was also interested in understanding what was being done nowadays in terms of quality in health, mainly hospitals accreditation programs, she managed to schedule a meeting with DGS's quality Director (2012/18) and another with the current head of the hospital accreditation model that DGS currently has with Agencia de Calidad Sanitaria de Andalucía (ACSA). She also got to interview an internal auditor that works in the accreditation process. To get a deeper understanding and to validate data collected it was needed to talk with the former IQS's director (who is now the president of ARS-LVT). This interviewee opened the doors of the ARS's library to the researcher, which helped the researcher to get additional documentation for her investigation. After this interview the researcher took some time to read the documentation from IQS and re-started interviews in April 2018 and this time focused solely in HOSO's process. Interviews were

done with the person responsible for the administrative (heavy) process of accreditation program, a radiology technician who is also a quality enhancing element, five physicians (two were already retired) and three nurses (one was already retired, also).

3.3.3. Recording data

When using interviews as a method for data collection the researcher must choose how to record data. It may be done using field notes, tape recording (and transcription) or both.

The researcher opted to use field notes, transcripts and tape recordings as Tessier (2012) proposes. Yet according to Mason,

"While observational researchers may use a range of methods to record or construct "data" from their observations, including audio – or video-recordings, photographs, maps and diagrams, many would argue that their most significant activity is the writing of fieldnotes" (Mason, 2002:98)

The researcher tape-recorded the majority of the interviews (20), excluding 12 interviews in which the researcher opted to take field-notes. This occurred either when the interview involved the observation of processes or when interviews were made in the emergency room, preventing the researcher of tape recording them.

Despite the benefits of field notes (*as Emerson et al. (2001: 353) state "[f]ieldnotes (re)constitute that world in preserved forms that can be reviewed, studied and thought about time and time again"),* opting just for them in a research may present some disadvantages because "*field notes cannot be replayed, that is the event cannot be encountered more than once. This leads to a loss of information and a loss of valuable details*" (Tessier, 2012: 449).

Tape-recording interviews were extremely important to enable the access to data and use Gioia *et al*. (2012) approach to inductive research, conferring qualitative rigor. With this approach efforts are done to give voice to the informants in the early stages of data gathering and analysis and also to represent their voices prominently in the reporting of the research *(ibid).*

3.3.4. Different sources of data

As referred previously other sources of data were used in this investigation to collect evidence. In some interviews documents were made available to the researcher and they were a precious source for triangulating evidence. IQS's former director in the period of 2000/2005 provided access to documentation that, otherwise, the researcher would not have reached because they were not edited documents; they were documents delivered in hand in the presentation of the Portuguese Health Quality System, which was embodied in the document "A health strategy for turn of the century" (Ministério da Saúde, *no dated*). In HOSO it was possible to have access to accreditation manuals and prove that they did not contained any standard that would interfere with the medical act, guaranteeing the freedom and autonomy of these professionals.

The visit to the ARS library turned out very worthwhile. All the IQS's magazines and other publications from the Ministry of Health, related with the Community Support Framework III (QCAIII)[6] were made available and revealed essential to triangulate information that was already dated as well as understand the narratives and rhetoric employed with the introduction of the new logic in the field.

Internet sites were also a way to access other sources of data, mainly for European Union funds, for government programs, and to get access to reports from the European Commission, IOM, Portuguese Observatory of Health Systems (OPSS), WHO and OECD. Furthermore, the Eurohealth magazine was also reviewed as it contextualized European health sector in the years the researcher was investigating.

Main laws in health sector were analyzed, particularly between 1990 and 2008 to contextualize the changes that occurred in this sector (see Appendix IV for a list of these laws).

Direct observation was another source of data that was used by the investigator. This direct observation gave researcher the knowledge that quantitative research cannot present researcher: feelings and emotions. As an interviewee resumed "*there was hope, willing, people with know-how and money*". Health quality became a priority for government and changes were

[6] Document that framed the set of Community structural aid to Portugal, in the programming periods 1989-1993 (QCA I), 1994-1999 (QCA II) and 2000-2006 (QCA III) (Ministério do Planeamento, 2000).

lived and experienced by professionals. Direct observations also allowed researcher to verify the material and signing that this accreditation program introduced in HOSO.

3.4. Testing quality of conclusions

Bias is commonly understood as "*any influence that provides a distortion in the results of a study (Polit & Beck, 2014) - is a term drawn from the quantitative research paradigm"* (Galdas, 2017: 1).

In qualitative research two different approaches regarding bias subsist: one that recognizes bias and considers reliability and validity of data as the guard of research's quality as they ensure rigor (Morse *et al*., 2002); and other that considers that concepts such as rigor and trustworthiness are more pertinent to this type of (qualitative) research and that do not recognize bias as "*compatible with the philosophical underpinnings of qualitative inquiry"* (Galdas, 2017: 1) (see also, Gioia *et al.,* 2012; Reay & Jones, 2016).

Morse *et al.* (2002) advocate that rigor of quality research was compromised in 1980s when the concepts of reliability and validity (which were implemented during the research and were researcher's responsibility- a constructive procedure) were substituted by trustworthiness and utility (implemented when the study is completed and the reader of the quality study makes that evaluation - an evaluative procedure).

The first approach (i.e., the reliability and validity approach) relies on verification to ensure reliability and validity (the rigor) during the study. Morse *et al.* (2002) argue that strategies to guarantee rigor include investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy. These strategies should be part of the research process, i.e. they must be constantly revised, helping the researcher to identify when to continue, stop or modify the research process in order to achieve reliability and validity and ensure rigor.

As stated previously, in this investigation the researcher employed the pattern inductive technique to study institutional logics, which consists on "*the identification or capturing of logics based on ground-level data and a process of upward theory building"* (Reay & Jones, 2016: 450). This technique enables the researcher to convince reviewers that their interpretations are

trustworthy (Smets *et al*., 2012). Embracing a pattern inductive technique presupposes that the analyses of data to capture logics is made bottom-up, using an inductive approach (Gaudet & Robert, 2018; Reay & Jones, 2016). This implied that the researcher captured logics showing as much of the raw data as she could and allowed the researcher to show some of that data gathered together with the context of the study. It enabled also the researcher to provide insights into actor's explanations, helping to show values and beliefs of certain logic. Using raw data (quotes from interviewees) the meta-message to the reader is "*this is what the informants told us. We're not making this stuff up*" (Gioia *et al*., 2012: 23). Nevertheless, inductive research has been criticized for lacking scholar rigor. With the aim to create credible interpretations of data and present plausible and defensible conclusions, the researcher used an approach conceived by Gioia *et al.* (2012). This approach enables creative imagination and systematic rigor in qualitative grounded theory investigations. In this study, Gioia's framework was used to analyze and show data related (1) with the introduction of a new logic in the hospital and its coexistence with pre-existing logics, and (2) to analyze data related with the institutional work that was accomplished by an entrepreneur, within this process studied (cf. Figure 3.2). The first step, at the level of the informants' terms and codes, consisted on the analysis of transcripts, so it was possible to categorize them into large categories: the 1st order categories. With the progress of research it was possible to identify similarities and differences between 1st order categories and regroup them into fewer categories, now labeled by themes. This step, 2nd order themes is at the level of themes, dimensions and larger narratives and it is theoretical already. Themes chosen helped the researcher to arrive to concepts that explain the phenomena observed (Gioia *et al.,* 2012). Figure 3.2 demonstrate how researcher evolved from raw data to terms and themes culminating in aggregated dimensions – "*a key component of demonstrating rigor in qualitative research*" (Gioia *et al*., 2012: 20).

In addition to using Gioia to ensure accurate handling of the information collected, the researcher also ensured investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy, an active analytic stance, and saturation, as Morse *et al.* (2002) advocate. Responsiveness by the researcher is ensured as she was opened to decline some ideas that were not supported by data. Verification strategies were also taken into account: (1) methodological coherence, assuring that the methods applied responded to the research questions;

(2) appropriate sample, assuring that in the sample is composed by who best represent or have knowledge on the topic. Negative cases were also investigated but the researcher did not identify any.

To ensure construct validity of this qualitative research the researcher also heeded Yin's suggestions (2003, 2018) and (1) adopted multiple sources of evidence - documentation, archival records, interviews and direct observations; (2) established a chain of evidence - the adoption of Reay & Jones (2016) pattern inductive technique enabled the identification and the capture of logics from ground–level data and the engagement in a process of upward theory building; and (3) was able to discuss some of the findings with key informants. Notwithstanding it was not possible to have the case study report reviewed by key informants, given their lack of time in that period.

CHAPTER IV – HEALTH QUALITY EVOLUTION

Developments in the Societal Field Levels

This chapter addresses the theme of quality and it is divided in three sections. In the first section the theme of quality is introduced and a description of the evolution of this concept *in lato sensu* through time is presented. The second section addresses quality related to health care and it is dived in four sub sections: (1) the first steps and definitions of quality in health, presenting the Donabedian model; (2) the developments occurred at societal level and how health policy has been europeanized; (3) the transformations at field level generated by societal developments; and (4) the accreditation regarding health care. The last section analyzes the particular case of Portugal. It begins with the history of national health care over the years until the creation of NHS. It is followed by the presentation of the political cycles which contextualize the evolutions that occurred in health during 1976 - 2006. Afterwards, the period between 1998 and 2006 is analyzed, as it was extremely relevant to the implementation of accreditation programs in hospitals, grounded on Saúde XXI Operational Program (2000/2006) financed by the III Community Support Framework (QCAIII) and implemented by the Health Quality Institute (IQS).

4.1. Quality *in Lato Sensu* – evolution through time

Quality has been a concern ever since men and women started to build and manufacture goods and exchange or sell them. According to Dooley (2000) the evolution of quality can be described through three paradigms: *caveat emptor* paradigm, the paradigm of quality control and the paradigm of total quality management.

In the pre-industrial era, quality was subjective and experiential, based on basic senses and experienced immediately and trough use. This concept of *caveat emptor* – let the buyer beware – was based on the principle that the consumer was responsible for ensuring, through observation, the quality of the product. The concern for quality was the need to obtain value for the money payed (Komashie *et al.*, 2007). In medieval society the manufacturing knowledge that was passed through generations became important for the quality of goods (Dooley, 2000; Komashie *et al.*, 2007). Guilds[7] started to appear and formalized professions with its embedded knowledge – there was no school, and apprentices learned from observation. Nonetheless, standards to measure quality were still inexistent, and buyer's observation was not trustworthy in all situations. In order to discourage poor quality production, punitive actions were taken, against producers whose goods presented poor quality, and the name of the craftsman, as a mark, started to appear inscribed on goods. The inscription of the producer's name on the product made traceability of poor-quality goods possible enabling the punishment, in case of bad quality, but also became a "*source of pride*" (Dooley, 2000: 8) and a synonymous for quality, streamlining the supply chain by suppressing prior inspection for marks that were already known as quality trustable. Still, there was some local variation that already anticipated the next paradigm of quality control. That is the case of military systems that were rigorous on "*standardization, control and conformance*" and emphasized the standardization of practices as a way to quality (*ibid*: 8). A paradigm change occurs rapidly and several factors contributed to the departure from the existing paradigm to the new paradigm of quality control, as industrial revolution and the increasing complexity of products and processes in factories. The new management systems were based on labor division (separation between labor and management) and unit compensation schemes, to keep workers motivated. In what concerns quality, inspectors began to work side by

[7] A medieval association of craftsmen or merchants, often having considerable power.

side to workers and under production foreman. However, as conflicts between inspectors and production workers began to occur, firms decided to take inspectors out of production's control and inspection gained autonomy, becoming the embryo of quality control department, the basis for the forthcoming quality management. These changes led to a quality paradigm change where the responsibility for quality shifted from consumer to producer and it became a systematized and functionalized process, "*like everything else in early 20th century organizational management*" (*ibid*: 11). In 1929, Dodge and Romig published their sampling plans for the enumeration of product quality, and in 1931 Shewhart published his concept of control charts for the identification of process variation and stability which became known as the Shewhart Cycle. The Shewhart Cycle consisted in four main points: Plan, Do, Check/Study and Act, that was used continuously. Each step was linked to the previous one and it was not possible to move on to the next step without, previously, completing the preceding one (Cantiello *et al.*, 2016). Shewhart's quality control approach settled the basis for industrial quality methods (Komashie *et al.*, 2007) Through the decade of 1930's several societies and standards on quality management were established and the same happened in Europe with the establishment of the German Standards Committee, in 1926, and the British Standards Institution, in 1931 (Dooley, 2000). The fact that standards were being written and textbooks were being edited evidences that a new paradigm was being created and that *normal science*, rooted on that new paradigm, was being performed (Kuhn, 1970). Until World War II quality was ensured by inspection and tests that attested the compliance with the specifications. With World War II, the number of weapons to be inspected was so high that US Government had to rely on sampling inspection. Thus, a series of standards were produced and established to control production process. Military suppliers attended courses to implement standards; a model course was developed at Stanford and adopted by war training program; at the same time statistical quality control courses were having more audience. These trained quality practitioners changed the quality management in organizations. World War II gave a strong impetus in the practice of quality in organizations as Dooley (2000: 13) states: "[*t]he great influx of newly trained quality practitioners changed once again the organizational structure designed to manage quality*". Nonetheless, these training professionals and the use of statistical methods did not impact industry as expected. Quality, as a discipline, evolved but that was not reflected in business environment. Deming, Juran and Feigenbaum, three quality experts during this era, pointed the finger at top management for those minor impacts in business.

Juran stated that *"it is most important that top management be quality-minded. In the absence of sincere manifestation of interest at the top, little will happen below."* (*in* http://asq.org/about-asq/who-we-are/bio_juran.html)

Feigenbaum (1961) reinvented the concept of quality control and was the first author to use the term total quality control (TQC) in his book published in 1961, assuming that quality control management would only be effective if it started with the design of the product and ended with the costumer's acquisition and satisfaction, concluding that quality is everyone's role in organizations. Nevertheless, total quality control lacked some elements that were later considered on total quality management (TQM), such as supplier developmental relationships, people empowerment and teamwork.

However, it was in Japan that results from quality control were most felt on organizations and the next paradigm started to germ. With the end of World War II, Japan was shattered and had to rely on its industrial capacity and creativity to upraise the whole country. Deming and Juran became key figures on Japan's upswing. In 1950, and after being in Japan for two working visits and established connections with Japanese statisticians, Deming was invited from the Union of Japanese Scientists and Engineers to teach statistical methods to Japanese industry. In 1954, Juran was also invited to lecture organizational structures and functions for quality management to managers, engineers and professors. They both found a receptive audience among industrialists, managers, engineers and the most influential members of the Japanese business elite. The courses were the same they have been lectured in the USA, notwithstanding, their effectiveness was totally different. The active participation of senior managers became the critical variable in Japanese quality leadership. As Juran stated:

"The difference was not what I said but whose ears heard it" (1993: 43)

The managerial focus lectured by Juran, integrated with statistical quality control taught by Deming, embedded in top management, created the necessary conditions for Japanese economy to bloom. By 1960 Japan was already into world markets. In 1962, Quality Control (QC) Circles were an innovation in Japan. The aim was to create small groups of workers in departments that would spend time (usually after work schedule) finding solutions for departmental quality problems (Dooley, 2000). This demonstrates the way Japanese looked

towards work division. Production workers were taken into account in planning actions, neglecting the, somehow, discriminatory nature of Taylorism vision on work division: planning for engineers and execution for workers. Still it was believed that workers volunteered for these QC circles (that took place after work hours, without extra pay and where working group was emphasized over individual work) as a result of Japanese manager's leadership, life time employment that generates security, and due to the way they conceived organizational structures. These quality control circles that led to a greater employee's involvement, meshed with detailed planning, and raised the definition of TQC to a next level: Japanese total quality control, a customer-driven strategy that spread throughout the world and represented the next quality paradigm: TQM. Several conditions lead to the emergence of this new paradigm in the West, in late 1960's, as the rise of consumerism, the request for higher quality from consumers and global markets with global competition. Although in late 1960's quality was already pointed as strategic important for firm success (Feigenbaum, 1961), it was only in the 1980's and 1990's that firm leaders strongly assumed quality importance. European Union (at the time European Economic Community) settled quality system standards that had to be accomplished by firms in order to access its markets. At an International level, the International Organization for Standardization (ISO) published, in 1987, the first standard regarding quality, the first of many standards from ISO 9000 family. It became to be the most well-known and best-selling standards, "*used by manufacturers to reassure consumers that products are of high quality*" (ISO, website).

TQM paradigm implied vast changes in quality practice such as the inclusion of services and information, enfolding areas as health care, education, government and religion. TQM is a management philosophy for continuously improving the quality of products/ services and its processes, and all who is involved in the production of goods or provision of services is responsible for this continuous improvement (Øvretveit, 2000). Quality became *all* responsibility, mainly management, instead a unique quality department responsibility. Benchmarking and best practices learning gained vision and followers. Quality continuous improvement methods became a mainstream organizational activity. The focus on customer satisfaction and requirements turned central to organizations that started to adopt measures of customer satisfaction and loyalty. TQM paradigm still continues and it is undoubtedly "*deeply embedded in organizational practice and will remain a part of the organizational landscape*" (Dooley, 2000: 21).

4.2. Quality of Healthcare

4.2.1. First steps and definition(s)

A hundred years ago, hospitals barely existed and the same occurred with the conception of health systems we have today (WHO, 2000). Contrary to what happened in product's quality evolution, where, even in *caveat emptor* stage, consumers demanded quality, in healthcare the early motivations for quality evolution were of professional nature. There is no historical evidence of consumer's demand for quality, until the latter part of the 20th century (Komashie *et al*., 2007). In 1847, American physicians felt the need for a tougher, standardized medical education system, and the American Medical Association was created. In 1854, during the Crimean War, an English nurse, Florence Nightingale, developed practices that decreased the mortality rate among wounded soldiers from 60 percent to a stunning 1 percent (Chassin & O'Kane, 2010). Those practices became standards in hospitals today: hand washing, sterilized surgical tools, regular change of bedding and wards cleaned. Thus, her meticulous records were the base for the actual statistical quality measurement and she was a precursor in collecting, tabulation, interpretation and graphical display of descriptive statistics – she named it a Coxcomb, which turned to the usually known pie chart (Sheingold and Hahn, 2014).

In 1913 the Clinical Congress of Surgeons of North America first discussed standardization and established a committee to determine how to evaluate the suitability of hospitals for training surgeons. This committee found that there were no generally accepted basic rules or standards by which one hospital could compare it to another. As a consequence, in 1917, the American College of Surgeons began working on a program of standards to respond to the wide variation in practices and conditions that existed in hospitals throughout the United States and Canada. In that year the first *Minimum Standards for Hospitals* was developed and the requirements filled just one page. In the following year only 89 of 692 hospitals surveyed were able to meet the requirements of the minimum standard. But in 1949, almost half the hospitals in US were participating voluntarily in the program (Wright, 2017).

In 1951, the Joint Commission on the Accreditation of Hospitals Organization (JCAHO) was founded by a collaboration of five leading provider organizations: the American College of Surgeons, the American Hospital Association, the American Medical Association, the American College of Physicians and the Canadian Medical Association. The JCAHO was a non-for-profit

organization to provide voluntary accreditation to hospitals and used the American College of Surgeons' minimum standards (Chassin & O'Kane, 2010).

In 1955, Sheps in a paper entitled *Approaches to the quality of hospital care* resumed the attention paid to this theme on those days: "*Increasing attention is being paid to the problems of improving and of appraising the quality of health services in general and of hospital care in particular. The general problems of measurement and evaluation in all these areas are similar. Basically, they involve finding valid and reliable measurements of quality and interpreting these measurements when made."* (p. 877)

In 1974, IOM defined that "*the primary goal of a quality assurance system should be to make health care more effective in bettering the health status and satisfaction of a population within the resources which society and individuals have chosen to spend for that care*" (IOM, 1974: 1).

Later, in 1988, Donabedian developed a structure-process-outcomes model to assess health services and evaluate quality of care that is still at the basis of several frameworks to access quality of care, namely the OECD framework (European Commission, 2016). IOM also considered its definition of health care as "*consistent with that proposed by Avedis Donabedian*" because it emphasizes outcomes but links the processes of health care to those outcomes, and also emphasizes the "*expected net benefit*" (IOM, 1990a: 23). Therefore, and considering the importance that such a model has assumed in subsequent models for assessing health quality, the Donabedian model will be presented next.

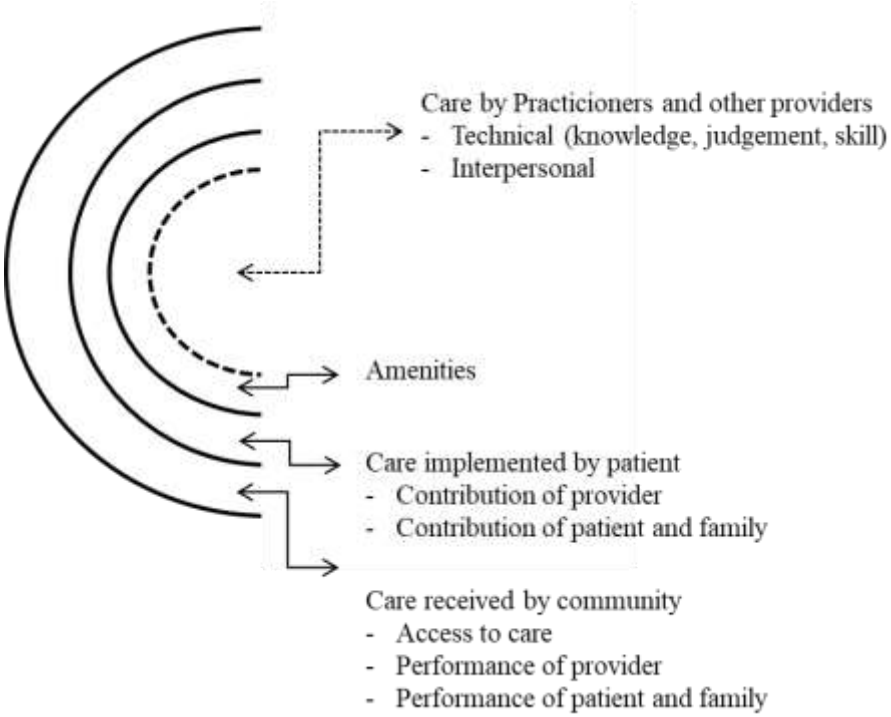
The Donabedian model

In 1966, Donabedian stated that "*the definition of quality may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part*" (1966: 167).

Later, in 1988, Donabedian concluded that there are several formulations possible and legitimate to define quality and he suggests that these several formulations can be viewed as steps of a ladder, or a series of successive circles with a target in the middle. In the foundation of that ladder, or in the target of those circles, resides the performance of physicians and other health care practitioners, cf. Figure 4.1 (Donabedian, 1988). The author defended that two factors

influence the performance of practitioners and they are (1) the technical care (the science), and (2) the management of the interpersonal process (the heart of health care). The technical performance is related with the knowledge and judgement that are applied in the conception of care strategies to use and the skills to implement those strategies. Technical performance is then compared with the best in practice. The best in practice gained prestige due to be known, in average, to achieve the best results in health. Donabedian calls the term effectiveness to measure the part of the best results that is achievable, creating a correspondence between the technical care administrated and its effectiveness. The management of the interpersonal process is often ignored because it is not easily available. It respects the communications between patient and physician and it is the vehicle through which technical care is applied and on which its success depends. Through the patient discourse physicians arrive to a diagnosis and through physicians' discourse patients have information on illness and treatments and are motivated to active participate in their recuperation.

Figure 4.1 – Levels at which quality may be assessed



Source: Donabedian (1988: 1744).

The next circle is related to amenities – "*the desirable attributes of the settings within which care is provided*" - as comfort, convenience, quiet, privacy, among others (Donabedian, 1988: 1744). Moving on to the next circle, Donabedian crossed an important boundary, including the contributions to care of the patients and their family members. The responsibility is shared by provider and consumer, assuming that the later also carry some responsibility on the success or failure of care. The last circle refers to the care that is received by community as a whole. Those who have more or less access and, having access, to what quality care is provided. Individual physicians' and institutions performance are important but this depends on multiple factors that are out of control from providers. With these circles Donabedian tried to demonstrate that the definition of quality embraces multiple factors as we move away from practitioner's performance.

The model proposed by Donabedian, the structure-process-outcomes model to assess health services and evaluate quality of care, is based on the idea that good structure increases the probability of good process, and good process increases the probability of good outcome. By structure Donabedian means the attributes in which care occurs – material resources (facilities, equipment and money), human resources (number and qualifications of personnel) and organizational structure (medical staff organization, peer review methods and reimbursement methods). Process includes patient's activities seeking care and practitioner's activities making diagnosis and recommending and implementing treatments. Donabedian considers outcomes as the effects of treatments on patient's health but he also considers the patient's knowledge, healthy changes in patient's behavior and the satisfaction degree of patients with care. Donabedian considers that patient satisfaction is indispensable to top assessments of quality but also to the design and management of health care systems. Therefore, and before quality assessment is undertaken, Donabedian considers mandatory a preexisting knowledge on the connections between structure and process – provided by organizational sciences - between interpersonal process and outcome – provided by behavioral sciences - and between technical care process and outcome – provided by health care sciences. Nevertheless, Donabedian considered that organizational and behavior sciences contributed little to quality assessment. Thus, quality assessment was considered "*neither clinical research nor technology assessment*" (Donabedian,

1988: 1746). Donabedian, considered it as an administrative tool used to monitor performance within acceptable bounds. Still he affirms that "*as a general rule, it is best to include in any system of assessment, elements of structure, process and outcome*" (1988: 1746). In 1988, Donabedian stated that quality of care, in a time not far away, was something that was not capable of measurement; it was real, perceivable and appreciated but not measured. In the 1980's this reality shifted "*too far in the opposite direction*" (*ibid*: 1743). The model presented by Donabedian explained, by levels, how the definition of quality changes as we "*move outward from the performance of the practitioners, to the care received by patients, and to the care received by communities*" and also "*becomes narrower or more expansive, depending on how narrowly or broadly we define the concept of health and our responsibility for it*" (1988: 1744).

Some years later, IOM recognized that 1974's definition did not defined quality of care and presented a new definition: "*the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*" (1990: 21). This definition was a result from the analysis of 100 definitions of quality. IOM identified 18 dimensions presented in those 100 definitions and selected the 8 dimensions that had the higher frequency of occurrence, cf. Table 4.1.

Table 4.1 – Key dimensions used by IOM in their definition of quality of healthcare

Scale of quality
Nature of entity being evaluated
Type of recipient identified
Goal-oriented care
Risk versus benefit tradeoffs
Aspects of outcomes specified or not
Role and responsibility of recipient asserted
Constrained by technology and the existing state of scientific knowledge

Source: adapted from IOM (1990a: 21).

For IOM, in quality definition a (1) scale dimension is needed so it is possible to distinguish between high, middle or low quality. Without this dimension quality could be just seen as a level above the unacceptable. Thus, it is important to (2) define the nature of the entity that is being evaluated, the scope of the analysis. *Health care*, for example, implies a larger number of services than *medical care*. It is also important to (3) identify the recipient of the care: an individual or a population. (4) Health care goals vary depending of what parties are involved in it (government, patients, hospitals administrators, physicians, agencies, among others). Goals will determine, using a Donabedian (1988) approach, the processes and the structures that will be used to achieve them. As Donabedian (*ibid*) defended, not all goals are of technical nature; the interpersonal process is extremely important, mainly in elder patients (IOM, 1990b). (5) The dimension of risk versus benefit tradeoffs allows considering that any health care carries some risks. The main idea is the net benefit, that is, the degree of risk or harm comparing to benefits. (6) The way outcomes are specified or not is important because they may be referred as general (e.g., improved health, level of well-being) or can be more specific (e.g., least morbidity or psychological well-being). (7) The role and responsibility of recipient asserted is a dimension that has gained relevance. It asserts active participation in health care process; either it is an individual or a population. This is related, in most cases, to informed consent and decision making. (8) The existence of the dimension "*constrained by technology and the existing state of scientific knowledge*" in a quality definition means that quality care is limited by the "*inadequate knowledge of the effectiveness of many technologies and the vast domains of health care science yet unexplored*" (IOM, 1990b: 122). The IOM considered its definition of health care as "*consistent with that proposed by Avedis Donabedian*" because it emphasizes outcomes but links the processes of health care to those outcomes, and also emphasizes the "*expected net benefit*" (IOM, 1990a: 23).

In 2008, Legido-Quigley *et al*. (p.2) identified "*the most frequently applied definitions of quality of care*" in the literature (cf. Table 4.2)

Table 4.2 – Definitions of quality of care

Author/ Organization	Definition
Donabedian (1980)	Quality of care is the kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts
IOM (1990)	Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge
Department of Health (UK) (1997)	Quality of care is: - doing the right things (what) - to the right people (to whom) - at the right time (when) - and doing things right first time
Council of Europe (1998)	Quality of care is the degree to which the treatmet dispensed increases the patient's chances of achieving the desired results and diminishes the chances of undesirable results, having regard to the current state of knowledge
WHO (2000)	Quality of care is the level of attainment of health systems' intrinsic goals for health improvment and responsiveness to legitimate expectations of the population

Source: Legido-Quigley *et al*. (2008: 2)

4.2.2. Developments at societal level

During the post-war period in Europe in the 1950's and 1960's, the social politics were established on a stable, predictable and growth international economic environment. But in the 1970's, the oil crisis led to a stagnation of economies and social politics became unsustainable. The oil crises called into question the social state. Countries, which provided the public service through subsidies struggled and sought to introduce corporate mechanisms. Majone (1994) refers that, given the provider (the social welfare state) inefficiency, it was expected the emergence of a regulator state (neo-liberal state). This regulator state is characterized by the split between provider and financier functions, the sustained and directed regulation (apart from Government),

the efficient use of resources, and the introduction of (competitive) market rules. It is also characterized by the accountability of all hierarchical levels, the adoption of private management sector rules to public sector, incentives to production and productivity and the defense of accountability (*ibid*). Public sector had to become more efficient, transparent, and less spender. The solution found was to bring the concepts, techniques and business values typical of the private organizations to the public sector. A conscious management with the introduction of enterprise mechanisms was believed to, somehow, better ensure monitoring public spending and thereby, lead to greater efficiencies. This entailed major changes in public administration and the emergence of a new movement of reforms entitled by Hood (1991, 1995) as New Public Management (NPM), that started in the United Kingdom, in the early 1980's, with Premier Thatcher and it spread throughout the world.

During the 20th century a torrent of transforming reforms took place: the foundation of national health care systems, promotion of primary health care and the goal of health for all was assumed. But in the turn of the 21st century, centrally-planed economies (characteristics of a social welfare state) turned to market-oriented economies, reducing the state intervention on economies, which reduced governments control and enabled decentralization (characteristics of a neo-liberal state, with the state assuming a regulatory role) – the NPM movement attained health sector, mainly hospitals. This strategy, that sought to apply principles from the private sector into public sector organizations, emphasizes "*the centrality of competition and performance measurement*" (WHO, 1995: 52). Expectations on health services were greater than ever and WHO named this new vision as the "*new universalism*" that was based on the idea of "*delivery to all of high-quality essential care, defined mostly by criteria of effectiveness, cost and social acceptability*" (WHO, 2000: xiii). According to Markowe (1999: 5) there was a "*general demand for good quality comparable information relating to health determinants and outcomes*" originated by the enormous variations in health, healthcare and health services between the member states. Berman (1999: 9), suggested that these differences between state members might arise demands for "*accreditation of hospitals on a Europe-wide basis*" and recommended to the Commission and member states to consider "*if and how*" Europe-wide accreditations should be established.

As a result of these societal level transformations, the last two decades of 20th century were portrayed by actions and reports that show the growing concern over the issue of quality in health. In 1980, the WHO European Regional Office (EURO) organized seminars and workshops that gathered the first enthusiasts about health quality, and in 1985 one of those meetings, in Udine, Italy, gave birth to the International Society for Quality in Health Care (ISQua). IsQua's mission was *"to inspire and drive improvement in the quality and safety of healthcare worldwide through education and knowledge sharing, external evaluation, supporting health systems and connecting people through global networks."* (https://www.isqua.org/about.html)

In 1983, JCAHO was a private entity governed by representatives of hospitals and physicians that had as principal function the accreditation of hospitals. In theory accreditation was voluntary, but in practice it had an important role in licensing, certification and financing programs. Notwithstanding the fact of being identified as a private consultant, JCAHO played an important role in government regulatory programs, mainly the Medicare that relies on its accreditation to certify organizations for participation in it. Based on its standards and accreditation program, JCAHO had a major responsibility on the quality of care provided in American hospitals (Jost, 1983).

In 1984 a series of targets were developed by WHO European Region with the aim to reach the objective stated in 1978 – health for all by 2000[8]. Among those targets, Target 31 impelled every WHO member state to build effective mechanisms that would ensure quality of patient care by 1990 and, by 2000, to provide structures and processes that would allow continuous improvements in the quality of health care and appropriate development and use of new technologies. "*Target 31 explicitly requests member states to develop their quality assurance mechanisms*" (ISQua/ WHO, 2003: 131).

In 1995, the Health Committee of the Council of Europe created a Committee of Experts on Quality that drafted recommendations to Ministers of Health. According to those recommendations all member states should establish a quality improvement system. If necessary, states should create policies and structures to allow its development and implementation. In 1995

[88] The World Health Assembly (WHO) assumed the global goal of Health for all by the year 2000, in Alma-Ata Declaration, signed by 134 countries in 1978 (The National Academies of Sciences, Engineering, and Medicine, 2018).

an ISQua conference took place in St. Johns, Canada. In this conference it was stated that international credibility for accreditation in health had to be quickly established; otherwise, it would lose ground to International Organization for Standardization (ISO) that was spreading in business and industry and it was beginning to be applied in health, especially in Europe (Heidemann, 2000). The first step towards that credibility was that accreditors had to be accredited. That was the purpose of the Wellington Group, a group of "*representatives of long-standing national accreditation organizations who came together with people from countries where accreditation was only in its infancy*" (ISQua/ WHO, 2003: 19). Their main objective was to establish an assessment program for accrediting bodies though it became also an opportunity to share information about accreditation and discuss challenges. This group became part of Agenda for Leadership in Programs for Healthcare Accreditation [ALPHA] project led by ISQua and both projects "*contributed to the development of international health care accreditation*" (Heidemann, 2000: 230). The year of 1995 was a very profitable year with Wellington group and ISQua's accreditation initiatives but also with the preparation of the External Peer Review Techniques project [ExPeRT] that was established to examine the key quality monitoring systems used by EU countries, including Accreditation. The fund to this project arrived in 1996 from EU and it lasted until 1999. The difference between ExPeRT project and the previous two - Wellington group and ALPHA project - was that ExPeRT project was focused on "*health organization evaluation within the EU*" (*ibid*: 229). In the same year, a WHO report called attention to the fact that quality of health services was assuming an increasing importance: "*as a measure of value for money – reducing admissions and infection rates – and as a strategic instrument in a period of increased competition among hospitals*" (WHO, 1995: 38). It was becoming "*increasingly recognized that health care reform should address the quality of care provided*" (*ibid*: 203). In Europe, and until midst 1990's, quality issues were left to individual healthcare professionals, result of healthcare reforms that took place in Europe, during late 1980's and early 1990's, which focused on improving managerial efficiency and health outcomes, as a result of NPM.

In 1997 the European co-operation for Accreditation [EA] was created. EA is an association of national accreditation bodies in Europe that are officially recognized by their national Governments to assess and verify—against international standards—organizations that carry out evaluation services such as certification, verification, inspection, testing and calibration

(also known as conformity assessment services). The Portuguese Accreditation Institute, I.P. is the Portuguese member of EA. It was created in 2008, to answer the European Union Regulation No.765 that set the requirements for accreditation and market surveillance relating to the marketing of products and that assumed on number 11 that "*The establishment of a uniform national accreditation body should be without prejudice to the allocation of functions within member states.*" (Regulation (EC) No 765/2008 of the European Parliament and of the Council of 9 July 2008). Until 2008 the connections were made through Quality Portuguese Institute.

"*As the official guardian of the European accreditation infrastructure, EA has the overall strategic objective to safeguard the value and credibility of accredited conformity assessment services delivered by its Members and accredited conformity assessment bodies within the European market*." (http://www.european-accreditation.org, accessed on 21st June 2018)

Since 1980, the WHO Regional Committee for Europe constituted by 51 member states "*and their 870 million people living within an area stretching from Greenland in the north, the Mediterranean in the south and the Pacific shores of the Russian Federation in the east*" (WHO, 1998: 1), despite their differences, came together and created a common policy framework for health development. This policy sets targets to improvement and strategies to turn national policies into practical operational programs at local level (*ibid*). In 1999, there was an update that set the agenda until 2005, year for the next revision, and from that update resulted "*Health 21: the health for all policy framework for the WHO European Region*" (WHO, 1999) that established a series of targets that could be used as benchmark to measure the progresses made by each country. These targets, twenty-one as a whole were presented as "*an inspirational framework for developing health policies in the countries of the European Region*" (WHO, 1999: 9). Table 4.3 shows the twenty one targets, the main strategies to achieve them and the long term objectives they aim to achieve. Target 16 approaches the theme of quality of care and, especially 16.2., refers that "*all countries should have a nationwide mechanism for continuous monitoring and development of the quality of care for at least ten major health conditions, including measurement of health impact, cost effectiveness and patient satisfaction.*" (WHO, 1999: 126)

In 1999, in Vienna, European Union Health Ministers agreed to collaborate on quality in health care. Successive funded programs, by the European Union, have encouraged quality

related research programs, previously referred – ExPeRT, ALPHA and the Wellington group project. All these initiatives by WHO and ISQua had impact all over the world and several governments established quality units in their MoH or used advisory groups from multi-agencies. Looking across Europe, all countries were facing challenges on healthcare systems. NPM ideas spread and reforms on healthcare were taking place and, simultaneously, quality issues were on the agenda (Simonet, 2011).

In 1999 the Institute of Medicine (IOM) released two reports in 1999 and 2001 that called attention to the urgent need for quality improvement in health care. Those reports, *To err is human: building a safer health system* (IOM, 1999) and *Crossing the quality chasm: a new health system for the 21st century* (IOM, 2001), hold responsible the health care system as a whole, instead of individuals, following Deming and Juran's philosophies. Since the disclosure of those reports, health care organizations and health care providers became aware of the reality and have been working on improving practices to reduce errors, improve patient safety and health care quality.

Table 4.3. - Regional Health For All targets, strategies and the long term objectives they aim to

HEALTH21 – HFA policy framework for the WHO European Region – 21 targets	Strategies for target attainment (highlights only)	Long Term Objectives
1. Solidarity for health in the European Region	Sharing of vision, resources, knowledge and expertise in Europe More and better coordinated external support to countries in need, in line with their HFA-based development plans	By the year 2020, the present gap in health status between member states of the european region should be reduced by at least one third.
2. Equity in health	Reduction of social and economic inequities between groups, through policies, legislation and action	By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all member states, by substantially improving the level of health of disadvantaged groups.
3. Healthy start in life	Investment in social and economic wellbeing of parents and families Access to good reproductive and child health services	By the year 2020, all newborn babies, infants and pre-school children in the region should have better health, ensuring a healthy start in life.
4. Health of young people	Creation of supportive and safe physical, social and economic environments Cooperation of health, education and social services	By the year 2020, young people in the region should be healthier and better able to fulfil their roles in society.
5. Healthy aging	Housing, income and other measures to enhance autonomy and social productivity Health promotion and protection throughout life	By the year 2020, people over 65 years should have the opportunity of enjoying their full health potential and playing an active social role.
6. Improving mental health	Living and working conditions shaped to gain a sense of coherence and social relations Quality services for people with mental health problems	By the year 2020, people's psychosocial wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems.
7. Reducing communicable diseases	Eradication/elimination of poliomyelitis, measles and neonatal tetanus Internationally agreed surveillance, immunization and control strategies	By the year 2020, the adverse health effects of communicable diseases should be substantially diminished through systematically applied programmes to eradicate, eliminate or control infectious diseases of public health importance.
8. Reducing noncommunicable diseases	Prevention and control of common noncommunicable disease risk factors Healthy public policies, including a Europe-wide movement for healthy lifestyles	By the year 2020, morbidity, disability and premature mortality due to major chronic diseases should be reduced to the lowest feasible levels throughout the region.
9. Reducing injury from violence and accidents	Higher priority to safety and social cohesion in living and working environments	By the year 2020, there should be a significant and sustainable decrease in injuries, disability and death arising from accidents and violence in the region.
10. A healthy and safe physical environment	National and subnational action plans on environment and health Legal and economic instruments to reduce waste and pollution	By the year 2015, people in the region should live in a safer physical environment, with exposure to contaminants hazardous to health at levels not exceeding internationally agreed standards.
11. Healthier living	Actions to facilitate healthy choices regarding nutrition, physical exercise and sexuality	By the year 2015, people across society should have adopted healthier patterns of living.
12. Reducing harm from alcohol, drugs and tobacco	Broad strategies to prevent addictions and treat victims	By the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all member states.
13. Settings for health	Multisectoral mechanisms to make homes, schools, workplaces and cities more healthy	By the year 2015, people in the region should have greater opportunities to live in healthy physical and social environments at home, at school, at the workplace and in the local community.
14. Multisectoral responsibility for health	Through health impact assessment, all sectors to be accountable for their effects on health	By the year 2020, all sectors should have recognized and accepted their responsibility for health.
15. An integrated health sector	Primary health care for families and communities, with flexible systems of hospital referral	By the year 2010, people in the region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system.

HEALTH21 – HFA policy framework for the WHO European Region – 21 targets	Strategies for target attainment (highlights only)	Long Term Objectives
16. Managing for quality of care	Health outcomes to drive health development programmes and patient care	By the year 2010, member states should ensure that the management of the health sector, from population-based health programmes to individual patient care at the clinical level, is oriented towards health outcomes.
17. Funding health services and allocating resources	Funding systems fostering universal coverage, solidarity and sustainability Sufficient financial resources allocated to priority health needs	By the year 2010, member states should have sustainable financing and resource allocation mechanisms for health care systems based on the principles of equal access, cost–effectiveness, solidarity, and optimum quality.
18. Developing human resources for health	Education based on HFA principles Public health professionals educated to act as key enablers and advocates for health from community to country level	By the year 2010, all member states should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health.
19. Research and knowledge for health	Orientation of research policies to HFA needs Mechanisms to base practice on scientific evidence	By the year 2005, all member states should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.
20. Mobilizing partners for health	Advocacy, coalition-building and joint action for health Sectors and actors identify and account for mutual benefits of investment in health	By the year 2005, implementation of policies for health for all should engage individuals, groups and organizations throughout the public and private sectors, and civil society, in alliances and partnerships for health.
21. Policies and strategies for health for all	HFA policies (with targets and indicators) formulated and implemented from country to community level, involving relevant sectors and organizations	By the year 2010, all member states should have and be implementing policies for health for all at country, regional and local levels, supported by appropriate institutional infrastructures, managerial processes and innovative leadership.

Source: WHO (1999: 173)

In 1998, the Court of Justice of the European Union (CJEU) recognized that patients may access health care across the EU, as they do with goods and services within EU internal market. The CJEU highlighted that protection of public health and maintenance of high-quality national healthcare systems should be ensured. But it was only in 2011 that the European Parliament and the Council reached an agreement on the patient's right directive - Directive 2011/24/EU - in response to the CJEU case. In addition to hard law – the directive that gave patients the right to be reimbursed on cross-border care - the Lisbon Treaty (2009) underlined the principle of universality and access to good quality care. By doing that, those principles gained strength (Vollaard *et al.*, 2013). Cross-border health care in Europe brought to agenda and to discussion the health quality theme. It was necessary to ensure that European citizens could travel to get health care with quality. In 1999, Andrea Fischer, the German Minister of Health during the German EU Presidency stated that "*European health policy must become more visible and comprehensible for the general public…. The EU does not build hospitals. Nor does it pay for medical services. But it can improve the requirements that guarantee the necessary quality of care provision everywhere*." (Fisher, 1999: 2).

In 1999, the European Commission launched an European strategy for social protection systems that identified as one of the four key objectives to guide future action (that should concern all member states) "*the challenge of providing a high quality health care while containing the overall costs"* (European Commission, 1999: 12). At that time, there was a growing attention on this subject shared by WHO, OECD, the Council of EU and by the EU member states, with non-binding communications (from European Commission) and recommendations (from the Council) (Vollaard *et al*., 2013). This attention from all of those entities resulted in "*definitions and indicators facilitating international comparison and assessment of quality of care in all its facets*" (*ibid*: 3).

In 2000, the European Community published a communication that aimed to set out the need for a health strategy in EU, but it did not define it. One point that this strategy should focus was, in the words of Paul Belcher[9] and Philip Berman[10], to ensure *"that citizens know which hospitals meet international standards by overseeing accreditation of hospitals throughout*

[9] Senior Editorial Adviser of the Eurohealth, LSE Health & Social Care and Head of European Union Affairs at the European Health Management Association
[10] Director of the European Health Management Association

Europe." (Belcher and Berman, 2001: 1). They also agreed that *"the time has come to make a solid move towards establishing a meaningful and coherent health policy for the European Union. Concentrating on influencing 'other' policies is just not good enough"* (*ibid*: 1).

In 2000, the idea was that to achieve higher quality on health care more and better information was required, may it be on existing provision, or interventions done or constraints on service implementation. WHO (2000: 137) considered that "*supporting mechanisms as clinical protocols, training, licensing and accreditation processes*" should be used. In 2000, Murray & Frenk released a framework for WHO on assessing health system performance. The aim was to make the information on health systems performance comparable and meaningful. This would enable analysis, explanation of variations and would strengthen the "*scientific foundations of health policy at international and national levels*" (*ibid*: 717). One major application of this framework was to be included in the statistical annexes of the World Health Report, initiating in 2000, and including health system performance information for each country. The authors defined three main goals for health systems that formed the basis for assessing health system performance in World Health Organization's programs: health, responsiveness to the expectations of population and fairness in financial contribution.

In 2001, the project Health Care Quality Indicators [HCQI] – was created under the umbrella of the OECD with the aim to improve patient outcomes and develop and report common indicators that would make enable international comparisons of health care quality. This would help country members to compare their results with the best performances and identify priority areas for quality improvement (Carinci *et al*., 2015). As Mattke *et al*. (2006: 11) refer "*The long-term purpose of the Health Care Quality Indicators Project is to develop a set of indicators to raise questions about health care quality across countries for key conditions and treatments. In essence, they should be used as the basis for investigation to understand why differences exist and what can be done to reduce those differences and improve care in all countries*".

In 2004, in a document produced by WHO European Regional Office, Shaw concluded that pressures for harmonization between countries were felt especially in the EU. Due to the

mobility of patients and professionals and freedom trade it was necessary "*a common approach to the definition, assessment and improvement of standards in health care*" (Shaw, 2004: 28).

With the aim to enable information sharing on quality of care, EU started to fund some research projects in this area, such as Safety Improvements for Patients in Europe (SIMPatIE), that took off in February 2005 and lasted two years, and Methods of Assessing Response to Quality Improvement Strategies (MARQuIS), that lasted from January 2004 to June 2008 (Vallejo & Suñol, 2009). SIMPatIE project objective was to establish a common European vocabulary, indicators and internal and external instruments for improving safety in health care. The aim of MARQuIS project was "*to assess the value of different quality strategies, and to provide information on quality requirements for cross-border patients. In addition, it aimed to provide individual hospitals with information on the development of their quality strategies*" (Groene *et al*., 2009: 69). One of the main achievements of these projects was their contribution to place *"the topics of quality of care and patient safety high on the European Agenda"* (Vallejo & Suñol, 2009: 1) and they also provided toolboxes and recommendations to work on safety and quality (Vollaard *et al.*, 2013). This need (and willingness) for standardization involve also a non-binding prescription on how to diagnose and treat certain diseases as the quality guidelines concerning cancer screening and surgery and drugs prevention (*ibid*).

In the health program for 2014-2020[11] it is stated that, in order to facilitate the access to better and safer healthcare for EU citizens, cooperation between states should be supported and encouraged. This includes (1) sharing good practices on quality assurance systems, (2) developing guidelines to standardize health information and (3) tools for monitoring health, collecting and analyzing health data and (4) dissemination of the results of the program. This need for standardization and the deeper EU involvement can be justified by the Directive 2011/24/EU, referred previously, as the differences in how EU countries ensure quality and safety of care can be considered as an obstacle for this objective. Notwithstanding, Vollaard *et al.* (2013) demystifies this argument explaining that the number of patients that are using this facility is marginal. They argument that this variation among countries regarding their quality policy may also be observed as a unique characteristic of every single country once there are cultural, practical and institutional differences and different concerns between countries. The choices for

[11] Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014

specialized or non-specialized services, centralization or de-centralization are just some of the particularities that every EU member state has in their legacy and are unique characteristics of each one (*ibid*). As there are several different understandings on what concerns the policy of quality of care, the authors advocate that it is important to discuss "*which actor should be allowed to determine the policy of quality of care*" (*ibid*: 7).

In 2014, an expert group on health systems performance assessment (Expert Group on HSPA) was created by the European Commission to address this challenge: "*European Union could play stronger role in supporting member states to develop and exchange knowledge on how to monitor and measure the performance of health care systems"* (Expert Group on HSPA, 2016: 20). All European community members were invited as well as the OECD, WHO Regional Office for Europe and the European Observatory on Health Systems and Policies. The main aims were to exchange experiences, support national policy-makers for developing Health Systems Performance Assessment and intensify the cooperation between EU and OECD and WHO. The expert group was divided in two sub-groups: one addressing quality of care and the other the integrated care. The group that was responsible for the quality of care had as main objectives "t*o collect and share examples of best practices that have been implemented by member states, and to make this information available to the whole group and to identify ways and approaches by which quality assessment can be used to inform policy making, based on observed good practices at national and subnational level*" (Expert Group on HSPA, 2016: 21) and concluded that "*the challenge often faced by national policy makers is to identify those quality strategies that have positive impact on their health systems*" (*ibid*: 21). A key point for this group is that "*quality indicators do not measure quality but can only indicate that a system may be delivering high or poor quality*"; and they should never be read alone, they must be analyzed within a broad context (European Commission, 2016: 54).

Europeanization of health policy

To understand the aim of the funds from European Community it is necessary to go back to EU birth. Since its inception, in 1957, with the Treaty of Rome, the European Economic Union considered a regional policy. The regional policy is the EU's main investment policy and it targets all regions and cities in the European Union in order to support job creation, business

competitiveness, economic growth, sustainable development and improve citizens' quality of life. With the admission of Greece in 1981, Portugal in 1985 and of Spain in 1986, the Structural Funds were integrated into a global cohesion policy, with the aim to adapt these new arrivals. The Cohesion Policy first program (1989-1993) had a budget of €64 billion.

The Maastrich Treaty, in 1993, introduced the Cohesion Fund, the Committee of the regions and the Principle of subsidiarity, to ensure that decisions are taken as closely as possible to the citizen. Except in cases where the EU has exclusive competence, action at European level should not be taken unless it is more effective than action taken at national, regional or local level. Subsidiarity is closely bound up with the principles of proportionality and necessity, meaning that any action by the Union should not go beyond what is necessary to achieve the objectives of the Treaty[12] The resources for the structural and cohesion funds of the next program (1994-1999) were doubled and achieved a third of the EU budget. They reached a budget of €168 Billion. In 1995 a special objective was added to support the sparse population regions of Finland and Sweden that had joined EU.

The Lisbon Strategy, in 2000, was a remarkable mark in EU existence. Europe had a deficit in terms of technological capacity and innovation and this was the shift Europe needed to assure competitiveness; *knowledge society*, became the strategy's best-known slogan. The EU's priorities became to be: growth, jobs and innovation and the cohesion policy shifted its priorities to reflect this. In 2004 ten more countries joined EU – the population increased 20% but GDP only 5%. The budget for this program (2000-2006) reached €213 billion for the 15 members. In 2004, with the 10 new members, there was a new budget of more €22 billion.

The process that underlies the steps and how funds are approved allow us to perceive the institutional pressure and the way that European Commission interferes in domestic policies. The process begins with the Council strategy for the next period (usually 10 years before). The Regional Development Program (RDP) is presented to the European Commission by each member state. Based on the RDP, and within the framework of the priority regional objectives of EU, Structural Funds co-financing are discussed and the Commission, by mutual agreement with the member state authorities, establishes the priorities for action and the level of financial

[12] https://eur-lex.europa.eu/summary/glossary/subsidiarity.html, accessed in December 2018

assistance EU will provide – structural program. In some cases, the adoption of the structural program presupposes the adoption of a Community support framework (QCA) that establishes the general strategy for Regional assistance and the member states' strategies (e.g. Portugal).

In Portugal, each QCA presupposed several operational programs that were the development instruments for a sector or a region. Each operational program contained a coherent group of subprograms with pluri-annual actions. To be carried out, it was possible to request one or more Structural Funds. In QCAIII, Health Operational Program – Saúde XXI – was one of those Operational Programs. QCAIII started in 2000, 1st January, and lasted until December 2006. There was a tremendous growth in the budget that was allocated to Health in this QCAIII: from €544M (in QCAII) to €1022.5M, an 88% raise in funds. "*EU has tried to promote social investment through soft institutional pressures aimed at shaping national policy agendas and reform capacities*." (Ferrera, 2017: 331).

Notwithstanding, health policy is perceived by member states as domestic policy and healthcare systems as national concern, reflecting the spirit of the Treaty that established the European Community, in article 168 (cf. Figure 4.2) which refers to public health. This article states that EU is committed to encourage cooperation and coordination within governments and between member states and EU. Nevertheless, and although health professionals and national governments still think health policy as national, specialists in this field are completely aware that European integration, in terms of health policies, is far beyond national competences (Lamping, 2015). In European countries, health policy has been an important instrument to shape societies, by increasing their capacity and economies and reducing individual's risks and fears (Steffen, 2015). Health policy is related to the policies that concern the development of medical care and the organization of healthcare systems (*ibid*). This reasoning is based on the premise that "*healthy populations are not only economically more productive, but also socially more cohesive*" (*ibid*, 2015: 1). In 2006, Greer affirmed that the EU was "*emerging as one of the formative influences in health policy*" (2006: 134), despite the careful isolation of health services from EU interference, carried out by member states, ever since (*ibid*).

Figure 4.2. - Article 168 (ex Article 152 TEC)

1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health. The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns: (a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures; (b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health; (c) measures setting high standards of quality and safety for medicinal products and devices for medical use.

5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Source: Consolidated version of the Treaty on the Functioning of the European Union - https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A12008E168 (accessed in June, 9th 2019)

But how can we define Europeanization? Steffen (2015) presents five possible perspectives for Europeanization. (1) The first one is to look at Europeanization as institutional-building at a supranational level with its focus on policy-making by formal institutions, networks, guiding norms and shared ideas. This traditional perspective has little to do with health policies that are still perceived as national policy field. (2) In the second perspective, Europeanization is seen as an adaptive process for each country, where European integration impacts internal politics and public policies. This adaptation to Europe has recently been addressed in terms of institutions "*fit*" or "*misfit*", whether there is national compatibility, or incompatibility, with European policies and institutional set-ups (Steffen, 2015: 6). Drawing on this perspective, Hix & Goetz (2000) define Europeanization as the series of changes that occur at institutional level and internal practices as a result of European integration. Public health and healthcare are considered a fertile sector when addressing the impacts, responses or non-responses of each country and institutions to European pressures (Steffen, 2015). (3) The third perspective is a political view of Europeanization. It can be seen as a cycle: EU-level activities strongly influence domestic policies and politics (top-down process). National actors interpret these stimuli and apply them into domestic political games (bottom-up process). Thus, recreating this bottom-up process, they bring domestic issues to a national level, and try to influence these processes at a European level, according to their interests. This perspective analyses this mutual process of influencing as a process of feedback loops within the two levels, EU-level and member state level (*ibid*). (4) The fourth perspective brings a smooth vision on how ideas and problems are transferred to domestic level. European themes (values, requirements, policies) are diffused on national arena through the creation of shared frames (by framing common ideas and beliefs) and through the framing of domestic structures and activities (by introducing actors in member states so they incorporate a European dimension in each one). This framing policy impacts domestic discourses, when national actors communicate Europe, and the content of domestic politics and can be seen as a "*process of convergence towards shared policy frameworks and beliefs*" (*ibid*, 2015: 7). In health sector this process has several examples such as cost containment, risk reduction and equal access (and more recently, health quality) (Vollaard *et al.*, 2013) – ideas and beliefs that are convergent in all EU. The effect of this dissemination depends on the influence that knowledge communities have and in health sector these communities were reinforced by networks of issue-groups and by the institutionalization of problem-solving through a range of instruments such as the "*creation of*

European agencies and observatories, comprehensive databases, comparative information systems, diffusion of best practice and incremental extension of regulatory competences" (Steffen, 2015: 7). These networks of issue-groups include health policy experts, EU representatives, national researchers, member states representatives, specific interest groups and non-governmental organizations (as patients' organizations). These groups work together with the Commission that uses them strategically, to support and legitimate its policies. This European interference in national health policies is underestimated despite the fact that, European integration and the EU, as an actor, frame and focus increasingly, the developments and solutions to national problems. (5) The fifth, and last, perspective on Europeanization is related to the changes it brought to domestic structures, due to the impact it had on the distribution of power and resources, on the arising of new actors while traditional ones are weakened, on the introduction of new norms and new challenges and opportunities to impel already existing marginal policies. National actors (by government or interest groups) have the opportunity to act at European level and accomplish strategic domestic and transnational partnerships. Health policies are interpreted in a wider range, considering prevention policies and health promotion – "*work, living conditions, environment, traffic, safety, nutrition, smoking and physical exercise*" (Steffen, 2015: 9). These health policies, from economic interests view, may be seen as capable of generating economic growth for businesses related to this sector.

Notwithstanding, governments like to assume healthcare as a national competence and that is enshrined in EU treaties where it is emphasized that EU should play a complementary role in public health (Vollaard *et al.*, 2013). In article 168[13] is stated that *"the union should respect the responsibilities of the member states for the definition of their health policy and for the organization and delivery of health services and medical care"*. Lamping describes this process as an "*example of a very successful process of stepwise denationalization of a core public policy*" (2015: 21). Nevertheless, the creation of a European single market has been increasingly affecting European health care systems and "*even the core of health care policy, the quality of healthcare services*", is on EU agenda (Vollaard *et al*., 2013: 1).

[13] Treaty on the Functioning of the European Union, 2008

In the 2014-20 cohesion policy[14] from EU, a significant instrument of institutional pressure was assumed by linking the flow of EU funds with "*certain structural investment-enabling conditions in place*" (Deffaa, 2016: 2). That was concretized by the introduction of *ex ante* conditionalities (ExAC) that can lead "*to the suspension of the funding*" (*ibid*: 4). These conditionalities ensure that there are conditions for the efficient and effective use of the European Structural and Investment Funds and they consider three categories: (1) strategic, (2) regulatory and (3) administrative. (1) Strategic conditionalities were addressed due to the many cases of "*one-off individual projects that were neither sustainable nor embedded in a regional or national strategy. This limited the effectiveness of EU funding*."(*ibid*: 3) The new generation of European Structural and Investment Funds (ESIF)[15] projects are co-financed only if they correspond to EU defined strategies. The strategic ExAC that are considered by the Common Provisions regulation[16] comprehend "*transport plans/frameworks, health strategies, strategic policy frameworks for digital growth, a water pricing policy, waste management plans, and a strategic policy framework for improving vocational, education and training systems*." (*ibid*: 3). (2) Regulatory conditionalities regard relevant legal provisions that must be in place, in specific sectors before investments take place. That applies in particular to "*investments in energy efficiency, and in the waste and water sectors." (ibid*: 4*).* (3) Administrative capacity conditionalities were considered because experience showed that " *the capacity of member states and regions to absorb the funds (and to use them efficiently and effectively) largely depends on the capacity of the administrations in the beneficiary countries to devise strategies, build up project pipelines, manage projects, organize proper tender procedures and run efficient internal*

[14] EU's main investment policy, to support job creation, business competitiveness, economic growth, sustainable development, and improve citizens' quality of life (see section 5.2.3.1.) (https://ec.europa.eu/regional_policy/sources/docgener/informat/basic/basic_2014_en.pdf)

[15] *"The European Structural and Investment Funds (ESIF) comprise five EU funds which promote investment and structural policies in the EU: the European Regional Development Fund (ERDF), European Social Fund (ESF), Cohesion Fund (CF), European Agricultural Fund for Rural Development (EAFRD), and European Maritime and Fisheries Fund (EMFF)*". (Deffaa, 2016: 155)

[16] Set of common rules contained in one overarching Regulation to improve coordination and harmonise the implementation of the ESI Funds. It lays down common provisions on the European Regional Development Fund, the European Social Fund, the Cohesion Fund, the European Agricultural Fund for Rural Development and the European Maritime and Fisheries Fund and lays down, also, general provisions on the European Regional Development Fund, the European Social Fund, the Cohesion Fund and the European Maritime and Fisheries Fund and repealing Council Regulation (EC) (https://eur-lex.europa.eu/)

controls" (*ibid*: 4). Therefore member states have a series of ex ante conditionalities as "*the effective implementation of EU public procurement, state aid, Environmental Impact Assessment rules, as well as a strategic policy framework for reinforcing administrative efficiency*" and they are also "*obliged to develop an antifraud strategy*" (*ibid*: 4). These administrative capacities to implement the strategies set out to fulfil ex ante conditionalities were considered by EU as "*key for effectiveness of this mechanism*" (https://europa.eu/regions-and-cities/programme/sessions/120_en, accessed in June, 9th 2019).

A first assessment made by the Commission in 2017 showed that ExAC had a high value, and that the preconditions proved to be a powerful incentive for reforms (Bachtler *et al.*, 2017). They "*triggered strategic, regulatory and institutional and administrative changes*" but also "*policy reforms and delivery on relevant country-specific recommendations at national and regional level that should lead to more effective and efficient spending and improving the investment environment in the EU*" (*ibid*: 24). Notwithstanding, the experience showed areas for improvement, mainly regarding the reduction of the complexity of ExAC process and the administrative burden (*ibid*).

4.2.3. Field level transformations as a result of societal developments

As previously described, although EU treaties state a limited EU involvement in domestic healthcare policies, the reality demonstrates that national healthcare systems "*have been increasingly affected by the creation of a single European market*" (Vollaard *et al*., 2013: 1). EU interference in the quality systems of member states and their quality of services increased from "*sharing information to standardization and even to the first signs of enforcement*" (*ibid*: 1). The creation of a single European market and the recognition of health systems as economic activities like any others changed the way health systems gain and use resources (Greer, 2006). Health professionals, medical devices, pharmaceuticals and health services started to move freely. From health promotion and access to health care, the scope of EU policy broadened and started to include quality of care in the early 1990's. In 1992, within the scope of a wider social protection

agenda, the Council[17] of EU recommended[18] to all member states that "*they should maintain and develop a high-quality health care system*" (Hervey & Vanhercke, 2010: 106).

All these initiatives, movements and recommendations towards quality in health had repercussion in countries, at health field level. In France, accreditation became mandatory for all Health Care Organizations (HCOs), whether public or private, in 1996. The aim was to bring health care funding under control, making the professionals accountable and responsible for part of cost control. Still safety was a major objective. The National Agency for Accreditation and Evaluation in the Health Sector (ANAES) was created to evaluate the quality and the safety of care and accreditation was presented as a tool that ensured that medical activities followed the concept of "right care". The support from the government was essential for the fast development of the process, being aware of the need for professional ownership of the process. In this regard the choice of the agency board was judicious, being chosen 25 professionals of hospitals and two representatives from the MoH. Financing was assured partly by the government and partly by the HCOs (Shaw, 2004). In the case of Poland, a National Center for Quality Assessment in Health Care was established in 1994. The hospital Accreditation program started in 1998 based on Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and Canadian models with the support of the U.S. Agency for International Development. In 2008 the program was still ongoing and it was eligible for a 2 Million Euro financing by EU (Operational Program Human Capital – Priority II) and all hospitals in accreditation process were eligible as well as newcomers. Italian health system in 1999, unlike the British NHS, was a mix between public and private health care provision where private providers played an important role. Fattore (1999) explains that as it was happening throughout Europe, competitive mechanisms in the provision of services were introduced by the government. But Italian *quasi market* had unique particulars as, for example, the possibility that patients had to choose where they wanted to receive care, as long as the delivering organization was accredited, and both public and private organizations could be accredited. At that time, 1999, the expectations were that MoH would strengthen monitoring activities and its power in what respected the definition of the accreditation systems (*ibid*).

[17] Intergovernmental organization with focus on human rights and democracy
[18] Council Recommendation 92/442/EEC.

In ISQua/ WHO (2003)'s report it is possible to see some examples of national policies for quality in health, that were taken by governments (cf. Table 4.4). *"The increase in information was accompanied by a rise in the number of health care agencies, for example: the National Accreditation and Health Evaluation Agency (or Agence Nationale pour l'Accréditation et l'Evaluation in Santé) in France; the British Care Quality Commission to monitor health care standards and efficiency and for publishing the NHS "star ratings"; (...). These monitoring bodies were needed because health care is person-centered and politically sensitive. They also signal the rise of an audit society.*" (Simonet, 2011: 819)

Table 4.4. – Examples of national policies for quality in health care

Country	*Year*	*Title*	*Reference*
Sweden	1993	National strategy for quality improvement	Defined responsibilities for quality assurance; technology assessment.
Finland	1994	Quality policy for health care	Client-orientation, integration; every provider to formulate written quality assurance policy
Belgium	1995	National policy proposal	Ministry of public health and environment
Slovenia	1996	Quality in health care: a proposed national policy	Ministry of Health (MoH), Directorate of environmental health
Portugal	1998	National health strategy: quality policy	Develop and implement continuous quality improvement nationally using European Foundation for Quality Management (EFQM)
Italy	2000	National health plan	Seven priorities for public health improvement; national targets

Source: ISQua/WHO (2003: 26)

The same report from ISQua/WHO (2003) demonstrates examples of national executive agencies for health quality. Portugal is presented as having a national executive agency - Health Quality Institute (IQS) as it can be seen on Table 4.5. IQS was not a national agency. It was a Health Ministry service with scientific, technic and administrative autonomy. The aim was to

create a national accreditation agency with IQS's evolution. Notwithstanding, that never happened (will be developed in section 4.3.3).

Table 4.5 – Examples of national executive agencies

Country	Year established	Title	Function
Netherlands	1979	IHI/CBO (1)	National organization for quality assurance in health care; technical assistance to hospitals, training, research and development, information exchange
Finland	1994	STAKES (2)	National care registers, quality indicators, patient satisfaction databases, health technology assessment
Poland	1994	National Centre for Quality Assessment in Health Care	Support for local quality assurance programs, performance indicators, practice guidelines, health technology assessment, accreditation
France	1997	ANAES (3)	Accreditation, clinical guidelines, health technology assessment
Portugal	1998	Instituto de Qualidade em Saúde (IQS)	Clinical practice guidelines; MoniQuOr assessment and monitoring of organizational quality in health centers; development of hospital accreditation program with UK King's Fund Health Quality Service
UK	1999	NHS Quality Improvement Scotland	Assessment and accreditation of clinical services

(1) Institute for Healthcare Improvement, USA / CBO Centraal Begleidings Orgaan (Institute for Health Improvement, The Netherlands)

(2) Finnish National Research and Development Centre for Welfare and Health

(3) L'Agence Nationale d'Accréditation et d'Evaluation en Santé

Source: ISQua/ WHO (2003: 30).

4.2.4. Accreditation in health care services

As stated previously in this chapter, in 1917, in the United States, the first quality standards for hospitals were introduced – Minimum standard for hospitals. In 1947, mainly due to the increase in international trade after the Great War II, the International Standard Organization (ISO) was created. Accreditation in health care gave its first steps in 1951, in the United States, with the constitution of the JCAHO. In the decade of 1950's literature on hospital's accreditation started to be published – Crosby (1952) studied the goal of accreditation; Gonzalez (1953), highlighted the importance of medical staff for this process; Gundersen (1954) investigated the benefits that hospital accreditation had on the medical profession; and Sheps (1955) approached hospital accreditation when studying the quality of hospital care. The latter was considered by Donabedian (1966: 197) as "*an unusually successful crystallization of thinking concerning the evaluation of quality*". It is relevant mentioning that "*accreditation was called hospital accreditation, as it originally referred only to hospitals*", having expanded to other areas thereafter (Fortes *et al*., 2011: 235).

The JCAHO programs reached Canada and Australia in 1960 and 1970, and Europe in 1980, but it was in the last decade of 20th century that accreditation programs were disseminated all over the world (Alkhenizan & Shaw, 2011). In 1990's there were a number of health care reforms in developed and developing countries that increased privatization in this sector, led to greater autonomy by organizations and the use of outsourcing grew (Montagu, 2003). This was coincident with increasing interest in high efficiency and quality improvements, both in private and in public. Governments started to use External Quality Assessment[19] to improve the quality of healthcare services in OECD and in developing countries. This was possible to implement due to the existence of standards that were already been tested for a wide range of healthcare facilities and that were adaptable to different realities (*ibid*). "*Accreditation is one of the most attractive forms of External Quality Assessment for healthcare organizations*" (*ibid*: 3).

WHO considered that licensure, accreditation and certification were "*being adapted to meet the changing demands for public accountability, clinical effectiveness and improvement of quality and safety*" but the greatest development was in accreditation (Shaw, 2004: 5). Regardless

[19] WHO uses the term 'External Quality Assessment' to refer to all kinds of organizational review which use written standards (Montagu, 2003)

the fact of having different purposes and capabilities licensure, accreditation and certification are systems that respond to the need for quality and performance information. The choice for one or a combination of them must be made regarding the user's needs and expectations (Rooney & Ostenberg, 1999). The authors present a summary of definitions of licensure, accreditation and certification, cf. Table 4.6. Since 2004, licensure is used worldwide to regulate and improve healthcare organizations and presupposes permission by a government authority to a health professional, or health organization, to operate in an occupation or profession (Alkhenizan & Shaw, 2011; Peabody *et al*., 2008). Governments license individuals or organizations because "*they meet minimum standards for operation*" while accreditation compares the organization with the "*ideal achievable standard of quality*" (Montagu, 2003: 8). Accreditation and certification are, most times, used in an undifferentiated way, although accreditation is only applied to organizations while certification is applied also to health providers (Alkhenizan & Shaw, 2011).

Accreditation, quality and continuous improvement have become usual terms in health services discourse (Greenwood & Braithwaite, 2008). For IOM, accreditation is "*a common mechanism for improving the quality of facilities, both within and outside the health sector around the world*" (The National Academies of Sciences, Engineering, and Medicine, 2018). Shaw (2004: 5) defined accreditation as "*a public recognition by a national healthcare accreditation body of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards*". Montagu (2003) defines accreditation as an external review of quality that has the aim of encouraging organizational development and that is characterized by being based on written and published standards; by being peer-reviewed and by being administrated by and independent body.

Table 4.6 – Definitions of licensure, accreditation and certification

Licensure is a process by which a governmental authority grants permission to an individual practitioner or Licensure health care organization to operate or to engage in an occupation or profession. Licensure regulations are generally established to ensure that an organization or individual meets minimum standards to protect public health and safety. Licensure to individuals is usually granted after some form of examination or proof of education and may be renewed periodically through payment of a fee and/or proof of continuing education or professional competence. Organizational licensure is granted following an on-site inspection to determine if minimum health and safety standards have been met. Maintenance of licensure is an ongoing requirement for the health care organization to continue to operate and care for patients.
Accreditation is a formal process by which a recognized body, usually a non-governmental organization Accreditation (NGO), assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. An accreditation decision about a specific health care organization is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years. Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation.
Certification is a process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria. Although the terms accreditation and certification are often used interchangeably, accreditation usually applies only to organizations, while certification may apply to individuals, as well as to organizations. When applied to individual practitioners, certification usually implies that the individual has received additional education and training, and demonstrated competence in a specialty area beyond the minimum requirements set for licensure. An example of such a certification process is a physician who receives certification by a professional specialty board in the practice of obstetrics. When applied to an organization, or part of an organization, such as the laboratory, certification usually implies that the organization has additional services, technology, or capacity beyond those found in similar organizations.

Source: Rooney & Ostenberg, (1999: 3)

Voluntary or mandatory?

Accreditation is prosecuted by a team of health professionals from several areas and the evaluation usually includes "*self-appraisal, on-site surveys, peer review interviews, review of documentation, checking of equipment, and the appraisal of key clinical and organizational data*" (Ng *et al.*, 2013: 434). It consists, usually, in a voluntary program (at national or international level) or mandatory at governmental level (regional or national), where external peer reviewers assess the compliance of healthcare organizations with pre-established standards (Alkhenizan & Shaw, 2011; Shaw *et al.*, 2014; Quimbo *et al.*, 2008). Montagu (2003) approach relates the effectiveness of the accreditation program to the combination of evaluation and supportive consultation. The author states that this is the reason why a voluntary program is more

effective than a mandatory one: *"The effectiveness of accreditation is dependent on its voluntary nature, non-threatening process, and interactive process with external reviewers as a means of effecting and ratcheting up quality improvements*."(*ibid*: 4).

Pomey *et al.* (2005), in their research on French accreditation system, concluded that the mandatory nature of the process may lead to a situation where the program is seen as an inspection and not as a continuous improvement program. Thus, authors highlight the fact that when accreditation results are directly connected with resource allocation, hospitals can adopt strategic behaviors just to achieve that goal. El-Jardali (2007) corroborates these findings on his study in accreditation policy in Lebanon, stating that hospitals might adopt opportunistic behaviors in order to achieve accreditation and ensure (additional) funding. Shaw (2004) states that the strongest drive for hospital accreditation is the perspective to access additional funding, adding that organizational development is another major motive hospitals present to implement an accreditation program.

Leadership involvement

Leadership and staff engagement are considered by literature, key figures in a successful implementation of an accreditation program. El-Jardali *et al*. (2008) considered that leadership commitment and staff involvement were predictors of quality improvement during and after the accreditation process. Braithwaite *et al.* (2010) also found a positive correlation between accreditation performance and leadership. Ng *et al.* (2013) reported that teamwork culture supplemented by leadership can increase the likelihood that accreditation will advance quality improvement. They highlight that an involved leadership is important to the willingness of staff to undertake improvement (*ibid*). Groene *et al*. (2014), based on the results of the Deepening our understanding of quality improvement in Europe (DUQuE) project and other empirical studies, reviews and expert knowledge, concluded that "*the board and senior management must be involved with quality. Quality needs to be on the agenda at the highest level.*" (p.14). DUQuE - financed by the EU 7th Research Framework Program (Nov2009/Aug2014) - studied the effectiveness of quality improvement systems in European hospitals, with 188 hospitals participating in the data collection. Seven countries were involved in this study: Czech Republic, France, Germany, Poland, Portugal, Spain and Turkey and reported that "o*ne thing that we have*

learned is that the board and senior management have got to be concerned with quality. Quality needs to be on the agenda at the top level" (Groene O *et al*., 2014: 14).

In line with the same conclusions, the National Academies of Sciences, Engineering, and Medicine[20] (2018: 18) state that a culture of continuous improvement would only be possible to achieve with "*strong leadership at all levels, characterized by widespread cooperation"*. This idea is based on the thought that **"***when top leaders guide their own actions according to science-based principles of systems thinking and support continual learning as the mainstay of their organization, they can liberate enormous energies and aspirations in the workforce. With proper methods and leadership, improvement can soar"* (*ibid*: 19).

Impacts of accreditation

The National Academies of Sciences, Engineering, and Medicine states that studies regarding accreditation in healthcare provide evidence that an accreditation process "*can create a safety and quality culture in addition to yielding real improvements in health outcomes*" (2018: 245). However existing studies do not prove that accreditation is a tool for quality improvement in all settings (*ibid*; Greenfield & Braithwaite, 2008). Thus, Groene *et al*. (2014: 8) in DUQuE project concluded that: "*There is mounting evidence to suggest that undergoing accreditation improves the organization of work processes, promotes changes and professional development. (…) External assessment supports assurance of payers, patients and the public at large. It helps to raise the bar. It also stimulates internal quality improvement and helps to align work processes. Nevertheless, despite these effects the impact of health care accreditation and certification on health care outcomes remains unclear"*.

Related to the same problematic, Shaw *et al.* (2014: 100) also concluded that "*there is little hard evidence of the impact of these systems on hospitals to justify the amount of time and money spent on organizational assessment or to choose between available programs*".

[20] This organization started in 1863 as the National Academy of Sciences. In 1964 included the National Academy of Engineering and the National Academy of Medicine who, in 1970, was established as the Institute of Medicine (IOM). Its mission is to "*provide independent, objective advice to inform policy with evidence, spark progress and innovation, and confront challenging issues for the benefit of society*" (https://www.nationalacademies.org/about)

It is expected that professional's attitude towards an accreditation program have an impact on its successful implementation, regardless the fact that there is no real evidence for that (Groene *et al*., 2014). Nonetheless, it is demonstrated that the attitude revealed by professionals regarding an accreditation process is determined by their trust in its positive impacts on quality, organizational performance and on decision-making; by their belief that it is a bureaucratic, timeless and costly process; and by their perception of difficulties to meet standards and collect data *(ibid)*. Greenfield & Braithwaite (2008) on their review on accreditation literature found contrasting views from professionals, supporting and criticizing the program.

The National Academies of Sciences, Engineering, and Medicine (2018) considers that it is essential additional research on how accreditation programs create a quality improvement culture and on how accreditation programs link to clinical indicators, proving also that organizations, beyond the compliance with the standards, are capable of implementing innovative ways to track improvements. Only with studies that prove those correlations will be possible to mitigate the preconceived, and not yet demystified, idea that meeting standards may be a formality and not the result of a quality improvement culture (*ibid*). Health care accreditation literature *"reveals a complex picture*" (Greenfield & Braithwaite, 2008: 181), with mixed views and inconsistent findings (Greenfield & Braithwaite, 2008; Halasa *et al.*, 2015). Quimbo *et al.* (2008) concluded that, by its nature, accreditation programs focus on structural elements of care, neglecting the relation between the provider and the patient. This initial gap has led accrediting entities to include process and outcomes-based performance standards, besides structures-based standards. Nonetheless, progress has been limited primarily by the difficulty to accurately measure outcomes and also due to the resistance from facilities to measure items that are no structural inputs (Quimbo *et al.,* 2008). The authors question if it is "*an effective quality screen for patients, payers, or policymakers*", despite the fact that accreditation is a "*widely held practice*", and conclude that accreditation alone is not a sufficient quality assurance mechanism (*ibid:* 2). In this research authors confirmed that a proper design payment scheme, along with an accreditation program, improved quality. Nonetheless, they concluded that accredited organizations scored higher in quality than non-accredited facilities (*ibid*). Greenfield & Braithwaite (2008: 172) state that while "*anecdotal literature contains argument about the value and merits of accreditation, the evidence has not been assembled and reviewed*". They

concluded, after a systematic literature review on healthcare accreditation, that the health care accreditation industry "*appears to be purposely moving towards constructing the evidence to ground our understanding of accreditation*" (*ibid*: 172).

In 2013, Ng *et al.* used a SWOT analysis, considering the strengths, weaknesses, opportunities and threats, based on previous findings from other researchers, with the aim to identify the factors that affect the implementation of an accreditation program and also to understand the potential impact of the accreditation exercise on quality improvement in public hospitals. This study was conducted in Japan and Table 4.7 summarizes the SWOT analysis authors reached on hospital accreditation.

Table 4.7 – SWOT analysis of hospital accreditation

	Internal	External
	Strengths	**Opportunities**
Positive	• Staff engagement and communication • Multidisciplinary teambuilding and collaboration • Change in organizational culture • Enhanced leadership and staff training • Integration and utilization of information • Increased resources dedicated to CQI	• Continuous Quality Improvement (CQI) • Identification and prioritisation of improvement areas • Enhanced patient safety and reduction of medical errors • Additional funding • Public recognition • Advantage in market competition • Development of suitable accreditation standards for local use
	Weaknesses	**Threats**
Negative	• Organizational culture of resistance to change • Increased staff workload • Lack of awareness on CQI • Insufficient staff training and support for QCI • Lack of applicable accreditation standards for local use • Lack of performance outcome measures	• Hawthorne effects and opportunistic behaviours • Resource and funding cuts • Lack of incentives for participation • A regulatory approach for mandatory participation • High costs for sustaining the programmes

Source: Ng *et al*. (2013: 440)

*The Hawthorne effect "*concerns research participation, the consequent awareness of being studied, and possible impact on behavior*" (McCambridge *et al*., 2014: 267).

With this analysis the authors aimed to identify the internal strengths and weaknesses and also external opportunities and threats that might affect the implementation of an accreditation program and their potential implications. Internal strengths concerns factors that may facilitate a successful implementation of an accreditation program. Internal weaknesses relates to barriers that may affect negatively that implementation. External positive factors as identification of areas to improve or public recognition were identified as opportunities. External negative factors as opportunistic behaviors or high costs to sustain the program were identified as threats to the successful implementation of an accreditation program. Authors highlight the fact that accreditation programs involve different stakeholders and this implies that an opportunity/ threat or a strength/ weakness may be different according to the point of view or expectation of the actor that is analyzing. They also identified a strong relation between the success of external quality mechanisms, as an accreditation program, and the political, social and economic reality of the country, because "*they will determine the incentives and disincentives for participation*".

Halasa *et al.* (2015) compared two accredited hospitals with two matched non-accredited hospitals with the aim to study the impact and value of accreditation on hospital performance measures. The first conclusion on their investigation was that their findings were consistent with Donabedian's theory which conceptualized quality of care as a combination of structure, process and outcomes. A good structure (environment and staff) increases the likelihood of a good process (contents or courses of services). And a good process increases the likelihood of good outcomes (results of service). The authors concluded that being accredited improved structure and outcome measures, when compared to the pre-intervention period, supporting the hypothesis that "*the preparation for and participation in the process of accreditation enhances and accelerates adherence to quality standards*" (*ibid*: 96). Authors concluded that accreditation improves the level of completeness of medical records markedly and also impacts positively the staff turnover. These two results show that accreditation process improves two structural measures – staff turnover and medical records. It also improved one outcome measure that was related with the reduction in the rate of patients re-admitted in intensive care unit (ICU).

Saut *et al*. (2017) evaluated the impact of accreditation on Brazilian healthcare organizations, through a quantitative study. From their investigation they concluded that "*the impact of accreditation is mainly related to internal processes, culture, training, institutional*

image and competitive differentiation" (*ibid*: 713). Thus, accreditation programs were also positively correlated with institutional image and competitive differentiation. Notwithstanding, authors could not confirm a correlation between accreditation programs and financial results nor with patient involvement.

4.3. Portugal

4.3.1. Health evolution

In the end of 15th century, more precisely, in 1492, the construction of Hospital Real de Todos os Santos became a reference in Europe, due to its grandiosity: it offered 130 beds. It was ordered by King D. João II and stated a transition in the way healthcare was provided to people. After that, in the 16th century, 'Misericordias' (religious charities) were created and assumed the responsibility of all healthcare services and the administration of all establishments that provided that services, from hospitals to asylums, to support services to orphans and incurable people. At the end of 17th century there were 134 Misericordias and every single one managed hospitals. In 1779, Coimbra's University Hospital was transferred to the Jesuits College and achieved 120 beds. In 1886 the first wards were installed on Santo António Hospital, in O'Porto and in 1889 the first sanatorium was created in Outão, Setúbal.

The first public health services act took place in 1901, with a law that created a network of medical officers responsible for public health. Only in 1945 another law established public maternity and child welfare services (Barros & Simões, 2007). In 1946, the first social security law was approved and its cover was limited to industrial workers that, through compulsory contributions that were shared between them and the employers, provided out-of-hospital curative services. This social security cover spread through other sectors and dependents with several posterior amends. In 1946 Law no.2011 of April 2nd, establishes the organization of the existing health care services, laying the foundation for a hospital network. A program of hospital construction begins. Those hospitals will be delivered to 'Misericórdias' (www.sns.gov.pt). It is relevant to highlight that the leading international health organization - the World Health Organization (WHO) - was only created on April 7, 1948 (www.who.int). In 1958, through DL No. 41825, of August 13th, the protection of public health services and public assistance services

cease to belong to the Ministry of the Interior, passing to the newly created Ministry of Health and Assistance (www.sns.gov.pt). And in 1963, Law No.2120, of July 19th, promulgated the bases of health and care policy, assigning to the state, organization and maintenance of services that could not be delivered to private initiative. (www.sns.gov.pt)

In 1968, through DL No.48357 of April 27th and DL No.48358 of April 27th (which respectively created the Hospital Statute and the General Regulations of Hospitals) hospitals, their organization and health care careers (doctors, nurses, administration and pharmacy) have been standardized and regulated. (www.sns.gov.pt)

In the 1970's, Portugal had very bad socio-economic and health indicators and the health financing was really limited (Bentes *et al*., 2004). The health services were spread among Misericordias hospitals, a few major public hospitals (located in the few big urban centers), Social Medical Services (usually called "Caixas de Previdência") that had their own physicians for their beneficiaries and Public health services that protected health (vaccines, mother and childhood protection, among others). Private services were oriented to the higher social classes. The state, through its government, only assumed fully health costs for civil servants (OPSS, 2001).

Nonetheless, in 1971 the reform of the health system and care (prosecuted by Gonçalves Ferreira and Arnaldo Sampaio) (OPSS, 2003) was initiated and although it was a sketch for a true NHS, during the eight years between 1971 and 1979, it has never been fully implemented (OPSS, 2001; OPSS 2008). Nevertheless, two relevant structures were created: health centers and hospitals. The MoH began to guide the entire health policy through the General Directorates of Health and Hospitals (which were considered substantive organs of the system) (Barros & Simões, 2007). In 1971 the right to health for all citizens was recognized for the first time (DL nº 413/71, 27 September) which created the basis for certain measures that were taken after 1974's revolution (Barros & Simões, 2007). However, access to services was limited, to the human, technical and financial resources availability (www.sns.gov.pt). In the same day, another DL was published, DL nº 414/71, which established the legal regime that would allow the progressive structuring and the regular operation of professional careers for the different differentiated groups of employees who were working in the Ministry of Health and Care. It was a measure that aimed,

in addition to the organization of work, to implement, in articulation with other steps, a policy of health and social assistance (www.sns.gov.pt).

Some of the measures that were taken in 1971 regarded health care prevention and promotion, that were "*issues of great concern in the international community, as can be seen by the resolutions taken in Alma-Ata, seven years later*" (Barros & Simões, 2007: 15). Nevertheless, the major problems still existed until the creation of the National Health Service (NHS) in 1979 as (1) the asymmetric geographical distribution of health services and human resources, (2) low level of sanitation, (3) coverage not universal, (4) the decision-making process was centralized, (5) no coordination between facilities and providers and no evaluation, (6) the existence of several sources of financing and no equity in benefits among population groups, (7) no congruence between legislation, policy and the provision of services and (8) health professionals had low remunerations (Barros & Simões, 2007; Bentes *et al*., 2004). In 1973, through DL no. 584/73, November 6th, the MoH became autonomous in relation to Assistance (www.sns.gov.pt).

In 1974, there was a revolution that ended with the 48 year-long Salazar-Caetano totalitarian regime and gave birth to democracy in the country. Massive nationalization of health services began in 1974 with district and central hospitals being taken from religious charities. The DL no.704/74, of December 7th, determined that the hospitals from 'Misericórdias' started to be managed by commissions that were appointed and responded to the secretary of state. The state began to have an equipment network that allowed it to manage health at a national level. In 1976, the new Constitution was approved, and article 64 dictated that all citizens had the right to health protection and the duty to defend and promote it. This right is effective through the creation of a universal, free and universal national health service. In 1978 a *Despacho ministerial* (published in Diário da República, 2nd series, dated July 29, 1978), which became known as the *Despacho Arnaut*, constituted a true anticipation of the NHS, since it opened the medical service access to all citizens, regardless of their ability to contribute. This ensured, for the first time, the universality, generality and free of charge of health care and drug reimbursement. This massive health services nationalization culminated with creation of NHS in 1979 (Law No. 56/79, of September 15th), within the scope of the Ministry of Social Affairs, as an instrument of the state to ensure the right to health protection, in accordance with the Constitution (www.sns.gov.pt) that established

"*the right of all citizens to health protection; a guaranteed right to universal free health care through the NHS; access to the NHS for all citizens regardless of economic and social background; integrated health care including health promotion, disease surveillance and prevention; and a tax-financed system of coverage in the form of the NHS (only when health care could not be provided through the NHS would outside services be covered)* (Barros & Simões, 2007: 17).

Since then, the state embraced the two functions in health service: financier and provider of health care services – characteristics of a social welfare state. The NHS became one of the most important, if not the most important, achievement of April's revolution (OPSS, 2001). According to the 2001 Spring report from Portuguese Health Systems Observatory (OPSS), since 1975 Portugal suffered major transformations (concerning health services) in a short period of time: in 1974 the process of democratization and consequent decolonization; in 1985, the entrance in Economic European Community, and in 2000, the integration in the European Monetary Union. During more than 40 years it is clear that it has been made an effort to promote health and health services (OPSS, 2001).

4.3.2. Political Context and Health evolution

Analyzing the lapse of time that is crucial to this investigation, it is possible to identify four periods that correspond to four different agendas: (1) 1974/1985 (cf. table 4.8.) when the National Health Service was created in a democratization and decolonization national context, and in an economic global context that was still recovering from the negative impact of oil shocks during the 1970s (OPSS, 2003; Bentes *et al*., 2004); (2) 1985/1995 (cf. table 4.9.) considered a liberalization period in health, when a new health law *Lei de Bases da Saúde* was created, changing the public / private border in favor of the private, without prejudice to measures aimed at improving the NHS (OPSS, 2002); (3) 1995/ 2002 (cf. table 4.10) a period when there was a NHS reform (Saúde XXI), considered a challenge for the Portuguese Health System Qualification; (4) and 2002/2005 (cf. table 4.11) the era of hospital transformation – from 'SA' to 'EPE' (OPSS, 2006).

Notwithstanding, looking back it is disturbing to see that reforms were not totally implemented, due to management limitations, change resistance or politic discontinuity. In fact, in this period it is possible to conclude that even with the same Prime Minister, the change of Health Ministry led to substantial changes in agenda (Sakellarides *et al.*, 2005).

Table 4.8- Political context 1974/1985

The creation of National Health Service (NHS)

Constitutional Government	Parliamentary term	1º Minister	Health Minister	State Secretary for Health
I	1976-78	Mário Soares	-	-
II	1978	Mário Soares	(1) António Arnaut	Mário Mendes
III	1978	Alfredo Nobre da Costa	(1) Acácio Pereira Magro	Mário Marques
IV	1978-79	Carlos Mota Pinto	(1) Acácio Pereira Magro	Mário Marques
V	1979-80	MªLurdes Pintassilgo	(1) Alfredo Bruto da Costa	António Correia de Campos
VI	1980-81	Francisco Sá Carneiro	(1) João Morais Leitão	-
VII	1981	Francisco Pinto Balsemão	(1) Carlos Chaves de Macedo	Paulo Mendo
VIII	1981-83	Francisco Pinto Balsemão	(1) Luís Barbosa	Paulo Mendo
IX	1983-85	Mário Soares	(2) António Maldonado Gonelha	-

Source: adapted from www.portugal.gov.pt (1) Minister of Social Issues (2) Minister of Health

The adoption and implementation of the NHS, in 1979, is related with the political and social democratization process which occurred in 1974. This implementation was not an isolated case in Europe. In the same period, countries from south Europe also implemented their NHS: Italy (1978), Greece (1983) and Spain (1986). The Portuguese National Health Service was created in 1979 by the hand of António Arnaut, but it was only in 1983, in the 9th Constitutional Government, that a health Ministry was nominated. Until then, there was only a state secretary's for health (cf. Table 4.8). The implementation of NHS in Portugal was not consensual because

some physicians defended a health system based on conventional medicine, that is to say private medicine financed by public money. This fracture had, and still has implications in NHS and led to the maintenance, and creation, of health subsystems out of NHS, such as ADSE (Illness assistance for state workers), SAMS (Medical and Social Assistance Services for banking sector), PT-ACS (Health Care Association for Portugal Telecom workers, Altice workers today), among others (OPSS, 2002). The NHS changed radically the way Portuguese people access to health care services. It is based on universal and tendentiously gratuity service logic: the NHS law in 1979 stated that "*access to the NHS should be guaranteed to all citizens independently of their economic and social status*" and the 1989 revision of the Constitution changed "*free"* services by "*services tending to be free*" (Bentes *et al*., 2004: 89) In a short period, the NHS allowed a notable coverage of the Portuguese population. It also permitted the development of a structure for professional health carrier (OPSS, 2002).

Table 4.9 - Political context 1985/1995

Liberalization period in health – New *Lei de Bases da Saúde*

Constitutional Government	Parliamentary term	1º Minister	Health Minister	State Assistant Secretary for the Minister of Health
X	1985-87	Aníbal Cavaco Silva	Leonor Beleza	António Baptista Pereira
XI	1987-91	Aníbal Cavaco Silva	Arlindo de Carvalho	Jorge Augusto Pires
XII	1991-95	Aníbal Cavaco Silva	Paulo Mendo	José Lopes Martins

Source: adapted from www.portugal.gov.pt

This was a decade characterized by an "*unprecedented political stability*" with a one-party base government and a parliament majority in 8 of the 10 years (Bentes *et al*., 2004: 89). Portugal entered the Economic European Community in 1985 and started to be "*eligible for European funding for social and economic infrastructure development, including the health sector*" (Simonet, 2014: 57). Simonet refers that countries started to be compared through budget deficits, taxation levels and GDP's "*Budget deficits, taxation levels, and the share of health expenditures*

in the GDP – rather than quality indicators such as life expectancy and infant mortality – became essential tools in comparing country achievements." (*ibid*). According to the author, France's EU integration was a factor that "*allowed NPM to permeate the health system in a politically correct manner*" (*ibid*). The same happened in Portugal were emphasis was on benchmarking and performance evaluation. In addition, concerns with costs, transparency and efficiency were raising in Portugal and around the world, particularly in Europe. Portugal, in the 1990's, was already seeking to introduce better tools that would allow benchmarking between different health institutions. It was a time for major changes, especially on health sector.

In the 2nd mandate (1987/91) of Cavaco Silva as Prime Minister, a new Health law was approved – Health Basis-Law (Lei de Bases da Saúde) (Law nº 48/90 de August, 24th). This law opened doors to a greater participation of private capital in the financing of the NHS. Following the spirit of change and less state participation, in 1993 the new NHS statutes were approved (DL nº11/93, January, 15th). For the first time, it considered the existence of Public-Private Partnerships (PPP's) in the Portuguese National Health Service. The new statutes also created the Health Integrated Units of Health Care and the new Health Administration Regions (ARS's). The Health Administration Regions's were created in 1982 (DL n.º 254/82, June 29th), but were discontinued and recreated by this new law. With this reformulation, the Minister was implementing the trend that was crossing all Europe: management decentralization in regional levels, achieving a real proximity between decision makers and the community (Major and Magalhães, 2013). Decentralization was seen as the solution for public organizations of social welfare state, that were criticized for being "*cumbersome, inefficient and insensitive to user's preferences*" (WHO, 1995: 52). It was seen as "*a mean of resolving the problems that have arisen in complex public bureaucracies*" (WHO, 1995: 52). Decentralized institutions presented several advantages as more flexibility and faster responses to changing circumstances; more effectiveness, problems are better identified at the micro-level, as well as opportunities; more innovative in the solutions adopted; and capable of inspiring, create more commitment and more productivity (*ibid*). In 1993, it was also created the Health Informatics and Financial Management Institute (IGIF)[21], by the DL 308/93, September 2nd. IGIF's assignments were to

[21] resulted from the integration of Informatics Service of the Health Ministry and the Financial Management of Health Services Department, both extinct earlier in 1993, by DL nº10/93, January 15th

study, orientate, evaluate and execute the information systems and manage the financial resources of NHS. With the NPM ideology spreading in Europe, and reaching Portugal in the late 1990's, the quality of public services became a concern. In 1993 the Directorate-General for Health (DGS) created a norm that stated that "*quality commissions should be established in all health facilities, with the aim of developing and implementing quality programs*". This norm had no practical effects because the few commissions that were created had no action (Pisco & Biscaia, 2001: 45). Nevertheless, health quality concern started, in a very shiny way, to give its first steps in Portugal. In 1985 the Public Health National School (ENSP), in association with WHO and public health schools of Brussels and Jerusalem universities, organized an International seminar entitled *Evaluation of primary health care services* (Pisco & Biscaia, 2001: 44). After that there was another seminar named *Evaluation and quality control in health services,* also organized by WHO, the Health studies and planning department and General Directorate of Primary Health Care. Thus, in the period 1986-89 there were six Portuguese-Spanish seminars, titled *Quality assurance in primary health care*, that were organized by Public Health National School and General Directorate of Primary Health Care. Quality was beginning to gain relevance in health sector. Those seminars were ministered by Professors Pedro Saturno and Emílio Imperatori, whose work was regarded as important in the diffusion of quality ideas in Europe (*ibid: 44*). *"These two Professors were crucial to the spread of health quality culture in Portugal." (IQS's Director 2000/05)*. The seminars took place across the continent and islands and it had an empirical component. After doing the first seminar, doctors were asked to apply the methodology learned in the field. After six months, when the next seminar took place, results were presented and discussed. It created the first groups of people, majority in primary health care services that had training in quality. Following this trend of quality concern, Health Administration Regions's also promoted several training sessions during late 1980's, which lasted through the end of the 1990's (Pisco & Biscaia, 2001). In the same period, hospitals invested also in quality training at a departmental level. Some voluntary and mono-professional group projects started to appear but they weren't successful due to the multidisciplinary hospital reality (*ibid*). Yet according to the final report of Health Operational Intervention – IIQCA, during 1986-96, almost one third of health budget was addressed to health quality training. Despite all the investment, the results were not visible, mainly because it was done by multiple entities (Public Health National School, General Directorate of Primary Health Care, Health Administration Regions, DGS) without a

concrete framework and a specific direction. The positive factor of this situation was that the seeds of quality were being spread and gaining roots (Pisco & Biscaia, 2001). This period was also characterized by important investments in NHS infrastructures, as health centers and hospitals. Nevertheless, no novelties brought consubstantial changes in the way health services functioned (OPSS, 2001).

Table 4.10 - Political context 1995/2002

1995/ 2002 – Portuguese Health System Qualification Challenge – NHS Reform

Constitutional Government	Parliamentary term	1º Minister	Health Minister	State Assistant Secretary of Health	State Assistant Secretary for the Minister of Health
XIII	1995-1999	António Guterres	Maria de Belém Roseira	Francisco Ramos	-
XIV	1999-2002	António Guterres	Manuela Arcanjo (Out99/Jul01) António Correia de Campos (Jul01/Abr02)	Francisco Ramos	Carmen Pignatelli

Source: adapted from www.portugal.gov.pt

According to 2001 OPSS's Relatório de Primavera, and referring to the first political mandate between 1995 and 1999, structural reforms were not done but the Health Ministry seemed to be taken measures to progressively improve health. This was a result of a one-party based government supported by a parliament minority situation that was not favorable to major reforms. Therefore, "*a cautious and stepwise reform process was adopted centered on the principles of NPM*" (Bentes *et al.*, 2004: 91). The first experience of a management concession by a private group (PPP), Grupo Mello, was done in 1995 in Hospital Fernando da Fonseca

(Amadora/Sintra), through a *concurso público*[22] for a five-year period, renewable. The capital remained public and it stayed as a Public-Private Partnership until 2009, when it was turned it into an EPE Hospital. Other experiences of quasi-market in hospitals took place. The first one took place in São Sebastião Hospital, in Santa Maria da Feira, in 1996. In 1999, it was on the Local Unit of Matosinhos, covering not only the Pedro Hispano Hospital in that city, but also the four health centers in their area, and in 2001 the last experience was on the Algarve, in Barlavento Hospital (Barros & Simões, 2007).

"*The effect of NPM in our country is related to the relaunch of a hospital management reform program, under the responsibility of the state for the provision of health care established by the Constitution, which resulted in several innovative management experiences, such as the granting of the management of the Hospital Fernando Fonseca (Amadora / Sintra) to private hospitals in 1996, the almost entrepreneurial experiences of the São Sebastião Hospital in Santa Maria da Feira in 1996, the Local Health Unit of Matosinhos (1999) Hospital de Barlavento Algarvio in 2001 and the attempts to delegate competencies in organic intermediate management structures through the creation of the Integrated Responsibility Centers in 1999*." (OPSS, 2009: 86)

This was the first assumed step of a major reform based on NPM principles. After that, contracting agencies were created in order to achieve greater transparency, accountability and rationalization. This was the inception of the split off between service purchaser (the financier) and health care providers. Five Contractual Agencies were created inside each Health Regional Administration in 1997. In fact, the creation of the contracting agencies introduced this philosophy of greater accountability, greater transparency, greater cost efficiency, and greater accountability of middle management levels and the assumption of explicit contracts in a perfectly contractual philosophy.

This new government puts end to a 10-year governance and the new Health Ministry assumes Health Quality as a priority (Dra.Maria de Belém Roseira). There was also a renewed

[22] Concurso público nº 8/94, Setembro 14th, based on Portaria nº 704/ 94, Julho 25th. The signing of management contracts must be preceded by a specific tender procedure, which may contain a negotiation phase in accordance with the provisions of the respective standard procedure program (DL nº 185/2002, August 20th - frames the establishment of public-private partnerships under a private management and financing regime, in which the forming principles and instruments are established.)

team in DGS: a new General Health Director (Professor Constantino Sakellarides) and, for the first time, there was a Health Sub-Director for Quality (Dr. José Luis Biscaya). During 1996 and 1999 several initiatives were taken with the purpose to analyze and influence the development of Portuguese health care system (Pisco & Biscaia, 2001). In 1996 the Health Reflection Council (CRES) was created with the aim to study and submit proposals for health reform (Ministry Council Resolution nº 13/96, February 8th). The Health Reflection Council "*develops its activity freely, with total independence and technical autonomy, without any institutional link to the Ministry of Health*" (CRES, 1998: 9). The creation of the Health Reflection Council reflected the position of political power that assumed: (1) the need for a structural reform in health; and (2) the need to prepare reasoned proposals, but always keeping in mind that it was crucial to ensure a broad basis for reflection, cooperation and support in shaping and implementing that reform. Nevertheless it is also clear that the implementation of the reform proposals was not foreseen in political and financial priorities of the legislature in progress (Sakellarides, 2000). In line with the nature of its mandate, Health Reflection Council created a document to deepening the debate – *Options for a national debate* (CRES, 1997), promoted an extensive consultation of stakeholders and a wide dissemination of results through a report *Recommendations for a Structural Health Reform* (CRES, 1998). This report referred the importance of the quality of health care services stating that "*it has thus evolved from an internal process of quality assessment confined to an institution or a group of professionals to external evaluations by independent supra-institutional entities (corporate, economic and political powers) of recognized prestige*" (*ibid*: 58). It also referred that Governments were gradually adopting imperative or indicative quality standards in order to guarantee citizens with health care at certain levels of excellence and concretizes by giving the example of the United Kingdom where the Regional Health Authorities in their role as purchasers of health care established their contracts with service providers (hospitals, general practitioners) already including a set of quality assurance and patients.

During the period between 1996 and 1999 the Health Ministry had to respond to two complementary needs: one at a short-term to address the many problems that NHS faced; and other, at a long term, aiming to establish a strategic framework that would allow immediate measures to be placed in a sustainable development process converging with the results of the Health Reflection Council analysis. This process culminated in the beginning of 1999 with the

disclosure of a new strategy for health *Saúde, Um compromisso: uma estratégia para o virar do século 1998-2002* (Ministério da Saúde, 1999) originating the Saúde XXI program, which will be analyzed in section 4.3.3.

In its second mandate (1999-2002), the Government proposes a new national intent: "*to overcome, within a generation period, the structural delay that still separated us from the center of European Union*" (Presidência do Conselho de Ministros, 1999: 3). With that intention in mind, a series of priorities are proposed and health is, due to its importance and recognizable need for improvement, the high priority on social area in this legislature, as stated by Sakellarides (2000: 27): "*The government declared, in October 1999, health as their main social priority*". The XIV Constitutional Government program (1999-2002) reflects that aim and describes what were the objectives and the ways to achieve those objectives: "*In presenting its program, the XIV Constitutional Government assumed the priority of health in a way unequivocal, unprecedented in the last quarter of century of Portuguese democracy*: *In this the legislature, health, by the importance of and its recognized improvement, is in the area of the highest priority: in increasing resources available, while combating waste and systematizing a reform that has already begun (Portugal, Presidency of the Council of Ministers, 1999)"* (Sakellarides, 2000: 27).

The fundamental concern was to improve the health care field and that had to be based on a quality system: "*More service and better service*" – the aim of this program (Presidência do Conselho de Ministros, 1999: 14). Public resources were reoriented to health and had the extremely important contribution of the III Community Support Framework (QCA III). QCAIII was the driver for these reforms with Saúde XXI QCA's Operational Program for health with two main objectives: to obtain gains in health and to ensure health care quality. Nevertheless, in 2000, with the change of ministerial health equip, the NHS reform stopped. 2003 OPSS's Relatório de Primavera (p.7), evaluated these six-year governance period (1996-2002): "*one prime-minister, three governs, without parliament majority, with decreasing duration, contrasting orientations mainly due to limited capacity of implementing the agenda. Several innovations as 'contratualização', integrated responsibility centers, EPE's hospitals, and 3rd generation health centers had an incipient implementation"*. OPSS (2003: 7) goes further and concludes that in the period between 1985 and 2002, *"despite the agenda in course, the Portuguese political system did not have the capacity to institute health governance processes technically coherent and with*

a social base of sustainable support. Understanding this phenomenon is fundamental for the future."

Finally, in 1999 the Court of Auditors discloses a report of the audit made to the National Health Service (Tribunal de Contas, 1999). It was the culmination of a set of audits, essentially administrative and financial, made to MoH's institutions in previous years, considering the analyses and proposals of Health Reflection Council, the OECD and of the MoH (Sakellarides, 2000). In this report the Court considered appropriate to recommend that "*the accreditation of health institutions to users, by certifying the quality of the services they provide within the scope of the national health system should be promoted, as in other areas*" (Tribunal de Contas, 1999: 34)

Table 4.11 - Political context 2002/2005

2002/2005 – The hospital transformation continues – from 'SA' to 'EPE'

Government Constitutional	Parliamentary term	1º Minister	Health Minister	State Secretary of Health	State Assistant Secretary
XV	2002-04	José Manuel Durão Barroso	Luís Filipe Pereira	Carlos Martins	(1) Adão Silva
XVI	2004-05	Pedro Santana Lopes	Luís Filipe Pereira	Regina Bastos	(1) Mário Patinha Antão

Source: adapted from www.portugal.gov.pt

The new MoH that assumed functions in March 2002 "*exercised intense government action in the first year of his mandate, triggering a vast array of measures in a short space of time. These actions were supported by the executive as a whole, not only in terms of a clear expression of political support, but also through the provision of substantial financial support*" (OPSS, 2003: 85). This was a time when NHS was "*thought of as a network of health care delivery services*" belonging to public, private or social sector (Bentes *et al*., 2004: 92).

Public hospitals were particularly affected by NPM reforms whose aim was to achieve more efficiency in service production. Likely in other European countries, this has led the Portuguese health sector to assume a business orientation although this was a sector that was thought to be relatively apart from this ideology. As Simonet (2011: 816) stated "*NPM prompted the adoption of new management techniques to sectors that were thought to be relatively immune to them, like the health care sector. "*

In 2002, 34 SPA hospitals of NHS were transformed in 31 Anonymous Society Hospitals [Hospitais SA] (Law nº 27/2002, November 8th). This new management model ensures that the social capital of hospitals now corporatized is exclusively assumed by public capital entities. The aim was to change the management model without changing state responsibility for health care, a Constitutional imposition.

In the concrete case of Portuguese hospitals, accreditation process had a positive impact in the transformation of hospitals SPA in hospitals SA, when comparing hospitals that were in an accreditation program and hospitals that were not (IQS, 2005b). "*The new management model introduced, which transformed this hospital into an SA hospital, would have been more difficult to apply had it occurred two years earlier because the institution would not be so prepared to face such a change*" (IQS, 2003: 30). A complementarity has been established between the objectives of the new hospital SA model - which places the user at the heart of the hospital management system - and the demands on the quality of service and safety associated with the hospital accreditation model implemented by Portuguese hospitals in the beginning of the century - the King's Fund accreditation process. "*This accreditation process led to the reorganization of services, the systematization of procedures and the adoption of integrated management and control tools for the different functional areas - changes that were fundamental to the entrepreneurial process of the hospitals that transformed SPA hospitals into SA at the end of 2002"* (IQS, 2003: 29).

In 2003, by the DL nº309, December 10th, the Health Regulator Entity (ERS) was created. At the time of its creation there was no consensus among the Ministry Council. The Health Systems Portuguese Observatory in *2004 Relatório de Primavera* assumed that the creation of the Health Regulator Entity was indeed an innovative and unprecedented initiative, due to the fact

that there was no other entity, in Portugal or abroad, with the same characteristics and assignments. It was an independent entity, which responded only to the Republic Assembly. The Health Regulator Entity, acting in a social area, had the objective of protecting users by guaranteeing universal access and quality of services. In this last point it is clear a duplication of assignments with IQS, a point highlighted by Physicians Order, previously on the Health Regulator Entity creation (OPSS, 2004).

In 2003, the Ministry Council Resolution nº15, created the Hospital Mission Unit with the purpose to accelerate and support the transformation of Anonymous Society [SA] and Administrative Public Sector [SPA] hospitals into anonymous companies with public capital exclusively [EPE]. Following this mission, the 31 SA hospitals plus five SPA hospitals turned into EPE Hospitals in 2005 (DL nº93/2005, 7th July) with the intention to "*make it clear that privatization of hospitals was not on the political agenda*" (Barros & Simões, 2007: 118). EPE hospitals became to be subject to a "*dual relationship of ministerial tutelage*": on one hand, in the area of their financial activity they were subject to the joint supervision of the Minister of state and finance and the MoH, and, on the other, in what concerns the health care activities carried out by them, they had the guardianship of the MoH (Tribunal de Contas, 2011: 39). The Finance and Health Ministers are responsible for the appointment, evaluation and dismissal of their boards of directors. This new legal regime for hospital management has "*accentuated the hospital management model based on the business paradigm and the members of the management body of EPE hospitals are also subject to the Statute of the Public Manager and the adoption of principles of good governance of companies of the state business sector* ", according to the Court of Auditors (Tribunal de Contas, 2011: 36). The business paradigm, besides having determined the change in the legal status of EPE hospitals, also confirmed the change in their economic relationship with the state, since it transformed them in entities that provide services. Thus, EPE hospitals are financed by the state budget, through the execution of *contratos-programa* that establish "*the objectives, the qualitative and quantitative targets of the activity to be produced, the prices and performance evaluation indicators of the services and the level of user satisfaction and other obligations assumed by the parties"* (*ibid:* 37).

According to OPSS (2005) in this transformation from SA to EPE the main changes were (i) the state responsibilities due to the changes in the legal regime with an increase in the

amplitude of the state as an instrument of economic intervention; (ii) the capital is exclusively public, and cannot be alienated to private entities, therefore the transfer of participations can only occur between public entities, while in the SA model, capital could be deprived; (iii) the accountability is sent to the Inspectorate-General of Finances to issue an opinion, then referred to the Ministers while in the SA model, the certification of accounts was made under the terms of the Commercial Company Code, by statutory auditors; (iv) as regards to bankruptcy for economic reasons the new model prevents bankruptcy for economic reasons while in the SA model it could occur under the terms of the Commercial Company Code; (v) regarding the labor contracts, the new Labor Code calls for an approximation of the individual contract of employment, but the rule is the submission of the staff regulations to the administrative law discipline while in SA model, the personnel status corresponds to the individual employment contract regime.

In 2005, also as a result of the DL 233/2005, December 29th, three new hospital centers were created and assumed an EPE legal status. One of these three hospital centers was Setúbal's hospital center, that got together S.Bernardo's hospital and Sant'iago do Outão's Orthopedic Hospital (HOSO) originating Setúbal's Hospital (cf. Table 4.12 A). The Hospital centers that already existed and were SA were transformed in EPE (cf. Table 4.12 B) and some SPA Hospital centers remained with that legal status (cf. Table 4.12.C). The same law transformed two SPA hospitals in EPE: Hospital de Santa Maria and Hospital de São João (OPSS, 2006).

Table 4.12 A – Creation of new Hospital Centers EPE

Centro Hospitalar do Nordeste, EPE	Centro Hospitalar de Lisboa Ocidental, EPE	Centro Hospitalar de Setúbal, EPE
• Hospital distrital de Bragança, SA • Hospital distrital de Macedo de Cavaleiros • Hospital distrital de Mirandela	• Hospital Egas Moniz, SA • Hospital de Santa Cruz, SA • Hospital S.Francisco Xavier, SA	• Hospital de São Bernardo, SA • Hospital Ortopédico Sant'Iago do Outão

Source: Relatório de Primavera (2006: 90)

Table 4.12 B – Transformation of Hospital Centers SA into EPE

Hospital Centers EPE
• Centro Hospitalar do Alto Minho
• Centro Hospitalar de Vila Real/ Peso da Régua
• Centro Hospitalar da Cova da Beira
• Centro Hospitalar do Médio Tejo
• Centro Hospitalar do Baixo Alentejo
• Centro Hospitalar do Barlavento Algarvio

Source: Relatório de Primavera (2006: 91)

Table 4.12 C – Hospital Centers that remained in SPA

Hospital Centers SPA
• Centro Hospitalar Póvoa do Varzim/ Vila do Conde
• Centro Hospitalar de Vila Nova de Gaia
• Centro Hospitalar de Coimbra
• Centro Hospitalar de Lisboa (Zona Central)
• Grupo Hospitalar dos hospitais civis de Lisboa
• Grupo Hospitalar Psiquiátrico da região de Lisboa e Vale do Tejo

Source: Relatório de Primavera (2006: 91)

IGIF was discontinued in 2006 by the DL nº 212/2006, October 27th within the framework of the guidelines defined by the State Central Administration Restructuring Program (PRACE) and the objectives of the Government Program for administrative modernization and improvement of the quality of public services. Its functions were assumed by Health System Central Administration (ACSS) that was created in 2007, DL nº 219/2007, May 29th. and whose mission and assignments were described in Art.3º "*ACSS, I.P. has the mission of administering the human, financial, facilities and equipment, systems and information technologies of the National Health Service and promoting the organizational quality of healthcare providers, as*

well as defining and implementing policies, standardization, regulation and health planning, in the areas of its intervention, in articulation with the regional health administrations."

In line with that new orientation, Portuguese hospitals suffered a corporatization process and in terms of regulation there was a separation between the payer - Health System Central Administration - and the provider of health care - hospitals. With these two main reforms, the way hospitals were financed was altered. From a budget based on last year costs (retrospective), hospitals became to be financed by a prospective system based on the previously referred *contratos-programa*[23]. The contracting process involves the participation of Health System Central Administration, Health Administration Regions, the MoH and the provider units, i.e., hospitals, hospital Centers and Local health units (Diniz, V., 2013: 34). Therefore, Health System Central Administration assumed the assignment of celebrating the *contratos–programa* with each NHS hospital, as defined in nº1 of art 18º DL nº219/2007: "*The competence for the conclusion of contratos–programa with the hospitals of the National Health Service, as well as the respective conference of invoices, is carried out by ACSS, IP, during 2007, in coordination with the Regional Administrations of Health, IP*." Nonetheless, in 2012 the DL nº219/2007 was revoked and DL nº35/ 2012, February 15th redefined Health System Central Administration's assignments. In what concerns contracting, nº4 of art.3º defines that Health System Central Administration assumes the "*the coordination and monitoring of the execution of PPP's management contracts, contratos-programa with EPE's entities and other contracts for the provision of health care with private and social sector entities*." Thus, it also assumes the elaboration of all Health Ministry budget. The origin of these alterations was DL nº124/ 2011 that also assigned to Health Administration Regions the responsibility to "*allocate financial resources to institutions and services that are integrated or financed by the NHS and to monitor and evaluate their performance, in accordance with the guidelines defined by ACSS, I. P*". Until 2011, the *contratos-programa* were signed by three entities: Health Administration Regions, Health System Central Administration and the hospital; from 2012, the *contratos-programa* have two entities: Health Administration Regions and the hospital.

SPA hospitals that were not converted into EPE hospitals, suffered an improvement in performance through the adoption of the best management practices introduced in SA hospitals,

[23] Portaria n.º 551/2004. DR 120 SÉRIE I-B de 2004-05-22

namely in the form of financing, now based on *contratos-programa*, which allowed them, even with no change in their legal status, to be considered as autonomous units (Pereira, 2005).

4.3.3. Saúde XXI Operational Program (2000/2006) and the III Community Support Framework (QCAIII)

As stated previously, from 1999 to 2003 much happened in what concerns quality on Health, mainly due to the QCAIII (2000-2006) and its *Saúde XXI* Operational Program (2000/06), with approximately €35M (5% of the total amount) for quality improvement in Health Care.

In terms of the health sector, the QCAIII conception meant a breakdown with the philosophy of previous QCA's: from a traditional infrastructure financing to a support for a Health strategy, as explained by Barros & Simões (2007: 50): "*The health funds for 2000–2006 (Saúde XXI program) have been determined as a result of negotiations between Portugal and the EU under the strategic assumption that health promotion and prevention along with supporting information systems and technologies are the pillars of any real investment in the health sector. There has been, therefore, a shift of focus from the previous funding of building and infrastructure maintenance to the funding of strategic structural support areas for health*."

European Commission also referred, in the QCAIII negotiating mandate, that "*The strategy for intervention in health sector is an important novelty compared to previous interventions in this field, mainly based on heavy infrastructures (hospitals and health centers construction) and traditional training for professionals in the sector. The regional development plan proposes to break with this type of action and concentrate on the main objectives: improving the quality of the health services. This strategy is in line with the needs of the sector and with the objectives of structural reform that has already started in Portugal*" (Ministério da Saúde, 2000: 4)

But this change was difficult and complex. Sakellarides *et al*. (2005) stated that the previous approach - the investment on resources and infrastructures - had a strong and obvious social support base, while this new model "*based on a Health Strategy (an approach by results) is usually misunderstood, difficult to explain and, typically, has a dim social support base. It rapidly changes, to the influent social actors, in a "bureaucracy that hinders the access to*

important and necessary resources", and, therefore, should be avoided" (Sakellarides *et al*., 2005: 15).

In 1999, October, changes happened in Health Minister, the team that leaded this process was replaced and, according to Sakellarides *et al.* (2005), this represented the beginning of the end for this Health Strategy. With the change of Health Minister some key strategic objectives were left behind, such as Health Strategy monitoring indicators, the development of contracting processes, the implementation of 3rd generation Health Centers and Health local systems (*ibid*). Some of the master basis of Health Strategy vanished and the philosophy of QCAIII returned to what it was until then: the financier bank for infrastructures that political agenda needed. The hope of a new philosophy regarding QCA's investment was postponed mainly after 2003 with the change of government party: "*It is clear that QCAIII helped to improve health infrastructures and that enhances health system performances. But it was not capable to change ways things are made. And that's necessary"* (Sakellarides *et al.*, 2005: 16).

Notwithstanding, during 1999 and 2003 much happened and quality in health became a major concern for Portugal (OPSS, 2002). Saúde XXI was conceived and negotiated as a health sector development instrument and it considered eight procedures / measures, grouped in three priority subprograms that, seen as a whole, constituted a coherent group of actions with the objective of improving health care delivery (cf. Figure 4.3).

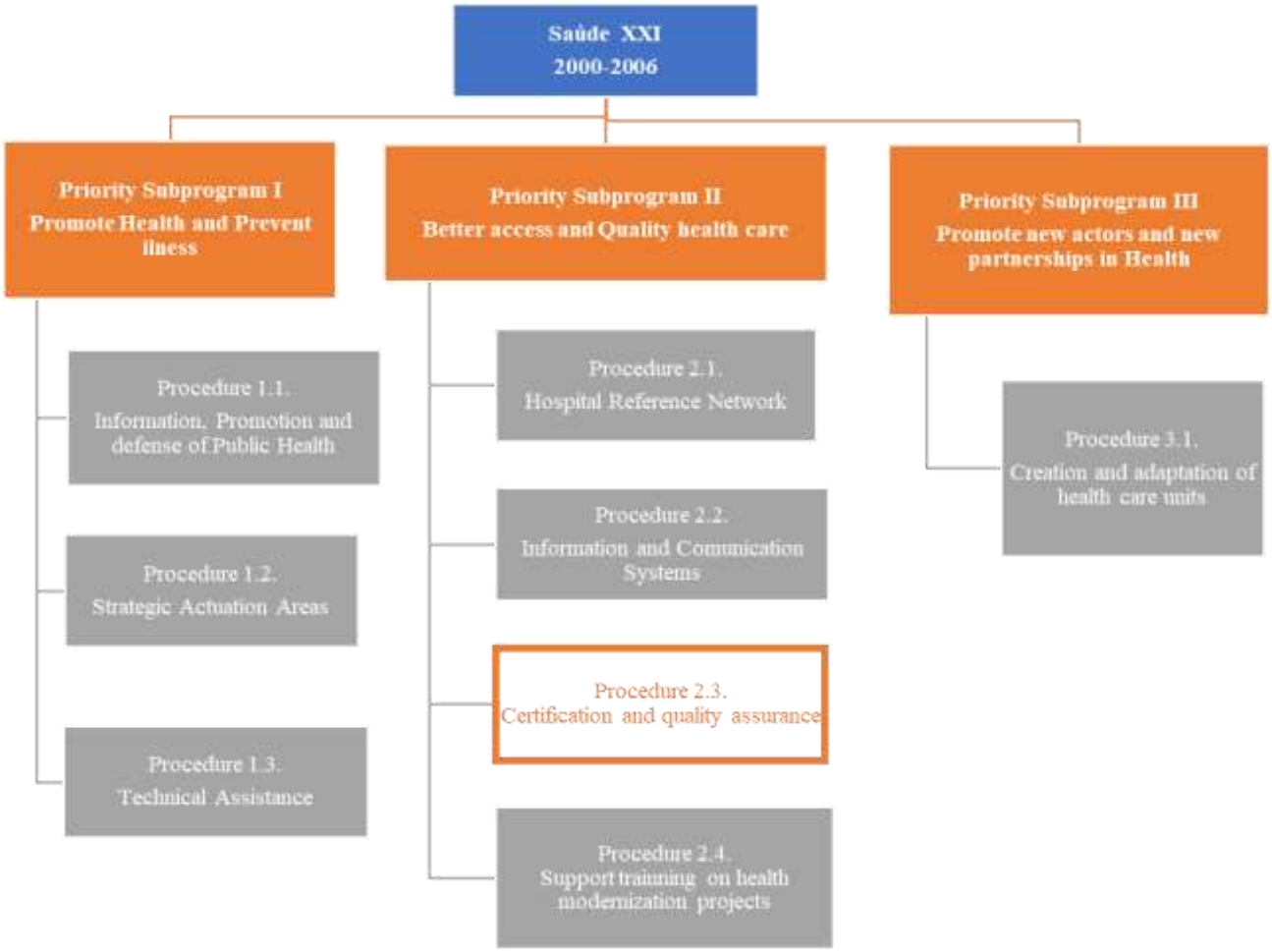
"*The entire Operating Program (…) contributed to structural changes in the Portuguese Health System and the implementation of the National Health Plan*", regarding the raising of the overall quality of health services (European Commission, 2010)

Carmen Pignatelli was, in 1999, the Health Operational Program Manager, but in May 2000 (Ministry Council Resolution nº27/2000) was assigned as QCAIII's Health Operational Intervention Manager, becoming state assistance secretary of Health Minister. The assignment included the technical, administrative and financial management of the Operational Intervention.

In the same Resolution, three coordinators were nominated and became responsible for one of the Sub-Programs: (1) Promote Health and Prevent illness, (2) Better access and Quality health care and (3) Promote new actors and new partnerships in Health. A new cabinet was created, the Health Operational Program Management Cabinet, and it contained approximately

twenty five elements. This Cabinet had several competences, as stated in nº 6, 5º of Ministry Council Resolution nº27/2000. Saúde XXI program was divided in three main sub-programs that aimed the: (1) promotion of health and prevent illness; (2) better access and quality health care; and (3) promotion of new actors and new partnerships in health (cf. Figure 4.3). The first subprogram, (1) Promote Health and Prevent illness, concerned three general objectives: (i) to improve the health information system, enabling better knowledge of the health status of the Portuguese people and their determinants and, on the other, to trigger the necessary measures to correct negative trends; (ii) strengthen health promotion, protection and safety infrastructure, with special emphasis on the implementation of the Public Health Services network; (iii) Develop projects that contribute to an improvement of the environmental conditions and, consequently, of the quality of life of the Portuguese.

Figure 4.3 – Saúde XXI Operating Program



Source: Ministério da Saúde (2000: 9)

The second subprogram, (2) Better access and Quality health care, specifically aimed to: (i) implement hospital referral networks by areas of specialization; (ii) strengthen the use of new information and communication technologies in the National Health Service; (iii) improve health care delivery through the introduction of quality systems and practices, the technical preparation of human resources for new tasks and the professional development of managers. The third subprogram, (3) Promote new actors and new partnerships in health, aimed essentially to: (i) increase and strength partnerships with the social and private sectors for the provision of health care in deprived areas; and (ii) contribute to the reduction of inequalities in health (Ministério da Saúde, 2000). Specifically related to the accreditation processes, the procedure 2.3. – Certification and quality assurance - considered financing for all actions that were needed for qualification (diagnosis of situation, definition of standards and reference standards, certification processes, improvement of equipment and processes, facilities, etc.). Physical investments (adaptation of facilities and equipment) linked to the certification or accreditation process, as well as other expenses related to these concerns were also supported (diagnostics, external consultations and constitution of certification processes) (Ministério da Saúde, 2000).

This strategy that was named Health Quality Portuguese System (HQPS), was centered and oriented to the citizen and assumed six major aims: (i) obtain health gains to Portuguese population; (ii) develop health local systems in conjunction with the hospitals reference network; (iii) deeply review of human resources development in health; (iv) achieve consensus for a new model for health financing that enhances health gains; (v) adopt a European dimension; and (vi) strengthen cooperation with PALOPs and the CPLP's countries (Ministério da Saúde, no dated).

"*This structuring tool was a true commitment of the administration to the citizens.*" (Barros & Simões, 2007: 64)

This new strategy assumed that "*the quality policy is indissociable and an integral part of health policy"* (Ministério da Saúde, no dated: 4)

Health Quality Portuguese System meant that a certain stage of development was recognized. It was the result of all the work that was done previously, such as: (i) health indicators, therefore, it was time to focus on health service organization, and reorient it in order to valorize the citizen that pays and uses health services; (ii) all the training and methodologies that professionals and

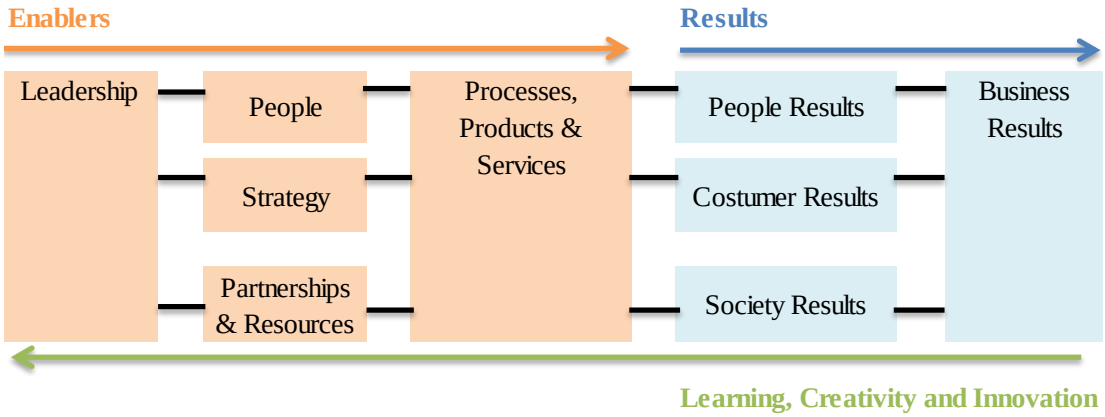
health units developed and participated; (iii) a quality culture was already emerging: through a set of legal diplomas and management instruments that were being finalized, an irreversible change in organizational context was expected and (iv) it was a natural insertion in the international movement, mainly in Europe (*ibid*). The Health Ministry considered that, after years of well-intended voluntarism with no global results, this HQPS was the definition of a policy, orientations and instruments to achieve it (*ibid*).

"It is a question of replacing a well-intentioned voluntarism, but with few results and continuity at a global level, for sustained development based on an unequivocal commitment of leadership, guaranteeing and empowering responsible participation of the various actors, defining a strategy for action, and the identification of explicitly and clearly time-bound objectives and commitments, as is the case here today" (Ministério da Saúde, no dated: 4).

In this process of continuous improvement there was a key element: health professionals' involvement. Health professionals, along with their professional associations, were considered crucial on training, specialization and continuous education and were also considered extremely important in the elaboration of clinical orientation lines and quality standards. Therefore, these professionals should also take an important part on external quality evaluation. In the document of the strategy *Saúde XXI* (Ministério da Saúde, no dated), given to all participants in the presentation session, was possible to understand that health care providers were considered as a key figure to have a quality continuous improvement: *"Reforms change the provision of health care context (rules, norms, incentives, structures). But provision of health care context is not the provision of the service itself. Only professionals have the power to change the provision of health care. If this is not achievable, the result will be simple: less and worst results"(*Ministério da Saúde, no dated: 7).

The Health Quality Portuguese System was framed on quality auto-evaluation model from EFQM (cf. Figure 4.4). This model is based on nine criteria. Five are *Enablers*, and cover what an organization does and how it does it (leadership, policy and strategy, human resources management and processes). The other four criteria are *Results*, and cover what an organization achieves (satisfaction of patients and professionals, impact and results).

Figure 4.4: EFQM Nine's Criteria Model



Source: EFQM website www.efqm.org, accessed on 20 March 2018.

EFQM describes how their model leads organizations to their main objectives: *"to achieve sustained success, an organization needs strong leadership and clear strategic direction. They need to develop and improve their people, partnerships and processes to deliver value-adding products and services to their customers. In the EFQM Excellence Model, these are called the Enablers. If the right Enablers are effectively implemented, an organization will achieve the Results they, and their stakeholders, expect."* [24]

In 1998 was believed that the use of this model would facilitate and help the change Portuguese health needed, because it would enable: (i) a structured and reliable approach to improving care; (ii) the creation and development of consensus on needs and problems, providing a common conceptual basis; (iii) the integration of various initiatives in the current practice of the organization; (iv) the evaluation of the organization's capacity to achieve its objectives; and (v) a basis to promote and share good practices in different areas of the organization, and between different organizations, allowing benchmarking (Ministério da Saúde, no dated)

In 1998, when the quality strategy was disclosed, four entities were considered the pillars for this new strategy, the enablers: (1) the National Council on Health Quality; (2) the National Accreditation Commission; (3) the Health Technology Evaluation Agency; and (4) the Health Quality Institute (IQS) (Ministério da Saúde, no dated). These entities were idealized and

[24] http://www.efqm.org/efqm-model/model-criteria, , accessed on 20 March 2018.

conceived to operationalize the model and give it structure. Notwithstanding, only the National Council on Health Quality and IQS were concretized.

(1) The National Council on Health Quality acted as a consultative body for Health Minister, within the framework of quality policy. It was responsible for the preparation of national recommendations regarding the development of the Health Quality Portuguese System. The board would be constituted by several entities such as IQS, INFARMED, Blood Institute, physician's, pharmaceutical's and nurse's professional associations, but also patient's representative, among several others. It was created in the 1st semester of 1999 (Ministério da Saúde, no dated).

(2) The National Accreditation Commission had the objective to develop the accreditation system. Its assignments would be coordinating and managing the accreditation program of health units and certification of health systems and be responsible for the accreditation of health units. It never came to fruition (*ibid*).

(3) The Health Technology Evaluation Agency aimed to objectify the clinical, social, ethical and economic impact of health technologies and procedures. Its objectives were: (i) to contribute to health policy-making and decision-making regarding the introduction of new technologies in clinical practice; (ii) to establish guidelines for the appropriate use of established techniques and procedures; and (iii) to collaborate with institutions and bodies related to the evaluation of health technologies, at national and international level (*ibid*). This agency was planned to start in the 1st semester of 2000 but never did, "*there were three attempts, but it was not executed*" (IQS's Director 2005/06).

(4) The Health Quality Institute [IQS] had the purpose of developing strategies and procedures that would support both health professionals and health organizations in quality continuous improvement in health care (Ministério da Saúde, no dated). The primary objectives of IQS were to promote: (i) the research and development of methods, instruments and programs for quality continuous improvement in health care; (ii) the development of quality certification methodologies for health care units, allowing their accreditation; and (iii) the framework for research and the continuing education of professionals in quality development through a multidisciplinary approach based on scientific evidence and on performance evaluation and monitoring. It was also expected IQS to promote a connection between similar organizations in

Europe, the US and Canada with the aim to create an international network of health quality institutes. The objective was to develop and exchange experiences, research projects, quality tools and methodologies. This institute, as it will be shown later, became crucial to the development of hospital accreditation process (IQS, 2000a). "*It was programed to be start working in the 4th trimester 1998, but it was created on 1999, April 27t. Curiously, the National Institute for Clinical Excellence (NICE), in UK, was established in the same month of 1999*" (IQS's Director 2005/06).

The development and implementation of the quality system has as its most relevant components several projects such as (1) MoniQuOr, (2) Quality manuals, (3) QualiGest, (4) Clinical Guidance Standards, (5) Quality Improvement Program, (6) "Quality in Health" Magazine, (7) Hospital's quality letters and the (8) Hospital's National Accreditation Program – IQS/King's Fund's Health Quality service protocol (some were initiated and developed under IQS's leadership, and others were pre-IQS).

(1)MoniQuOr was an evaluation and monitoring instrument for health centers organizational quality. It was the first evaluation and monitoring instrument for Health Centers Organizational Quality and it was based on criteria of EFQM self-evaluation model (IQS, nº0, 2000). MoniQuOr started in 1998, pre-IQS, by the hand of IQS's Director 2000/05. In the first year there was a participation of 290 health centers (82% of the universe), but in 1999 the number of auto evaluated centers dropped to 102 (Ministério da Saúde, no dated). In 1999 there was a cross evaluation (the previous were auto-evaluation) and in January 2001, the Health Minister announced a €150m grant to the first six health centers which achieved at least a 80% of criteria compliance in the cross evaluation of 1999 (IQS, 2000a; OPSS, 2002; Pisco & Biscaia, 2001). In December 2000, the MoniQuOr stopped, as planned since its beginning, to revise and improve criteria. It was stopped until 2004, when there was a new auto-evaluation, carried out voluntary by 55% of the universe of health centers (IQS, 2000a). Internationally, MoniQuOr was candidate for the award for Best European Project in the field of quality improvement (OPSS, 2002). In 2006, with the creation of Family Health Units, it was designed a new model – DiQuOr – based on MoniQuOr.

(2)The methods used in Quality Manuals were designed by IQS and they were externally validated by independent entities. There were several publications, all concerning health quality,

as quality manuals for the admission and organization of patient care, manuals for good service practices manual and also manuals for food safety practices (IQS, 2000a). In 2002, the OPSS reported that twenty-four health units had developed a "Quality Manual on Customer Care and Routing", twenty of which had already been externally audited, and had received declarations of compliance: *"The aim of this project was to improve the procedures in the scope of care and patient circuits in health institutions"* (Pisco & Biscaia, 2001: 48).

(3) In 1999, IQS launched a model of self-assessment of quality and promotion of modernization and excellence in health service management – QualiGest. The model was developed in partnership with the Portuguese Association for Quality and was based on EFQM's model of excellence (explained previously), based on principles of total quality management and organizational excellence. It consisted on a self-assessment grid for monitoring the quality performance of the management function of Portuguese health institutions. It endend up being a specific project to implement the EFQM model in NHS institutions (IQS, 2000a). This model had a first experience in December, 1999 in all health centers in Aveiro region. (OPSS, 2002) However, this project had no follow-up or apparent practical results.

(4) A clinical guidance standard [NOC] is "*a set of systematically developed recommendations that are intended to support the physician and the patient in making decisions about health care in specific clinical situations*" (IQS, 2005a: 39). IQS launched the first Noc's Manual in April, 2001 and in 2002, January the first NOC was concluded. It was entitled "Tobacco treatment for use and dependence". Several others followed (OPSS, 2002).

(5) The Quality Improvement Program appeared as a cultural continuity of the projects of productive improvement, review of use and technical courses of industrial engineering applied to the hospitals, introduced in our country between 1983 and 1987. They had the support of North American university academics and, perhaps, the most important example is the Diagnosis-related groups (DRGs) (IQS Boletin, 2000). It was based on the thoughts and methodologies of Deming and Juran. It was expected that its use, continuity, development and deepening would allow a truly silent revolution in Portuguese hospitals, focusing on satisfying the needs and expectations of both internal and external customers, reducing costs with non-quality (*ibid*). In May 2000 there were already several hospitals that had joined the program (district hospitals of Torres Vedras, Abrantes, Beja, Tomar and Torres Novas, Maternities Byssaia Barreto and Júlio

Diniz, and the hospitals of S. Sebastião and Santa Maria da Feira) and worked on 41 improvement projects (*ibid*).

(6) IQS's magazine, "Quality in Health" was launched in 2000, June and it had a quarterly periodicity. It was a challenge that aimed to fulfill the lack of technical and specialized articles on the area. It was another way to spread quality culture in health sector (IQS, 2000a). It lasted until 2006, November, reaching sixteen publications of "Quality in health".

(7) All health units had to elaborate their 'Quality Letter' regarding three aspects: (i) quality policy – defining efficient, citizen-oriented care, cooperation and coordination between providers, adequate management of resources, effective communication, and clearly defined tasks and responsibilities; (ii) quality improvement system – through the definition of indicators, criteria and quality standards to be achieved and mechanism for internal or external evaluation of the degree of compliance with these standards; and (iii) an annual activities report – a document that demonstrates the quality of the medical care rendered with special relevance in the involvement of the citizens and frequency of the quality evaluations. It was up to each health care unit to adapt these aspects to its reality as well as the operationalization of the respective criteria (Ministério da Saúde, no dated).

(8) The IQS and the Hospital's National Accreditation Program – IQS and King's Fund's Health Quality Service protocol, in April 1999, turned out to be one of the most, if not the most, important and consistent project from IQS, due to its significance, coverage and pioneering. The aim of this project was to create a continuous evaluation system for hospitals organizational quality. It would monitor systematically their performance and could be used as a tool for development and continuous improvement (IQS, 2000a). "*The Hospital's National Accreditation Program (PNAH) allowed the different professionals to know a new "language" that transformed their daily performance and the perspective of how their work was organized, through the quality in health*" (IQS, 2004b: 51)

The Role of Health Quality Institute (IQS)

As stated previously, IQS was set in 1999, April 27th. The aim was to be approved by a Law-Decree, and have financial autonomy, but in 1999 the government mandate was finishing, and it never had a parliamentary majority, so turned out to be approved by a "Portaria" (Portaria nº288/99, April 27th), which means that it didn't need promulgation in Parliament. IQS was a service of the MoH endowed with scientific, technical and administrative autonomy, depending on the Director-General of Health. It was responsible for the definition and development of norms, strategies and procedures that aimed the continuous improvement of quality in health care provision (IQS Boletin, 2000; Portaria nº288/99, April 27th). A Director was nominated, Dr. Luis Pisco, a general practitioner, who had already worked in the quality health area. From 1995 to 1997, Dr. Pisco worked with Prof. Emilio Imperatori Ruiz, DGS's Quality Services Director, in a project of indicators to evaluate 20 health centers. Dr. Pisco also worked with Dr. Biscaia, the subdirector for Quality when IQS was funded, and it was by recommendation of Dr. Biscaia that Dr. Pisco became IQS's Director 2000/05. There were also two Deputy Directors: Dra. Margarida França and Prof. António Vaz Carneiro. Dra. Margarida França had finished her Master's thesis on Accreditation and Dr. António Vaz Carneiro, was a renowned doctor. IQS had also a Consultee Council with 12 experts with recognized technical competence: two nurses, two hospital administrators, four academics, one physician and three hospital services directors (IQS, 2000a).

In 2002 the OPSS recognized that IQS was playing a relevant role in supporting the development of quality in the health system: *"Quality in health might have been the area where benefits from the existence of a strategy and a continuous politics execution were more evident." (OPSS, 2002: 64).* According to OPSS Spring report (2002), two reasons were pointed as explanations for this success. The first one was the "*tranquil but technically consistent and effective leadership of the Health Quality Institute (IQS). Created in 1999, it has fully fulfilled its mission and is today the reference of the subsystem of quality in health*" (OPSS, 2002: 64). The other reason was the existence of the QCAIII that had, for the first time, an important value (€3,5M) allocated to the health quality promotion policy- Procedure 2.3. - Certification and

quality assurance (cf. Figure 5.1. previously presented) (*ibid*). Ng *et al.* (2013) had also identified a strong relation between the success of accreditation programs and the reality lived in countries (political, social and economic) because it incentives or disincentives participation.

IQS's Director 2000/05 resumes the favorable conditions lived at that period "*One thing must be taken into account: for the first time, structural funds were being negotiated (Saúde XXI), and a very high financial package was negotiated for quality projects in health. There was funding to pay for accreditations, certifications, to pay for a number of projects through the QCAIII. There was political will and money here*". (IQS's Director 2000/05). In 2003 he reaffirms *"The financing provided by the Health Operational Program (Saúde XXI), in its priority axis II - Improve access to quality health care, especially in the 2.3. - accreditation and quality assurance, have been of crucial importance in this process, enabling initiatives that otherwise would be absolutely impossible to implement"* (IQS, 2003: 2)

IQS's Director was a member of The European Society for Quality and Safety in Family Practice [EQUIP], in the area of quality evaluation. This allowed him to be in touch with the best that was being done through Europe in what concerned quality improvement. It also permitted him to contact with the existing accreditation processes of King's Fund and Joint Commission. Health quality Portuguese system (HQPS) assumed the implementation of an accreditation system for health facilities that would be executed by an entity to be established under its purview. The options Portugal had were clear to the IQS's Director (2000/05): whether to create an original accreditation system (like the Dutch did, that took them seven years), or to implement an existing model. Reached this stage, it was obvious for IQS's Director, that the first choice was not reasonable for Portugal reality "*the option of constructing a program of its own with the elaboration of root patterns was clearly rejected."* (IQS, 2000a: 31). Therefore, the choice was between the already existing models: the English model by King's Fund, or the American / Canadian model by Joint Commission. The decision to choose the accreditation model to contract with, took into account several factors as the geographical proximity (it was much less expensive to bring technical support and auditors from England than from USA or Canada); and the legislative similarity (Britannic legislation is much more similar to Portuguese, than American or Canadian) (IQS, 2005a).

*"English legislation is within the EU and, culturally, English hospitals are not so different from Portuguese hospitals. American hospitals are very different, the culture is totally different, there is another pressure, an obligation that we did not have. And so, I would say that this partnership was somehow patronized by governments, the English embassy always participated, organized meetings, we [IQS] went to England several times and there was indeed a partnership system with the KF" (*IQS's Director 2000/05*).*

It took also into account: (1) the possibility to contract the transfer of technology and knowledge, as Portugal was not a rich country and could not afford to pay forever for that service (this option was not available with Joint Commission); and (2) the credibility factor.

"*The idea was "we do not want something like JC because we're going to be paying forever and on the day they leave we're left with nothing" - we have to have a Portuguese model, but we do not have seven years to create it like the Dutch, so we are going to negotiate with the British this process of five years: the first accreditations are made by the English, with English auditors, English manuals, everything is done by them. But afterwards we will work on the translation and validation of the accreditation manual, and this was done with the support of the British, we will train Portuguese auditors." (*IQS's Director 2000/05*)*

In the choice process the institutional power and its influence and the aura that this British Foundation had on the decision maker had its contribution. Bohigas *et al.*, (1996) concluded that, to provide a high-quality service, the accreditor must be perceived as accountable and reliable. Its ultimate success depends on the reliance that others have towards the accreditor entity. It was also taken into account the previous knowledge on King's Fund accreditation process. At that time King's Fund was a very recognized and prestigious institution but did not work abroad, only worked in England: "*King Edward's Hospital Fund for London is an independent, non-profit foundation founded in 1897 by the Prince of Wales, later Edward VII. It has legal personality and independent activity and has as Humanization voluntary commission the Prince of Wales. Its current mission is to contribute to stimulate good practice and innovation in all aspects of health care and management. The Health Quality Service [KFHQS] currently offers a unique accreditation process in the United Kingdom created specifically for health organizations and is the most important accrediting body in the country*." (IQS, 2000a: 32).

Previously to IQS's choice for King's Funds' protocol signing, Santa Marta's Hospital was also being accompanied by King's Fund in an auditory program since 1997. Isabel Pinto Monteiro (health sub-director) organized a series of conferences and brought Tessa Brooks to Portugal. Tessa was responsible for introducing hospital accreditation at the King's Fund. When ceased functions, Isabel Pinto Monteiro was placed as a delegate administrator at the Santa Marta's hospital and she mobilized the Board of Directors to start the accreditation project. A hospital team traveled to London and presented the challenge to the King's Fund - a hospital in Portugal wanted to apply its program. The culmination of this initial process occurred in 28th May 1998 where a workshop took place in Sta. Marta's hospital, and the State Secretary for Health and Health General Sub-director were present. It was titled "Santa Marta's Hospital: searching for perfection" (IQS, 2004b). The King's Fund model was characterized by high quality standards, using in one single methodology the best that existed in health quality: the King's Fund itself, the EFQM model (European Foundation for Quality Management) and the ISO (International Organization for Standardization) certification whose purpose is to evaluate the performance of a hospital by internal and external auditors: the "*three in one*" model (Griffiths, P, 2000: 23)

A collaboration protocol for the development of the Portuguese health quality system between the MoH and the King's Fund's Health Quality Service was signed for a period of five years, in 1999, 17th March, that was prorogated for more two (IQS, 2005a).

The objectives of this document were (1) cooperation in the development of quality health research projects and methodologies and instruments for the continuous improvement of quality; (2) development and validation of the King's Fund's health quality service methodology and hospital standards in Portugal; (3) and the participation of a maximum of five national hospitals, in the first year. Subsequently, IQS, by means of a contract, defined in more detail the conditions of this partnership, the transfer of technology resulting from the protocol and the commitments of both parties. In the same formal act, five hospitals signed contracts to participate in the King's Fund's Health Quality Service accreditation program, namely the hospitals of Barlavento algarvio, in Portimão, Doutor José Maria Grande, in Portalegre, Santa Marta, in Lisboa, Fernando da Fonseca, in Amadora and S.Teotónio, in Viseu. In early 2000 Garcia de Orta-Almada Hospital and the local health unit of Matosinhos joined the accreditation program, completing the first

group of seven "pilot hospitals" and overtaking the initial estimate of only five pilot units (IQS, 2000a). This protocol also included the transposition and validation of King's Fund's Health Quality Service's norms and methods to the Portuguese reality (*ibid).* Portugal would pay an amount for the copyright and they would help the country for a five-year period, until an autonomous Portuguese accreditation process was viable.

*"In fact, in King's Fund the idea was to try to create everything so that Portugal could be autonomous, although we had always the perception, and Dr. Margarida França also (she was the person that made the connection with the English partners) that it would be good to have a parity and that a Portuguese accreditation could always give rise to an English accreditation: in terms of prestige it is always different to say that one is accredited by an English institution. We tried to the utmost to maintain this parity, so that the criteria were recognized by the English, Dr. Margarida França went to London to participate in the final accreditation processes, but then there was never the political courage to say that it was time to cut this tie and walk alone." (*IQS's Director 2000/05*).*

As stated previously, the initial contract was signed for a five-year period and considered three distinct phases. The first one consisted on learning the process and applying it. It was followed by the establishment of all infrastructure and transition management. In the last phase there would be a revision and evaluation of the system and the definition of the terms for future collaborations (IQS, 2000a).

On September 1st, 1999 the accreditation program coordination and group at the national level was designated. It was a multidisciplinary team composed by "*three elements and it was added a representative element of each pilot hospital*" (IQS, 2000a: 6). The hospitals that were part of the first group were denominated as "pilot hospitals". Unlike the following groups, which were auto-proposed, "*this group was chosen due to their individual characteristics and invited to be part of this new project and great commitment of IQS*" (IQS's Director 2005/ 06).

"People were enthusiastic and saw a very valuable change process and that something was happening. That is, it was a wave of renewal of our hospitals. The first group of hospitals was somehow suggested, chosen among the new hospitals with new management models, and we wanted to bet on those hospitals, some of them with new facilities, such as the Barlavento,

*Matosinhos, to start well, but then the hospitals began to join enthusiastically. It was a very interesting phase. And that is still notorious, isn't it?" (*IQS's Director 2005/06*).*

In Portugal, this accreditation process consisted in four periods concerning different groups of hospitals that were chosen, in a first stage, and posteriorly the hospitals auto proposed to participate in King's Fund's Health Quality Service's program (cf. Table 4.13).

In 2004, the general feeling was that those who had chosen to fight for quality should have been recognized by the MoH. About this question, Dr. Larcher stated that: "*Hospitals that upgrade their quality must be recognized. Quality is an essential factor for the image and prestige of institutions. The differentiation between those who invest in quality and those who do not, has to come from abroad. ... has to be done by the market or the Ministry of Health as the great tutor of the whole system*" (IQS, 2004b: 21). Dr.Helena Pinho, physician from S.Teotónio's hospital, also corroborates this opinion: "*The King's Fund program is for professionals to uphold best practices and to enshrine all teamwork and it should be more distinguished and rewarded by the Ministry*" (IQS, 2004b: 26). The same feeling was expressed by the Alto Minho Hospital Center when emphasized as a constraining agent "*the lack of direct and permanent stimulus of political power that should prioritize the process and place it in the eyes of the community and of the professionals as an instrument of added value, necessary for the local, national and community credibility of the institution*" (IQS, 2004b: 39)

In 2005, IQS's new director (Dra. Margarida França assumed IQS's direction in November, 2005) considered that the six years of activity were positive "*taking into account, in particular, the context in which the IQS was created, which occurred at the end of the term of the Minister Maria de Belém, with a new "head" in health and, to this day, several ministers of the sector and different policies have been advocating. Although in the legislation that creates it, IQS is considered to be responsible for health quality policy, it is no more than a theoretical abstraction, because the true person responsible for this policy is obviously the Minister of Health"* (IQS, 2005a: 3).

Table 4.13 – Implementation periods of King's Fund's Health Quality Service accreditation program

1999 Sept Pilot Hospitals	2000	2002/03	2004
Santa Marta's Hospital (Lisbon)	Coimbra's Regional Center (IPO)	Santa Luzia's Hospital (Viana do Castelo)	Magalhães Lemos's Hospital (Porto)
São Teotónio's Hospital (Viseu)	Porto's Regional Center (IPO)		
Barlavento Algarvio's Hospital (Portimão)	D. Estefânia's Hospital (Lisbon)	Funchal's Hospital Center (Funchal-Madeira)	Divino Espírito Santo's Hospital (Ponta Delgada - Azores)
	São João's Hospital (Porto)		
Dr. José Maria Grande's Hospital (Portalegre)	São José's Hospital (Lisbon)	Águeda hospital center (did not finished)	
	São Marco's Hospital (Braga)		
Fernando da Fonseca's Hospital (Amadora-Sintra)	Anadia's Districtal Hospital (Anadia)	Mirandela District Hospital (Mirandela)	
Garcia da Horta's Hospital (Almada)	Dr.Francisco Zagalo's Hospital (Ovar)	Sant'Iago do Outão's Orthopaedic Hospital (Setúbal)	
Matosinho's Health Local Unit	Santo António's General Hospital (Porto)		

Source: Original, elaborated with information from IQS's magazines – Qualidade em Saúde, (IQS, 2004b : 41)

IQS remained as a facilitator in the accreditation process, mediating and helping hospitals until 2006, as the new director, Dra. Margarida França explained: "*We assist, provide information and tools; we help to change the installed culture and the way we do it. This is our obligation. The improvement is up to the professionals to do it*" (IQS, 2005a: 3).

IQS was exposed to the political cycles and their different decisions had impact on IQS's activity. Nevertheless, IQS kept focused on its objectives: "*Despite political vicissitudes and the reflexes that this always produced and still produces in the case of IQS, this institute had a set of*

*well-defined projects in the area of quality that no minister has ever questioned. Therefore, with more or less support, with ministers with a more explicit speech about quality than others, IQS ended up fulfilling its activity's plans and putting into practice the strategic objectives stipulated. As a result, important national level projects have been implemented, which have achieved extraordinary development, a degree of implementation which anywhere in Europe would be considered a good result. Examples of this are hospital accreditation projects or the implementation of quality manuals for the care of users of health centers and hospitals" (*IQS, 2005a: 3*).*

One thing that was common in all interviews done by the researcher was the unanimous opinion that whatever accreditation model chosen, the important is to be in one, even if in some aspects the hospital did not respond to all the requirements.

"*With the King's Fund it was perfectly possible to make gentlemen's agreements. São Jose's Hospital did an accreditation process when everyone knew that they could never achieve accreditation due to structural conditions. But at a certain time, a cost- benefit analysis was made and the idea was that the hospital even knowing that it will never be formally accredited, can do the process, because the organization and management of the process will definitely benefit. There were several hospitals which were believed to hardly have a formal accreditation only because of the structure [the building itself]. For this reason it was felt that they could participate in the process. They would benefit to the extent that they could benefit from. There was the notion that it was beneficial for the Hospital as a whole to participate in the process*." (IQS's Director 2000/05)

Notwithstanding, OPSS Report also drew attention to the fact that, *"without a quality system closely linked to health regulation and management, much of this effort will not have the desired impact*" (2002: 66). In 2003, IQS's Director 2000/05 stated also his concern about the future *"It is necessary that these efforts are not occasional, due to fashion or passing enthusiasm, or just because funding is available. ... The worst that could happen would be in the future at the end of the QCAIII, the last that our country will benefit, these projects stop, the organizations not to continue their certification and accreditation, have not achieved a positive impact on the culture*

*of organizations, the motivation of professionals and, above all, the quality of care provided to patients" (*IQS, 2003: 2)

In April 2004 (with a new government party in duty), a Hospital Mission Unit was created with the aim to manage all 100% public capital hospitals. This new entity chose a new hospital accreditation model to be implemented: Joint Commission International. "*The Hospital Mission Unit understood, at that time, that the King's Fund system was not suited to the philosophy of hospitals, and that the American system- Joint Commission - would be more appropriate. This created a lot of noise in the system. It introduced fourteen accreditation processes, but very few have avenged*" (IQS's Director 2000/05)

This created a buzz in the field because IQS had a contract with King's Fund for a five-plus- two-year period that would end in 2006 and the initial idea was to create a national accreditation agency, with all the transfer of knowledge and technology that had been made over the years under the contract with IQS. During 2004 and 2006, Joint Commission International and King's Fund programs coexisted but "*there was an uncomfortable situation*" (IQS's Director 2005/06).

"*A rare thing happened in Portugal, we are a country with 10 million inhabitants, 100 public hospitals and we have the levity of having acquired a model for Portugal and then allowed the Institutions individually to be accredited by the Joint Commission. We left the model we had bought, coexisting with another model. As hospitals have administrative and financial independence a hospital could, by default, acquire another accreditation model, and that is what some have done. At the time, when we made the evaluation of both models not only the King's Fund suited more but also it was much cheaper (Joint Commission is very expensive), but things went like this" (*Profª ENSP*)*

Notwithstanding, in 2004, the State Secretary for Health stated: "*It is necessary to clarify that the implementation of the Joint Commission model does not put into question the ongoing processes for accreditation by the King's Fund. Nothing prevents the same institution from being accredited by more than one system, especially when we are dealing with models with different approaches. The Ministry of Health does not have the aim to impose specific models, it is necessary to define the general and national principles of the hospital qualification system and to*

ensure that the models in practice are according to this framework. In fact, more than words, I decided that this was the way and I made concrete decisions on this matter." (IQS, 2004a: 5)

The new government defended that the Joint Commission was a prestigious international institution, as King's Fund, that focus on hospital outputs and defends the presence of Joint Commission model as a way "*to have diversity of models and certification processes and accreditation of units. The results will be the competitiveness, meritocracy, productivity, user and professional satisfaction and quality*." (IQS, 2004a: 5).

Notwithstanding, there was a duplication of work because there was a co-habitation of two entities under the same responsibility with the same assignment to promote quality methodologies: the IQS through King's Fund accreditation and the Mission Unit through certification by the Joint Commission. And this duplication occurred due to the lack of articulation between the two entities. IQS's Director 2000/05 explained this lack of articulation: "*the Mission unit has been working independently without ever contacted with IQS for any collaboration. It is a policy and a way of acting different from our*" (IQS, 2005a: 8)

The process with Joint Commission International was faster, as they had a "*condensed program for all-world"* (IQS's Director 2000/05; IQS's Director 2005/06; HOSO' quality director). Fourteen Portuguese hospitals joined the process but some came to IQS to look for help in implementation, which denotes some lack of support from Joint Commission International or from Unit Mission (IQS, 2006). From the 14 hospitals that initiated the Joint Commission International program only five reached the accreditation (IQS's Director 2000/05).

"*They [Health Minister] understood that this process [Caspe Healthcare Knowledge Systems] was very time consuming (it is cumbersome and time-consuming because it is a cross-hospital process), but in my view, it is important because it is a process of continuous improvement. But since it was very time-consuming and the minister wanted to see the hospitals all accredited, there were a number of hospitals to be accredited by the Joint Commission model, which had another methodology, faster to implement, using checklists, but in my view, in terms of institutional culture, did not have the benefits that a process of continuous improvement has. Each system has its advocates. Someone who has chosen Joint Commission or joins it will say*

*that the Caspe Healthcare Knowledge Systems process is a very time-consuming process, but the acculturation is done so". (*President of Board of Directors - HOSO*)*

In 2006 the QCAIII ends and IQS is discontinued, under the Restructuring Program of the Central State Administration (PRACE). Sakellarides *et al*. (2005) consider that 2002 was the final of a political cycle and also determined discontinuity. The idea towards a quality national system simply vanished. IQS's director 2005/06 explains that the ultimate objective of IQS – to become a national accreditation organism that was part of a national accreditation system - would cover not only health and environment (accreditation in education was not already in discussion):

"*The culmination of this idea would be the creation of a National Accreditation Commission/Institute. The main idea was to create a quality national system, depending directly from the Minister Council (not from the Economy Minister), and all subsystems (health, environment, etc...) would be connected to a national accreditation system. The work was done for IQS, in Health area, and also in Environment area. At that time, quality was not seen as crucial in education. This work was all prepared in 2002*" (IQS's Director 2005/06)

In 2005 one of the few remaining objectives from previous health quality decisions was the creation of a hospital accreditation national system as IQS's Director 2000/05 mentions: "*all the rights were acquired, namely the methodologies and everything that we translated and was validated for Portuguese in terms of criteria, the stock exchange of auditors was created and the stock of managers of clients as well*." (IQS, 2005a: 8).

But the creation of a hospital accreditation national system depended from the creation of a national accreditation commission and that was a decision that the MoH had to take among the existing hypotheses as explained by IQS's Director 2000/05: "*Or we become completely independent from the UK, and for that we have to create an exclusively national accreditation commission; or we may, for reasons of international credibility of the system, have a mixed accreditation committee with national and British recognized personalities; or we maintain the current agreement in which the entire process is carried out in the country under the PNAH and accreditation continues to be granted by the King's Fund"* (IQS, 2005a: 8).

In June 2005, IQS's Director 2000/05 explained what was expected for the future of IQS, concerning a new MoH team: "*Finally, and after a period practically fulfilling only the business*

plan, it is necessary to define the strategic guidelines of IQS. I believe that in the future IQS's activity will have a greater impact than it did in recent years" (IQS, 2005a: 11).

In December 2005, there was a change in IQS administration and Dra.Margarida França, (ex-IQS's Deputy Director) became the new director. The new management scheduled for February 2006 the assignment of comparing Joint Commission's and King's Funds methodologies, evaluate experiences, get to know Joint Commission's model and then take the right decisions (IQS, 2005b). Notwithstanding, in October 2006, IQS is extinct (DL 212/2006). The DL stated that: "*The following services and bodies are extinct and merged: c) The Institute of Quality in Health (IQS), with the respective attributions related to clinical quality integrated in the Directorate General of Health (DGS), and the other attributions integrated in the Central Administration of the Health System, I. P. (ACSS)" (alinea c, paragraph 2 of art.26 of DL 212/2006).*

Between 2006 and 2009 there was a void in what concerns quality in health services, mainly in hospitals. For some reason, quality area was divided in two: clinical quality and organizational quality. Organizational quality agency was assigned to ACSS and, as DGS did not want to lose quality [IQS was in DGS], the solution was to maintain clinical quality with DGS (Decree law 212/2006). Quality agency in ACSS never had a staff board and never got to nominate a director. For three years Health quality was not in national agenda.

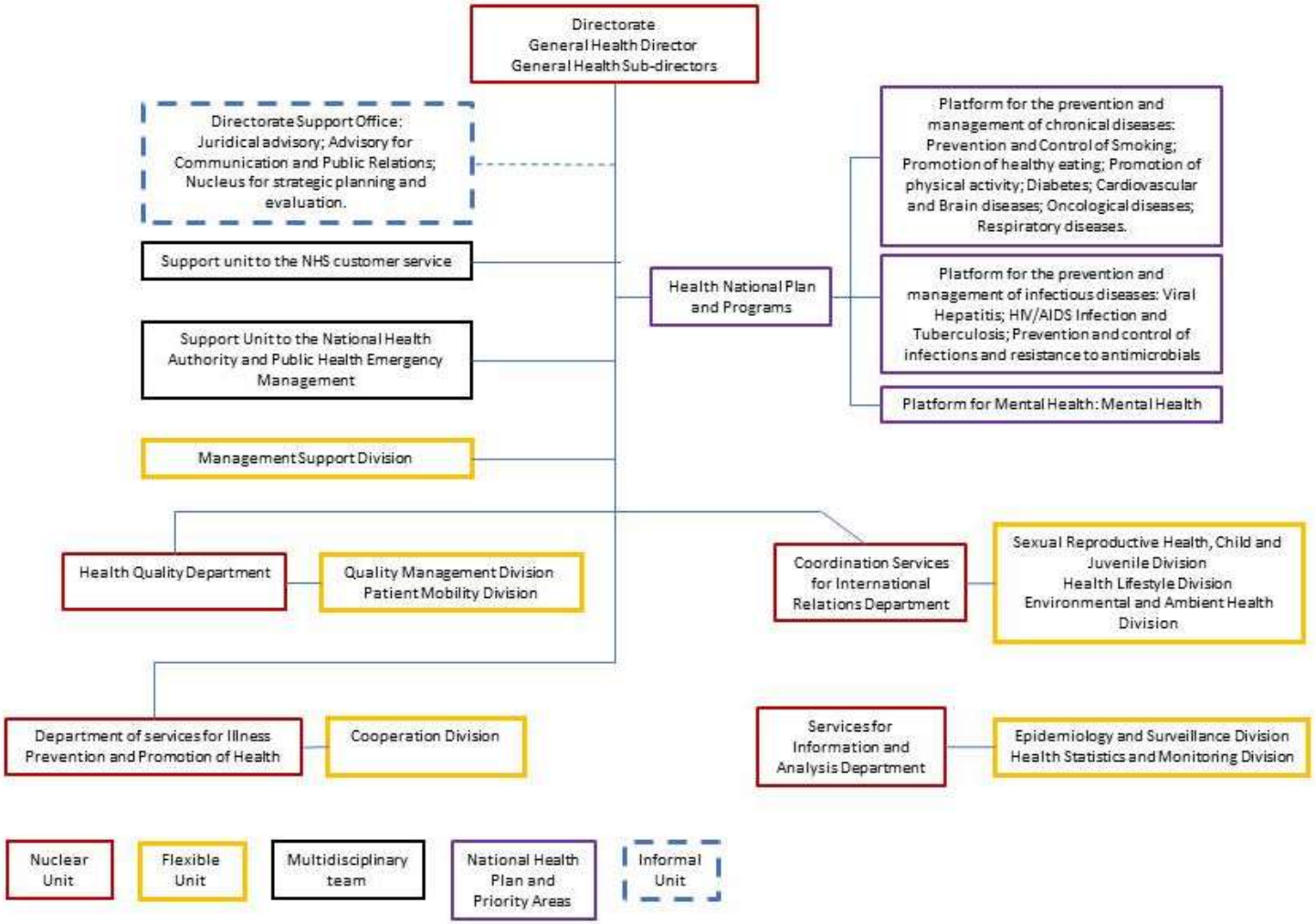
In 2007, OPSS referred: "*Regarding quality - and even due to the expectations related to the internal restructuring of the MoH with the emergence of a "Central Administration" with great potential for a more rational management of health resources - there is an apparent stagnation after the extinction of the Institute of Quality in Health (IQS), putting at risk the previous work*" (OPSS, 2007: 199).

In 2008, by DL 234/2008 December 2nd, the quality area, as a whole, is placed under DGS power and a quality department is created, divided in two divisions: quality management division and patient mobility division (cf. Figure 4.5). In 2009, a Health Quality National Strategy is approved (Despacho nº 14223/2009, June 24th). This new strategy stated the priorities for quality in health. The aim was to create a national and independent accreditation model, which would be officially implemented through a health accreditation national program.

"*The Health Quality Department of the DGS should create a national health accreditation program, based on a sustainable accreditation model and adaptable to the characteristics of the Portuguese health system, with the aim of guaranteeing the quality of health care organizations and promoting its voluntary commitment to continuous improvement, consolidating the culture of integral quality*" (Despacho nº 14223/2009, June 24th).

In order to adopt an accreditation model, three criteria were defined (1) alignment with the main lines of the National Strategy for Quality in Health; (2) transversally and ease of adaptation to the various types of units that exist in NHS, allowing evaluation by national health professionals and the possibility of extending it to other areas of health accreditation and (3) economic sustainability, in order to allow for a widespread adoption of the chosen accreditation model (DGS, 2009). Notwithstanding the merits recognized for the various accreditation models previously implemented in Portugal, the choice fell on the Agencia de Calidad Sanitaria de Andalucía (ACSA) Model, since it is the one that "*best adapts to the above-mentioned criteria and because it is a consolidated and recognized model, designed for a public health system of organization similar to Portuguese and identical recipients in demographic and epidemiological terms*" (*ibid*: 5). The choice for ACSA was done by the Director of General Directorate for Health, Francisco George (2005-2017), suggested by the ex- IQS's Director (at the time, coordinator of the Mission for primary health care) that had met ACSA's Managing Director, Antonio Torres, in an IQS's conference.

Figure 4.5 – DGS Organogram 2016



Source: https://www.sns.gov.pt/entidades-de-saude/direcao-geral-da-saude/ (accessed in 24 June 2019)

The ex- IQS's Director went to Sevilla with DGS's director and ended up acquiring a process to ACSA "*very similar to what IQS had with King's Fund, and that was to create an accreditation process, which at a certain stage, could be autonomous*" (IQS's Director 2000/05). ACSA was proposed as the national accreditation official model for health institutions by the Health Ministry in 31st August 2009, by the "Despacho" nº 69/2009. It was also stated that the approval of this model should not interfere with the accreditation processes in progress in public health institutions.

The major difference that this process had compared with the other two processes was the fact that accreditation could be done by services, it was not essential the engagement of the hospital as a whole, as it was demanded by King's Fund and by the Joint Commission. This was a relevant aspect in terms of costs; especially in the economic context that Portugal lived in those years. However, several professionals during this investigation reported that this model of ACSA accreditation, per service, makes people feel excluded, because it creates disputes between services. Currently, a service can auto purpose for an accreditation program, even if it is the only service in the hospital. According to several people interviewed this creates a climate of conflict and "islands" in hospitals. The DGS sees it in a different way by defending that quality culture spreads: "*There is an advantage in accrediting services: it raises competition and competitiveness within the institution. It is a cultural process. It starts to spread a culture, because if you are accrediting a service that has relations with others, it is related to the Complementary Diagnostic Means, the Pharmacy, the laboratory, leads the others by drag, because it cannot be believed if the process does not function to its fullest extent. And so this pleased me immensely" (DGS's Quality Director 2012/18).*

There are some voices that corroborate DGS's point of view: *"This model, ACSA, is slightly different from King's Fund, who accredited the Hospital as a whole; this model ACSA accredits services. What we noticed at the Hospital North Lisbon Center was that accreditation began in the pediatric service but there was a set of practices that had to be developed (at the level of training, facilities and equipment ...), which are now applied (the same procedures) for all services: it ultimately contaminates the organization as a whole. And it is much cheaper. It is possible to do it in a phased way which makes it easier. And it covers all services: hospitals, primary health care, etc."* (Profª ENSP).

"It is true that the models of King's Fund and Joint Commission were only for hospitals so this current situation has the virtue of transposing to health centers an accreditation model that was quite simple- through a check list" (President of Board of Directors - HOSO).

Notwithstanding, some opinions do not corroborate these points of view:

*"ACSA and Joint Commission are accredited by ISQUA. I was the one who evaluated the ACSA standards for hospitals. The fact is that there has been a very great evolution. For what I saw in the beginning and what exists today I would say that it is very good. Today they have something well structured. What exists in Portugal is a strategic mistake in implementation. It is not that the model is bad; on the contrary, it is the application of the model that it is being done in a less correct way. When reference centers are created within hospitals, we create islands. Islands of excellence that, if not well managed, can mean a setback in a process that began well back in the 1970s called "multi-disciplinarily, integration of services, and less hospitalization." When we start to create niches, we begin to isolate. The head of the center of excellence begins to feel that "nobody is like us". The initial idea is that a hospital that had a center of excellence accredited by ACSA would later be fully accredited by ACSA. That was the strategy of entry. But that caused a lot of confusion in hospitals." (*Caspe Healthcare Knowledge Systems' client manager).

"It only makes sense to me an accreditation that is transversal to the Hospital. That's unquestionable for me." (Quality Commission - CHS)

"*The King's Fund only accredited, or only accepted, hospitals globally. Now, with ACSA, accreditation is done for services. It is a question of philosophy that lies behind. The philosophy of the King's Fund is that there are no islands of excellence, it is not worth it to say that I have a urology service that is the "best", but everything around works very badly.*" (IQS's Director 2000/05)

"*What we are doing now is by service. I'm certifying immunotherapy and it's all about that service. What happens to the patient or what is done before or what is done afterwards is not taken into account. It's like the operating room, which is already certified. But that certification is from the moment the patient walks in through the door of the service until the moment he leaves the service. What happens next?*" (HOSO's Quality Commission)

"*The safety culture of an organization is measured by this .... for example, in aviation it is not just the airplane that has to be safe. It's the airport, it's the access levels, and everything has to breathe security. I do not see how the concept of safety / quality migrates from services to services when only one or two services are accredited in a hospital.*" (Dr. P, Physiatrist - HOSO)

Notwithstanding, DGS contradicts itself when refers that what counts is the patient's journey in the hospital: from the time he enters until he leaves. But if this course includes non-certified services, how quality can be guaranteed?

"*One of the things that was well-designed in the King's Fund project was precisely this whole idea of the hospital having to evolve as a whole and get organized, even because there was the patient's course inside the hospital. It does not make sense that this course is not organized*." (IQS's Director 2000/05).

The obligation to be accredited is not included in the "contratos-programa". However, it is mandatory to join a full accreditation program. In cláusula 28 nº2. b) of 2017 Setúbal's Hospital Centre's "contrato-programa" (that is similar to other contract-programs) it is stated that the hospital is obliged "*to join a total accreditation/ certification program that includes clinical services, support clinic services and administrative, logistic and general support services, as a management fundamental tool, with the aim of promoting actions that lead to continuous improvement of care quality, patient safety and professional's satisfaction."*

The contradictions are two. The first one is related to the fact that the DGS accreditation program is currently partial and still the contract refers that is mandatory to join a full accreditation program. Until now, after almost 10 years of collaboration between Andaluzia and Portugal, there is not a single hospital totally accredited by ACSA (www.dgs.pt accessed on May 2019). The second contradiction refers to the fact that, notwithstanding the mandatory nature of accreditation in contract programs, no penalty is considered in the case hospitals do not develop an accreditation program. It is a complex situation if one considers the hospital as a whole, with a contract program to fulfill and accreditation proposals are auto proposals from service units.

Nevertheless, the general picture regarding the accreditation of Portuguese hospitals, in 2019, reveals that the vast majority remains un-accredited (cf. table 4.14). The 111 existing public hospitals include 101 universal access hospitals, 6 military or prison hospitals and plus 4

Public-Private Partnerships. From that universe eleven hospitals are accredited by Caspe Healthcare Knowledge Systems, five have the accreditation of JCI and 20 hospitals have some services accredited by ACSA.

"*Probably because of this lack of strong statement from the state, we have left two models of accreditation to cohabit and today, when we evaluate, after all these years, we have most of the hospitals without accreditation. Therefore, we have mixed accreditation processes, some by JC others by KF, others by ACSA. It is not understood very well" (Profª ENSP).*

Someone who accompanied HOSO's accreditation program implementation and now works in a hospital that is being certified by ACSA analyses:

"*At that time, we had a very close relationship with IQS's team responsible for the implementation of the Hospital's National Accreditation Program; we could ask any questions we had. It is this support and guidance that I think today no longer exists. And what I see here are services self-proposing (model ACSA) to make a certification but they have to develop everything. The only time when there is a greater contact is at the audit. There is no such intermediate link during the process itself as we had, and I am not referring to auditors. We had this IQS framework that helped us in the implementation. The auditors came from outside because it was another entity. And when they came we were already very sure of what we had already developed and even the negotiation of audit's timing, was very comfortable. This happened because when we were negotiating the date, we already had things very well oriented and we already had the idea that we were being able to respond. Today, from what I see here in the services, there is no such accompaniment during the process. Services are very much left alone in what they do*" (HOSO's Quality Commission).

Nonetheless, it is possible to say that "*the culture has changed. Formerly the culture was centered on the doctor, today it is patient centered. The inputs of information come from several sources. We realize that if we can get in with the whole (the whole team) we get a better answer - the nurse is important, the psychologist is important, the technician is important, the doctor, the technical assistant (it's the first person to contact the patient), here everyone has their role and everyone is important, this brought this change of culture.*" (CHKS's auditor)

Table 4.14 – Accredited Portuguese hospitals 2019

Caspe Healthcare Knowledge System (CHKS) Accredited organisations (Updated: 13 May 2019)

- Centro Hospitalar de Lisboa Central EPE - Portugal
- Centro Hospitalar de Setúbal, EPE - Portugal
- Centro Hospitalar do Porto, Geral do Santo Antonio - Portuga
- Hospital da Prelada, Porto - Portugal
- Hospital de Braga – Portugal
- Centro Hospitalar do Medio Ave - Portugal
- Hospital do Divino Espirito Santa de Ponta Delgada, Azores - Portugal
- Hospital Garcia de Orta, E.P.E. – Portugal
- Hospital Prof. Doutor Fernando Fonseca - Portugal
- Instituto Portugues de Oncologia de Coimbra Franciso Gentil, EPE - Portugal
- Instituto Portugues de Oncologia Francisco Gentil Centro de Oncologia do Porto - Portugal

Joint Commission International Accredited organisations (Updated: 13 May 2019)

- Centro Hospitalar Cova da Beira, E.P.E.
- Centro Hospitalar de Leiria, E.P.E.
- HPP Hospital de Cascais - Dr. Jose de Almeida
- Hospital de Vila Franca de Xira
- Hospital Beatriz Ângelo (PPP)

Agencia de Calidad Sanitaria de Andalucia (ACSA) Hospitals with accredited services (Updated: 30 April 2019)

- **15 accredited services:**
- Centro Hospitalar de Lisboa Ocidental , EPE
- **8 accredited services:**
- Serviço de Saúde da Região Autónoma da Madeira, E.P.E. (SESARAM)
- **7 accredited services:**
- Centro Hospitalar Vila Nova de Gaia/Espinho, EPE
- **5 accredited services:**
- Centro Hospitalar Universitário de Lisboa Norte, EPE
- **4 accredited services:**
- Unidade Local de Saúde de Castelo Branco, EPE
- **3 accredited services:**
- Hospital Distrital Figueira da Foz, EPE
- Centro Hospitalar Barreiro Montijo
- Centro Hospitalar e Universitário de Coimbra, EPE
- Hospital Espirito Santo, EPE
- **2 accredited services:**
- Centro Hospitalar Universitário do Algarve, EPE
- Centro Hospitalar do Baixo Vouga, EPE
- Centro Hospitalar Psiquiátrico de Lisboa, EPE
- Hospital Santa Maria Maior, EPE
- **1 accredited service:**
- Unidade Local de Saúde do Norte Alentejano, EPE
- Unidade Local de Saúde da Guarda, EPE
- Unidade Local de Saúde do Norte Alentejano, EPE
- Hospital Distrital de Santarém, EPE
- Centro Hospitalar Universitário de Lisboa Central, EPE
- Hospital de Braga
- Hospital Narciso Ferreira

Sources: accessed in May 2019 –http://www.chks.co.uk/Accredited-organisations
https://www.jointcommissioninternational.org/about-jci/jci-accredited-organizations/?c=Portugal

https://www.dgs.pt/qualidade-e-seguranca/reconhecimento-da-qualidade/acreditacao-em-saude/unidades-de-saude-acreditadas.aspx

CHAPTER V - EMPIRICAL STUDY

In this chapter the researcher submerges in the reality of HOSO and in its accreditation process by King's Fund's Health Quality Service. In an attempt, through fieldwork, based on interviews with key people in this process, the researcher tries to understand how "bureaucratic-quality" logic was able to enter the institution and how it managed to gain space and co-exist (almost without conflict) with the other two main logics - professional and management's business-like logics. The hospital is presented and afterwards, the researcher explains the King's Fund accreditation program. Afterwards, the implementation in HOSO is approached: explaining the beginning of the works, the manual, how resistances were mitigated and the first audit. Evidences of the implementation of this process are then presented as well as the quality acculturation that was achieved in HOSO. The last section presents the accreditation process nowadays.

"*the important thing here is not the medal or the sticker that is out there, it is for embed and for alerting people to the need for this culture of safety and quality, which is fundamental in a health institution. The program is the vehicle*."

(Dr. P, Physiatrist - HOSO)

5.1. Sant'iago do Outão's Orthopedic Hospital (HOSO) - a different hospital

Sant'iago do Outão's Orthopedic hospital (HOSO) was built on a fortress dated from 1390. It served as true defensive focus through centuries. In the 20th century, after being converted into a prison and a residence for the Royal Family, the fortress was offered by Queen Amelia to install a sanatorium, the first in Portugal. More recently, with the drastic reduction of tuberculosis, it was transformed into an orthopedic and traumatic referenced hospital. In 29th December 2005, "*with the aim to provide better health care, through the optimization of resources*" (DL nº 233/2005), HOSO got together with S.Bernardo's hospital [HSB] originating Setúbal's Hospital Center, EPE.

HOSO is located in the outskirts of Setúbal, into Arrábida's mountain, and the fact that it was a small hospital, in terms of number of employees (around 300) created an atmosphere and ambience very different from what it is considered a "normal" hospital. The HOSO's President of Board of Directors emphasizes the humanization level that small hospitals present: *"Outão was a hospital far from the city, had a very particular culture, the human sense that existed was ... was different from what exists in these large organizations (hospital centers). People did their best for the organization because there were about 300 people, people felt the hospital… in my view, small hospitals have higher levels of humanization*" (President of Board of Directors - HOSO).

Being a small hospital created the feeling of family mentioned by a Quality Commission member: *"It was a tiny hospital. It had a very different philosophy, a very familiar philosophy, very homely".* A physician stated that "*It was a family, our second family*" (Physician1 - HOSO). A chief-nurse recognized that being small was an advantage in this process: "*I think that we felt this process differently than S.Bernardo's hospital. As we were a smaller hospital, a family, we had a sense of unity, of teamwork, of "let's work towards a common end*" (Chief-nurse 2- HOSO). A Service director also emphasized that aspect: "*When we arrived at the hospital, in the morning, we knew all the cars, and we knew that everyone was there, it was a big family. If I did not show up it was a bad thing. Everyone was there. In no other hospital I felt this feeling of belonging".* And he also tries to explain why that reality does not exist nowadays: *"I worked in many public hospitals, but HOSO, since I got there in 1979 until I left, in 2011, was a "family" hospital. There*

was an attempt of meetings between people even outside the hospital, to fraternize, with all kinds of professional classes (maintenance, nursing, doctors): it was a family. Today it does not exist anymore. Probably it is due to the junction with S.Bernardo's hospital. It was an authentic family. Though there was always respect but a great spirit of friendship. With Setúbal's Hospital Centre a lot of people had to go to work for S.Bernardo's hospital. A great bond of friendship has been lost."

Nevertheless, a Quality Commission's member at Setúbal's Hospital Centre introduced a factor that might have worked as a stimulus for this cohesion among HOSO's workers: "*I have no doubt that those who worked at HOSO had a sense of belonging, for a variety of factors. Big teams imply more complex management. This sense of belonging may also be explained by another factor. HOSO, as a central orthopedic hospital, had access to different funding and to an extraordinary source of funding that came from insurers. HOSO had a financial willingness to invest in certain things that most hospitals did not have. All that was orthopedics went to the HOSO and the insurers paid what they said. It was a source of Human Resources cohesion*". This vision was somehow corroborated by an HOSO's chief-nurse: *"HOSO was a different hospital ... all the professionals knew each other; it was a more familiar environment. And it was a hospital that reached the end of the year with a surplus. The professionals who came to work for the institution felt recognized for their work because they were able to manage and provide care so that at the end of the year, we had no debt. We all worked towards it and felt good. We were like a big family. We had certain kinds of conditions that gave us added value, even though it was a very specialized hospital, orthopedics and traumatology"* (Chief-nurse 1- HOSO).

This was HOSO's reality, in the late 1990's, when the first ideas of accreditation began to appear.

Quality issues were not a novelty for this hospital. In the 1990s the hospital had already mandatory commissions (e.g. infection control) and voluntary commissions for improving the quality of the hospital's facilities and services provided. For example, HOSO's President of Board of Directors led a Humanization voluntary commission, constituted by himself, a nurse, a social assistant and a physiotherapist with the aim of improving amenities, bathrooms, signage and waiting rooms. This commission was the possible contribution, at that date, to improve

facilities and services. There was state financing for actions that improved humanization and a national contest. HOSO competed with a set of actions done and won the national award of Humanization in 2000. According to the President of Board of Directors, the fact that they were a small hospital helped in this process. This prize can be considered as a root to the accreditation process.

"At the time there were two types of commissions: compulsory, such as the Infection Control Commission, or voluntary, in the case of HOSO we had a Humanization Commission that preceded this process... it was already an embryo." (President of Board of Directors- HOSO)

In early 2000's, an orthopedic physiatrist from HOSO, Dr. P attended a Conference about health quality in Coimbra and witnessed a communication about an on-going accreditation process on Santa Marta's Hospital, given by a colleague that was leading the project – Dr. Larcher, Sta. Marta's hospital Administrator and accreditation project manager. Dr. Larcher became also an IQS's consultant, who helped hospitals to implement the program. That conference was a watershed moment for HOSO's future. Dr. P perceived that HOSO had the sufficient conditions for implementing an accreditation program and presented the idea to HOSO's President of Board of Directors who reacted positively, as it was a program that met the expectations that he had for HOSO:

*"After attending the communication, I noticed that HOSO had the minimum and sufficient conditions to implement an accreditation program: because it was a very cherished hospital in terms of structure, in architectural terms (it has its own design), because it was an hospital with an excellent reference and an excellent feedback and with great importance in the population of the region and because there were already some prizes in this hospital (humanization prize) and good indicators of the orthopedic forum regarding the performance of the hospital." (*Dr. P, Physiatrist - HOSO)

At that time, hospitals did not have quality procedures, there was no fire plan and no one knew what to do with the patients in catastrophe scenery. Dr. Larcher described the reality in those days: "*There was no fire door or fire detection device in the hospital. The notion of risk was nonexistent and training in risk and security was nil*." (IQS, 2004b: 16)

In clinical area the reality was the same. Physicians did not share their experience; it was a time when physicians did not have to explain the reasons for their acts. No procedure was written. The knowledge was with the people, the physicians, the nurses and nothing was written. Teresa Sustelo, President of Board of Directors of Sta. Marta's Hospital, resumed the closed culture hospitals experienced:

"*We all know there has to be transparency in the processes but this is one of the things that people are afraid of. Even though they have nothing to hide. It's the habit of cultivating "what's mine is mine and I do not have to share with anyone else, possibly only with my most direct collaborators". The challenge was to shift a self-centered organizational culture to a culture centered on "us" (*IQS, 2004b: 17)

This fact was validated by Caspe Healthcare Knowledge Systems' auditor who described the closed culture that Portuguese hospitals experienced at that time: "*Portuguese hospitals had a closed culture, a kingdom culture: this is my kingdom, this is my service. I belong to the hospital but I have my world there: my service. This did not allow the institution to grow because we could not aggregate the knowledge of others and grow with the knowledge of the group. Imagine that I'm heading a service today, but I get fired and take everything with me. This was done. The documents were taken and whoever arrived had no knowledge of what had been done in that service until then".*

Also, there were few records of treatments and patient's history, as a nurse and project equip member in Sta. Marta's Hospital refers,

"*It was necessary that the professionals internalize that they would have to pass from a verbal culture to a written culture, which would allow to give visibility and continuity to the work developed. Although we knew there was a good performance there was no culture of writing. It was necessary to demonstrate to the professionals that their actions resulted in improvements, i.e., that the project was not only the production of procedures, but something that aimed to contribute greatly to the improvement of the health care provided in the Hospital*" (IQS, 2004b: 17).

In addition to this scenario, was the fact that more and more ideas of transparency, results, benchmarking and entrepreneurship were arriving to Portugal. And these NPM ideas were not

compatible with the reality lived in Portuguese hospitals. A change had to occur. It was in this atmosphere that in 2000 the President of Board of Directors received the proposal, to enter an accreditation program, as a way to solve some of the existing problems, mainly in the area of general risk. At that time the accreditation programs were clearly more oriented to that area than to clinical, which only came in a later stage. Back then there was very little in what concerns quality and prevention. There was hospitals good willingness and, in some cases, voluntary commissions like the Humanization commission in HOSO. Accreditation processes end up responding to a number of concerns from hospital management, as HOSO's President of Board of Directors explains:

"It was necessary to create a set of organizational structures that responded to a number of issues in the area of risk management and that were not structured. These (accreditation) programs were an opportunity for these hospitals to create a set of procedures and norms that aim to make continuous improvement, which is no more than a permanent organization process, but one that aims to create organizational situations that allow the patient to go to the hospital with a quality assurance in terms of certain occurrences. I slept better because I knew that there was a risk management committee that had certain procedures; that trained with simulacrum. There was an organized structure that allowed responding in case of a serious accident in the hospital. This was also a guarantee for those who came to the hospital".

The main objective of an accreditation program was to create structures that would allow the hospital to manage in an organized way and to guarantee the patient a degree of security. Furthermore, being accredited in early 2000's also carried a sense of recognition of work done, of being more capable than the pairs, of pioneering. In a universe of 70 hospitals, being part of the small first groups that achieved that goal, by auto proposal, meant something about proactivity and the will to do better of that Institution.

"*Accreditation, nowadays, is a more publicized process used by almost all hospitals (if they are not accredited at least they have quality commissions), but when we launched the process, we had two objectives. The first one was the motivation of the professionals, which was fundamental, and people responded. There was a lot of professional involvement. The second one was for the hospital to present itself to the community with a process like these, which was a gain in terms of*

recognition and trust towards the users. They would feel safe when using hospital services." (President of Board of Directors - HOSO)

A study committee was set up to study the implementation of a hospital accreditation program. This committee was multidisciplinary: a coordinator (the booster of this idea, Dr. P.), a nurse and a hospital administrator. The aim was to investigate what was being done in Portugal in terms of hospital accreditation, and what could be applied to this hospital. The committee attended many conferences within the scope of Health Quality Institute [IQS], several formations and elaborated a report of recommendations in which they characterized each system that existed and some institutions in Portugal that already had experienced accreditation programs. A consensus was reached. The partnership that IQS had with King's Fund (which was the national reference) and the Saúde XXI financial support to that program became the obvious choice.

"King's Fund accreditation program was a transversal tool, unlike others, which were more sectarian, this was a transversal tool that intersected the entire hospital, all services, had an eminently hospital aspect because other tools such as ISO 9001, (had a very laboratory accreditation of laboratories and parts of pharmacies), focused almost exclusively on document management. It was therefore, decided that the King's Fund would be the most appropriate since it had been set up, from the root, for hospitals". (Dr. P, Physiatrist - HOSO)

In 2003, 16th September HOSO signed an agreement with King's Fund's Health Quality Service, in partnership with IQS, and the accreditation process formally began.

"A contract was signed and we had a client manager from the King's Fund's Health Quality Service who came to the hospital periodically every 3 months. The client manager came to do the update, shared her views, her know-how and the people also appreciated it. The hospital signed a contract to be accredited in two years and in those two years they [King's Fund's Health Quality Service] came here every three months to have meetings and monitor the process." (President of Board of Directors - HOSO)

5.2 The King's Fund Accreditation Program

The accreditation process presupposed four major phases (IQS, 2000a): (1) first contact with the manual and its knowledge and understanding; (2) self-assessment, to look inside and analyze organizational development; (3) audit phase and (4) being accredited.

The manual of standards (1) was a document elaborated by King's Fund's Health Quality Service and translated and adapted to Portuguese language and reality, by IQS and hospitals. It was deployed by different levels of procedures and there was guidance to assist the compliance.

In the Manual hospitals found the standards and procedures that needed to be observed in order to be accredited. The manual (cf. Table 5.1) included 62 standards divided in five sections: institutional management (standard 1 to 10); resource management (standard 11 to 16); patient's individual rights and needs (standard 17 to 19); patient's course (standard 20 to 23); and specific services (standard 24 to 62).

Each standard or procedure was classified in three levels: "A", "B" or "C". Level "A" represented an "imperative practice" and it was related with legal and/or professional requirements, potential risk to patients, staff or visitors and patient rights. Level "B" represented "Good Practice" and Level "C" represented an "Excellent Practice". In the first accreditation process compliance with standards and procedures classified as "A" was mandatory. Although level's "B" and "C" standards and procedures were, in general, linked to "A" levels' they would not be considered in an early stage of the program's implementation. The aim was that, following a continuous quality improvement, after obtaining standards "A" total accreditation, institutions would commit to meet the requirements of level "B" (good practice), and later, of level "C" (excellent practice) (IQS, 2001a): "*Throughout this process we have been working towards compliance with criteria A, those that are basic and that should exist in any hospital*" (IQS, 2004b: 26). Each standard degree of compliance should be self-assessed as (1) total compliance, if the standard or procedure is integrally accomplished by the service; (2) partial compliance, if only part of the standard or procedure is accomplished within the service; (3) no compliance, when the standard or procedure is not fulfilled by the service, and (4) non-applicable, it does not apply to the hospital. When a standard or procedure is reported as "Partial" or "No" Compliance, an action plan should be developed in order to correct and/or improve so that the requirement was

met. The confirmation of compliance with standards and criteria classified as "A" was made through documented evidence or observed evidence by the auditors (IQS, 2001a).

The manual also provided orientations for some procedures. These guidelines are intended to help the interpretation of the procedures and refer to relevant legislation and professional guidance, provide guidance for compliance with the procedures and indicate areas that auditors will evaluate during the survey.

As an example, in Standard 9 – Risk Management, the standard concerning Health and Security was composed by various criteria (from 9.22 to 9.39) and some had orientations (cf. Table 5.2).

Table 5.1 – The Accreditation Manual for Hospitals 2000

Section I - Institutional Management
•**Standard 1:** Mission and objectives •**Standard 2**: Management and administration Structure •**Standard 3:** Contracting Services •**Standard 4:** Technology and Information Management •**Standard 5:** Finance Resources •**Standard 6:** Human Resources •**Standard 7:** Communication •**Standard 8:** Patrimonial management •**Standard 9:** Risk management Risk Management - Health and safety Risk Management - Fire safety Risk Management - Infection control Risk Management - Waste management Risk Management - Security •**Standard 10:** Quality improvement

Section II - Resource Management
•**Standard 11:** Service philosophy and objectives •**Standard 12:** Management and staff •**Standard 13:** Staff development and training •**Standard 14:** Action plan and services contracting •**Standard 15:** Facilities and equipment •**Standard 16:** Quality improvement

Section III - Patient's individual rights and needs
•**Standard 17:** Patient's rights •**Standard 18:** Patient's individual needs •**Standard 19:** Partnership with patients

Section IV- Patient's course
•**Standard 20:** Reference, access and admission •**Standard 21:** Patient's individual needs •**Standard 22:** Partnership with patients •**Standard 23:** Clinical process content

Section V - Specific Service
•**Standard 24:** Urgency Service •**Standard 25:** Day hospital service/ outpatient surgery •**Standard 26:** Secretariat/ Means •**Standard 27:** Catering Services •**Standard 28:** Pediatric Services •**Standard 29:** Imaging/ radiology service •**Standard 30:** Dietary Services •**Standard 31:** Clinical File •**Standard 32:** Cleaning Service •**Standard 33:** Laundry Service •**Standard 34 to 39:** learning disabilities (not applicable) •**Standard 40:** Library/ Documentation Center •**Standard 41:** Medical physics and biomedical engineering services •**Standard 42:** Medical service •**Standard 43 to 49**: Mental Health •**Standard 50:** Obstetrics service •**Standard 51:** Nursing service •**Standard 52:** Social reintegration (AVD/ technical assistance) •**Standard 53:** Operating room service/ anesthesia service •**Standard 54:** Outpatient clinic •**Standard 55:** Pathology service •**Standard 56:** Pharmaceutical services •**Standard 57**: General Services •**Standard 58**: Radiotherapy service •**Standard 59: S**pecial Care Service •**Standard 60:** Sterilization Center •**Standard 61:** Telecommun. service/ Telephone exchange center •**Standard 62:** Voluntary service

Source: Adapted from IQS (2004b: 45)

Table 5.2 – Standard 9 – Risk management – Health and Safety detailed

Standard 9 - Risk management

There is a structured approach to risk management in the organization that results in safer work systems, practices and facilities, and increased staff awareness of dangers and responsibilities
Classification: Imperative practice A, Good practice B, Excelent practice C

Criteria		Classification	Yes No Partial	Please coment on the progress done to achieve each criteria
9.1 to 9.21	**Risk Management - General** There is a person in charge of risk management	A		
9.22 to 9.39	**Risk Management - Health and Safety** There is an element at the highest level of management which has overall responsibility for the formulation, implementation and development of the health, safety and hygiene policy	A		
9.40 to 9.65	**Risk Management - Fire Safety** There is documented and up-to-date fire safety organization guidance	A		
9.66 to 9.80	**Risk Management - Infection Control** A member of theAdministration Council is responsible for establishing and maintaining infection control plans throughout the organization	A		
9.81 to 9.90	**Risk Management - Waste management** There is a documented waste management strategy	A		
	Risk Management - Health and Safety			
9.22	There is an element at the highest level of management which has overall responsibility for the formulation, implementation and development of the health, safety and hygiene policy	A		
9.23	There is a documented and up-to-date policy on safety, hygiene and health at the global level of the organization	A		
9.24	The safety, hygiene and health policy is annually reviewed	A		
9.25	There are ways to get competent advice in the area of safety, hygiene and health *Guidance:* *It must comply with the requirements of applicable legislation, namely DL No. 441/91 of 14 November; DL no. 26/94, of 1 February and DL no. 488/99, of 17 November.* *All organizations shall nominate or hire one or more competent persons or entities to support them in accordance with the law. These individuals or entities must have defined authority and responsibilities and a direct line should be established to report to the organization's CA.* *The organization may need more than one person / entity to cover all safety and health issues*	A		
9.26	There is a multiprofessional safety, hygiene and health commission (or commissions) at the organization's global level. *Guidance:* *The commission shall have the composition and powers provided for in Articles 6 and 7 of DL No. 488/99 of 17 November.* *The commission should, for example, be consulted on the development, implementation and monitoring of safety, hygiene and health policy.* *The commission should also be involved in the establishment and monitoring of performance standards for safety, hygiene and health*	A		
9.27	The commission reports regularly to the executive management team / CA	B		
9.28	The objectives and effectiveness of the safety, hygiene and health commission are evaluated annually and modified if necessary	B		
9.29	There is a documented and up-to-date safety, hygiene and health plan. *Guidance:* *The safety, hygiene and health plan should identify objectives, set targets and deadlines for action and should be developed in consultation with staff*	A		

9.30	An annual report on safety, hygiene and health is produced. *Guidance:* *This should be presented to the organization's executive management team and should be made available to all staff in the organization.*	A		
9.31	First-aid plans are implemented and in accordance with current legislation *Guidance:* *Law No 243/86 of 20 August (Art. 48) should be used,*	A		
9.32	The organization promotes knowledge of health, safety and health policies and issues *Guidance:* *This can be through, for example, news placards, leaflets, suggestion schemes.*	A		
9.33	There is a training program in safety, hygiene and health for all staff *Guidance:* *Most safety, health and hygiene regulations require proper training for personnel to know the risks and precautions required in their work.* *Training includes, for example:* *- integration training programs for all new elements, including clinical staff* *- regular retraining for all staff* *- training for personnel who are transferred or promoted (must be made before the departure of the holder of the post)* *In areas where there is a greater risk of violence, staff should be trained to deal with potentially aggressive situations*	A		
9.34	The safety, hygiene and health training program is subject to periodic review.	B		
9.35	Keep the safety training records, hygiene and health given to staff. *Guidance:* *this must be recorded for each element, together with the date on which the training took place*	A		
9.36	All temporary workers receive information on safety, hygiene and health aspects that can be found at their workplace *Guidance:* *Temporary workers include temporary replacement staff, contract staff, subcontracted staff, employment agency staff*	A		
9.37	The report of injuries, diseases and dangerous occurrences is carried out according to the current legislation *Guidance:* *All injuries, diseases and dangerous occurrences, which are reportable, must be reported according to the annual report of the Occupational Safety and Health Service, DL No. 441/91, of November 14, DL No. 109/2000, of June 30 and Ordinance No. 1184/2002, August 29*	A		
9.38	Safety procedures and danger warnings are: 9.38.1 disclosed by relevant personnel 9.38.2 produce actions or effects, which are recorded	A		
9.39	The safety, hygiene and health programs are reviewed regularly *Guidance:* *The elements of the health, safety and health management system to be reviewed include, for example:* *- politics* *- organization* *- policy planning and implementation* *- evaluation systems* *- review systems*	A		

Source: Adapted from IQS (2004b: 46)

After knowing and understanding the manual, it was time to start the internal work - self-assessment phase (2). This stage is undoubtedly the most demanding for the institution because a variety of aspects must be considered (IQS, 2000a). It was necessary to analyze processes and routines that had always been internalized, question it and decide if they responded to manuals' standards; it was necessary to shift from a verbal/ *had*-hoc culture to a written culture, so that everyone would know how to do and when. At this stage, the involvement of all professionals was crucial. Action plans were created for the whole institution in order to meet standards and set priorities. The hospital had a double support from IQS and the King's Fund client manager (*ibid*).

This phase was followed by a peer review – the audit (3). The program was based on a peer review philosophy and the conformity assessment practice and hospital performance against standards was assured by a multidisciplinary team of health professionals (IQS, 2000b) who brought their experience to the program: "*The fact that the auditors carry out their professional activities in the health sector generates constructive complicity. Understanding the difficulties and exchanging information about how each professional faces them in the context of their organization gave the process excellent space for reflection*" (IQS, 2004b: 49). The first audits were done by English auditors with English manuals; everything was done by King's Fund auditors (IQS, 2000b). But after that, the manual was translated and validated by Portuguese hospital's commissions, with English auditors' support. Then Portuguese auditors were trained. The auditors passed through a solid technical training on the accreditation manual and process methodology. It also included the area of behavioral development, teamwork, the peer interviewing technique and how to hold the feedback session in the hospital at the end of the audit week (IQS, 2003): "*From the auditor it is expected a consistent knowledge of standards, their interpretation and practical application, but also sufficient openness to accept different organizational cultures, diverse and equally valid ways of doing*" (IQS, 2004b: 49). After the course of auditor, all trainees were submitted to "*practical training as "shadow" auditors, accompanying the King's Funds' auditor, at least during three audits*" (IQS, 2003: 44). In a second phase the roles changed and the IQS's auditors assumed the role of lead auditor, passing the English auditor to be the "shadow" that observed and evaluated. This experience completed the training of IQS's auditors (*ibid*). The first experience, with a Portuguese auditor occurred in May 2003, in Santo António's Hospital, in Porto, and it was successful. After that experience all hospital audits, in the scope of Hospital Accreditation National Program, were divided between

Portuguese and English auditors (*ibid*). In 2003 IQS had 59 qualified auditors, from various health professions namely, administrators, nurses, physicians and technical senior, from all country (IQS, 2004b). The Portuguese auditors were chosen by the IQS team that was addressed to the accreditation process – two nurses and the IQS's Director 2005/06. When accompanying the process in hospitals, they identified the more enthusiastic health professionals with the process and invited them to participate in the auditor's training course, as IQS's Director 2005/06 stated: "*The IQS opted for a type of auditor's recruitment in the most common format, including the recruitment among hospitals in accreditation process or already accredited*" (IQS, 2004b: 3).

In hospitals, IQS often audited in advance to identify points to work on and improve before the final audit. Nevertheless, the first audit is, from all phases of the process, the one that generates a greater tension "*a mixed of courage and fear of not being sufficiently prepared to open the doors to the external evaluator*" (IQS, 2004b: 48). During one week auditors and audited hospital covered the 62 standards and more than 1000 procedures, in the manual, in meticulous prepared meetings. Visits to services happened constantly. Auditors searched for evidence, reviewed documentation, cross-checked information, and interviewed professionals and even patients, in some cases. They sought consistency that allowed compliance to be checked, whereas the burden of proof lies with the audited (*ibid*). Nevertheless, the feedback was positive:

"*Despite all the reluctance of the doctors, I think they were satisfied with the way in which the internal audits were carried out and with the objectives in view: not the oversight, but the incentive to think about their way of acting, their better definition and possible improvements to be made.*" (IQS, 2004b: 26)

The ultimate step is being awarded accreditation (4) by the Council Members[25] whose members represent Royal Colleges, professional institutes and other healthcare organizations and cover different healthcare sectors and specialties (IQS, 2000a).

After the final audit the auditors meet and issue a report. The report details the findings of the audit *versus* the standards. The report is written in the form of a plan of action in order to

[25] As volunteers, they bring independence to the accreditation process and a breadth of expertise that reflects the broad range of organisations we work with. The members represent Royal Colleges, professional institutes and other healthcare organisations, and cover different healthcare sectors and specialties. They meet every six to eight weeks specifically to review accreditation survey and monitoring reports and discuss accreditation awards (https://www.chks.co.uk/)

facilitate the development of the organization and the ongoing developments in the services so to meet the requirements of the standards. Throughout the audit the inspectors take several notes of their findings regarding compliance with the accreditation program (CHKS's General Standards for Health Care Organizations, 2016, Version 1).

There are four levels of conformity: Total, Partial, Non-conformity and non-applicable. The total level is achieved when the criterion is implemented, there is demonstrative evidence of it, there are written, observable and established practices and all staff are aware. When criterion is not fully implemented, however work is being done to change this and there is evidence that the issue is being addressed (resources have been identified, plans are being implemented, etc), it is classified as in partial conformity. The non-conformity occurs when no work is being carried out in the direction of implementation. Notwithstanding the existence of a desire to progress, no support actions or progression plans were made and the observed falls far short of the guidelines, documents are provisional and practices are unsafe. Non-applicable occurs when the department or service does not provide the service (e.g. pediatric services) or the criteria are beyond departmental or service control (CHKS's General Standards for Health Care Organizations, 2016, Version 1).

After audits there is a meeting with all the staff and each auditor (responsible for 3 or 4 areas) reports the results of the audit. The official report is then sent to the hospital, and if it contains a majority of conformities it is sent to the international accreditation panel with representatives from several countries who will pronounce on accreditation status or not. The CHKS's Accreditation Council is composed by two CHKS's accreditation directors and experienced health professionals appointed on behalf of the Royal Medical Colleges of the United Kingdom and professional health care associations. Reports and recommendations for concessions are presented at each meeting and the Accreditation Council decides what concessions to make from CHKS's accreditation based on the evidence presented in compliance with the CHKS's Accreditation Standards (CHKS's General Standards for Health Care Organizations, 2016, Version 1). Notwithstanding, if an inquiry report indicates partial compliance or non-conformity of "A" level weighted criteria, the service will need to conceive an action plan in order to achieve accreditation and will have to demonstrate that all pending actions will be completed within 12 months. If documental evidence is requested (not all criteria need

documental evidence) such evidence shall be compiled in order to show the findings of the audit report followed by a brief explanation of the measures implemented since the investigation (*ibid*).

The accreditation will be granted to services that have demonstrated full compliance with all applicable "A" level weighted criteria. Accreditation is valid for three years from the date of the audit and not from the date of the grant and is subject to satisfactory monitoring results. Nonetheless, accreditation may be awarded in cases where there is partial compliance as long as the client has demonstrated that corrective measures are in progress (e.g., construction of buildings or elements that are beyond the control of the service). The progress of these occurrences will be verified through monitoring actions (*ibid*).

5.3. The accreditation process in HOSO

The program was launched with a hospital session opened to all professionals, where the program was explained, as well as what was the accreditation manual and examples of criteria that were to meet. It was a work of initiation to new quality logic. The session approached the concept of quality in health, benefits, failures and resistances, in order to sensitize people to the ongoing accreditation program, which, in essence, was a culture change.

A multidisciplinary Accreditation and Quality Improvement Commission [CAMQ] was established. It had a coordinator - the physician who led the process, Dr. P - who started to have a percentage of his work time allocated to the accreditation process. It was also constituted by two hospital administrators, two physicians, two nurses, the general manager of the operational area (as the operating assistant's representative), the patient admission coordinator (as the technical assistant's representative), the diagnostic and therapeutic technicians' representative and an external consultant, via IQS, Dr. Larcher (Figure 5.1) . The choice for a physician to lead this process (Dr.P) was intentional, as a service Director explains:

"It was good, because Dr. P. as a doctor collaborated and helped us in establishing the standards. Every time we had doubts, we look for Dr. P. I think that choosing a doctor to lead the process was a good choice from the Board of Directors."

"It has always been said from the beginning - I myself attended several training sessions, in King's Fund, in which they defended that the program coordinator should, preferably, be a

physician to be a facilitator element with the clinical staff, increasing the receptivity of colleagues." (Dr.P, HOSO's Accreditation and Quality Improvement Commission's Coordinator)

As stated previously, Accreditation and Quality Improvement Commission was composed by a multidisciplinary team with the aim to give the opportunity to all areas of being involved in the process elaboration. They were the drivers of this new logic in their services. They would explain the accreditation process and what was needed to be done - they were the connecting link, stimulating elements. Within this group it was established that in order to solve and meet all the standards that the manual required, it was necessary to establish a Quality Improvement Strategy, which has prevailed until this day. This Quality Improvement Strategy defined the creation of a Clinical Administration Committee (CAC), which included both the Clinical Director and the Nurse Director and a liaison element to the Accreditation and Quality Improvement Commission - the coordinator (Figure 5.1). Several groups were created to work the clinical area within the services. The choice of the Clinical Director had the purpose to involve physicians and demonstrate the importance of the accreditation process. The same reason presided in the choice of the Nurse Director to the Clinical Administration Committee: to involve nurses and to understand all situations related to the clinical area.

"*At the time, this commission did not exist in other hospitals, as HOSO was the first Portuguese hospital to work with 2003 Manual*." (Chief-nurse 1 - HOSO)

Within the Quality Improvement Strategy, a series of standards and procedures needed to be worked in the area of general risk and clinical risk. As a response to that need, the Risk Management Commission was created and embraced both types of risk (clinical and general). This commission remains until now. The coordinator of this Commission was the President of Board of Directors, and many top elements, such as the Hospital Administrators Representative, the Infection Control Representative, the Director of the Pharmacy Services, all related areas of the Ethics Committee, and the Occupational Health Service also participated (Figure 5.1).

"At the time, the coordinator of the commission was the President of Board of Directors. This was intentional, with the purpose to show the importance of this commission. With hospital's top elements involved, it was noticeable that it was something that had importance." (Chief-nurse 1 - HOSO)

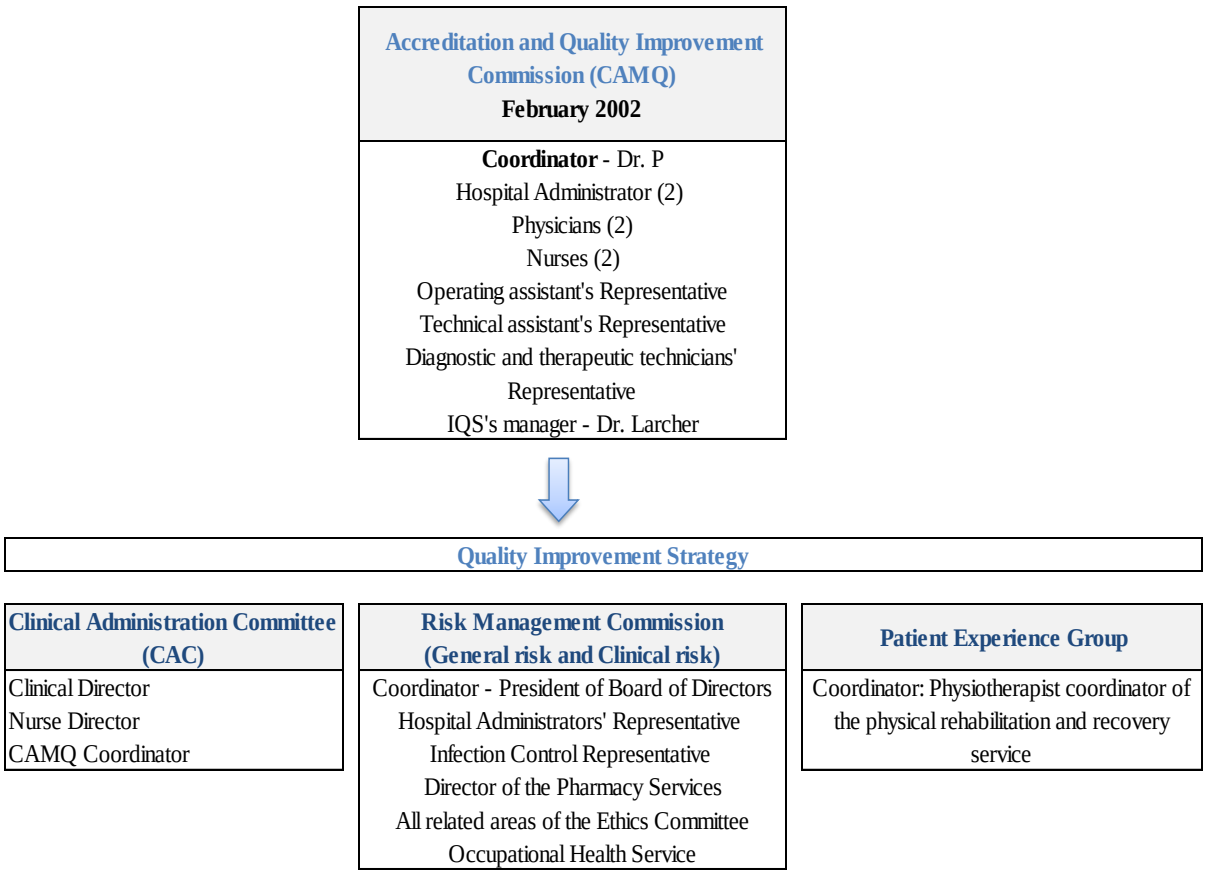
"The process was always led by the President of Board of Directors, otherwise it would not succeed. The main success factor is the involvement of management, and this is what happened at HOSO." (Dr. P, Physiatrist- HOSO)

Later, within the Quality Improvement Strategy, the Patient Experience Group was also created (Figure 5.1). It consisted in a group in which the coordinator was the coordinator of the physical rehabilitation and recovery service (a physiotherapist). She had a full vision of the patient and, together with the responsible from social services, made the connections and realized the needs of the patient. In figure 5.1 it is possible to visualize the commissions created to implement the Quality Improvement Strategy.

"*The manual has 6000 criteria to be met, but the manual does not say the procedure, says the standard, the good practice and we have to take it in our current practice, maybe change in some way (or not, if it meets the required standard) and write what we do. Hence the procedures are born. We interpreted the manual, read the criteria and in the end we set up the structure, Accreditation and Quality Improvement Commission is not enough. There must to be a structure. There had to be an external clinic commission, hence the Clinical Administration Commission, to validate all clinical procedures (the Administration Council does not have this sensitivity for the clinical area), and a Risk Management Commission that considered the clinical risk and the non-clinical*" (Dr. P, Physiatrist - HOSO)

It was always a concern to have top leaders leading the process, as literature and empirical evidence showed that it was a key factor to the success of these programs (El-Jardali *et al*., 2008; Braithwaite *et al*., 2010; Ng *et al*., 2010; Groene *et al*., 2014; National Academies of Sciences, Engineering, and Medicine, 2018).

Figure 5.1. – Commissions created to implement the quality improvement strategy



Source: original, based on information collected in interviews and hospital documentation

HOSO had, at that time, three hospital services (orthopedic 1, 2 and 3). Each service had a service director (a physician), that was in the top of the service's hierarchical structure, and also a chief-nurse. The Service Directorate is understood as this binomial between service director and chief-nurse.

"*It is critical that this doctor (service director) and this Chief-nurse pull to the same side. One problem that may exist is the non-involvement of the service director. There are also cases where the service director does not get involved but does not disturb and if there is a committed Chief-nurse ... everything is done*." (Quality Commission - CHS)

Each service is also constituted by physicians, nurses, technicians, operational assistants, technical assistants and health superior technicians. If the service is a support service (i.e.,

pathological anatomy, clinical pathology, physiotherapy) then the chief-nurse is substituted by a coordinator technician and there are no nurses either. Operational Assistants have a wide range of functions, depending on the services they are placed in, for example, in admissions, patient hygiene and feed and they also transport and referral patients within the building; in general services they take care of clothes, are kitchen assistants, gardeners, carry internal correspondence, etc. Technical Assistants can do clinical secretariat work (reception, registration and filing of documentation; telephone service; support in document management of clinical files; ...); attendance to the public (admission to the emergency room, external consultation; clinical examination sites ...) and management support (general secretariat; human resources staffing; financial services registration and invoicing; procurement procedures, etc.). The career of health superior technicians is developed in various fields: health engineering, pharmacy, hospital physics, genetics, laboratory, nutrition, veterinary and clinical psychology. It always presupposes a higher education degree.

This process was confronted with certain obstacles that HOSO's Accreditation and Quality Improvement Commission managed to overcome with the focus and the belief that they were in the right direction, as Dr. P synthetized: "*This is a matter of faith. Or you do have faith and get something in life or you do not have it and you do not leave the same place. This is a matter of faith*".

In the beginning, each service director was asked to nominate some people from their service to be part of "service" commissions that would be in charge to work in the specific standards, criteria and procedures for that service and obstacles started to appear:

"*In the beginning people refused to participate in commissions because it was not mandatory, it was just a group of people, volunteers, who worked on it. It was very complicated. It was a difficult process to manage, it took a long time. We were not used to it, it was a very time consuming process. It involved a lot of time in meetings. We already did the good practices, but they were not written as procedures.*" (Service Director - HOSO)

As Dr. P explains:

"*There was a whole work of initiation to a new logic in quality that went on to explain the concept of quality in health, benefits, failures, resistances, in order to raise people's awareness for this logic, which in essence is also a culture's change. A timetable was established, posters were displayed at the hospital. The Portuguese manager (IQS)*

accompanied the program and served as liaison link between the hospital and the King's Fund. There was a lot of training".

A chief-nurse explains the difficulty of the first phase:

"*I was a chief-nurse. We had meetings with a commission (where several professional classes were represented). The first meetings were to explain what the accreditation process was, the audits we were going to have, the rules and procedures we had to do; always based on what the British brought, and which we had to translate: "cadernos de encargos" that we had to adapt to each service. We had several meetings, several! This first part of "stone breaking" was difficult.*" (Chief-nurse 2 - HOSO)

As a result of this process (done by each commission) there were extra work hours after service, demanded to people working in the commissions and in the hospital, as stated by IQS's director 2005-2006:

"…the major difficulty, in the beginning of the projects, had to do with the need for commitment of time by the project team members. Much of the work was done outside of normal business hours and well beyond the working hours of the professionals as a result of enthusiasm and good willing from each one in a successful collective project. It should be noted that, for the removal of this obstacle, was absolutely essential the effort, and more than that, the unequivocal support given to projects by the Board of Directors, including the decision of material and human resources to be allocated to them." (IQS, 2000b: 19)

Many clarifying sessions, trainings and efforts were made so that health professionals could perceive the initiative as important. The involvement of everyone in the process was regarded as paramount as every single professional played a role in assuring the quality of the hospital's care service, as described by Dr. P:

"*All procedures would be done with the participation of all professionals, the same for the more general policies. The idea was that people would have a voice in the processes. They often express dissatisfaction, now they had the opportunity to say how they think it should be done*".

A chief-nurse also highlighted the idea that everyone was important for the process:

"In this accreditation process everyone is involved, all services, no one is left behind. We all work for a common good, for the institution. This was the main idea that was passed. We held meetings for all, opened to all. For me, in this process it is essential to show each person

that it is important, that it is part of the process, that without him/her, the puzzle is not complete." (Chief-nurse 1 - HOSO)

This latter discourse, that took place in 2019 in an interview for this research, is similar to a statement in a 2004 IQS's magazine where a member of the Board of Directors in Santa Marta's hospital stated "*it can be said that no service or hospital sector was left out, as well as guarantee that no professional class was relegated to second place*" (IQS, 2004b: 16)

One of the reasons presented to the good penetration rate of the program in HOSO was the fact that the meetings were held service by service.

The first phase, to get to know the manual, was ensured by The Accreditation and Quality Improvement Commission. The Commission had already accessed 1999's Manual to understand how it was organized regarding standards and procedures, and what they were supposed to do (the one worked by Sta Marta's hospital). Nevertheless, as it was planned a new Manual during 2003, HOSO opted to wait and implement the process with the new manual. "*The fourth group of hospital units is beginning to be selected and prepared to start the accreditation process under the Hospital's National Accreditation Program this year. In these processes the reference standard will be the 2003 International Manual of Accreditation of Hospitals, already in use in the HOSO and in the processes of re-accreditation of the Hospitals Fernando da Fonseca - Amadora / Sintra and Pedro Hispano, Matosinhos*." (IQS, 2004b: 52)

To the Commission's Coordinator this document had an enormous importance:

"*What these manuals bring us, I call it the Bible, is that each procedure was worked with a huge set of professionals around the world, to reach a standard, and that evidence had to be tested several times. Each procedure of the manual has a cycle, with expertise, with clinical evidence, studies, etc ... that is what makes it incontestable. This was explained to the doctors. That has a lot of strength. This is an awakening to walk towards the quality of health, with a script, which helps immensely*" (Dr. P, Physiatrist – HOSO)

The manual was examined firstly by the Accreditation and Quality Improvement Commission, as Dr. P explains: "*We received the manual and analyzed it. It was when we had the support of Dr.Larcher to help us to deconstruct the whole manual. We read it, tried to understand what was expected, and began to understand the philosophy. And then it was point by point.*"

The Commission was divided into groups and each group was responsible for a number of services and for the preparation of each "Caderno de Encargos"[26]. This "Caderno de Encargos" is a set of all standards and criteria, from the original manual (cf. table 5.3), that each service had to answer and the documents that had to be attached (documentary evidence). The "Caderno de Encargos" is divided in two parts (1) operating standards, referring to standards that are common to all services, whether clinical or general; it comprehends organograms, team constitution, job description, work team, the procedures in service meetings, among several others and (2) specific standards, refers to those standards that are specific for each service, and which are divided in clinic and non-clinic services. The manual has a specific chapter for each of these services and each service has a variety of procedures that have to be discussed and operationalized. It was also required evidence that the hospital was following that standard.

"If there was a specific procedure it was usually done by the service itself, it was not the Accreditation and Quality Improvement Commission. In the service they joined and created the procedure. Then it was sent to the Accreditation and Quality Improvement Commission to be evaluated, see if it met that criterion or not, if all the fields were fulfilled. Therefore, the specific procedures were done by the services. The operating procedures usually involved elements of various services." (HOSO's Quality Commission)

Each group scheduled their meetings with the respective service and there were innumerous meetings. The first meetings were held with the service director, the Chief-nurse, the service person who was liaising with the Accreditation and Quality Improvement Commission and the Commission's representative.

"We held meetings, for example, with all the elements of quality that were responsible for certain services - this is still a practice. The members of the Commission were the people who established the connection between the commission and those who were responsible for the services. All standards and procedures, related to the manual, that the service had to work and respond, or documents that had to do. We had meetings and we said, your specifications are this, these are the documents to prepare and we have to present evidence when the external auditors come. And then we helped people to work. In some situations, we even sat different services together. At the time there were three orthopedic services (O1, O2, and O3), with three distinct directors, three Chief-nurses (today it is a single service). We had to get

[26] set of all standards and criteria that each service had to answer adding, in some identified cases, documentary evidence

those services together. There were fortnightly meetings of the Commission to make an update of the situation." (Chief-nurse 1 - HOSO)

This necessity to get different services together and to sit people at table to discuss and think about procedures in group was considered as an added value of this program. When the objective was to trace the patient course it was important to bring people together.

"*It was usual to have physicians to one side and nurses to another; but this process joined nurses with doctors and with other professional classes at the hospital. There was an approach and a spirit of team, even with other professionals*" (Service Director - HOSO).

"*This process has brought greater team unity because sat at a table people who spoke with each other only by circumstance, to discuss these issues*" (Chief-nurse 2- HOSO).

"*Another advantage of this process was the increase in communication within the institution. People who did not even speak at each other had to talk and had to gather at the table to prepare a document; this broke up many barriers*". (Dr. P, Physiatrist - HOSO)

"*There was that culture of putting all people at the table thinking. And it was very welcomed and involved a lot of people. I remember, for example, the director of anesthesia that was something ... well, they never leave the block. At first, "they never leave the block, it will be very difficult". And it was not. At the time it was Dr. L. and I remember we had evenings of conversation, of discussion, and that led to people getting all involved. It was much internalized, at the level of the organization's culture*." (HOSO's Quality Commission)

This process implied extra work from all people from each service, especially for clinical body. A voluntary extra work was accepted by the more enthusiastic, as a contribution to the image of the institution, from which they would benefit also. This change process, that had quality as the objective, was seen as prestigious and a union factor, as HOSO's President of Board of Directors details:

"It was extra work especially for the clinical part, plus everything that they had to do every day. Why they joined? They have seen interest either professional or personal. And they recognized that they were contributing to an image of the institution from which they themselves would benefit. I think these were two major aspects. This collaboration was voluntary. In the background it was a feeling of identity, of institutional identity, to contribute to the improvement of the identity process of the Institution, which is also cause of pride for

the people who work here. It was attractive, they were English auditors who brought their culture, their knowhow; they brought doctors, nurses …"

A member of HOSO's Quality Commission enumerates the aspects he considers to be the key to the success of this implementation in HOSO: *"I think the group that started the process was also very committed and managed very well to involve everyone. We had a doctor, who was the coordinator, we had a nurse, who is also a super dynamic person and who gets very involved in things and pulls a lot of people with her. And we had a very big support from the board of directors, mainly from the President of Board of Directors. He was the one that was most connected to us. I think that on one hand, the team was able to motivate itself and motivate the hospital very well. And also the board itself fit very well this philosophy in its management. There was a great change of processes."*

As this process was extremely based in the production of great amounts of paper, it was imperative to create a system that organize this new process. A Quality Documental Management System (SGDQ) was created with a person allocated only to this function until today. All operating procedures and specific procedures were cataloged and organized. Document management had a circuit for the preparation, verification, rectification and dissemination of documents, perfectly established in the documentation that existed. A manual of hospital's policies and procedures was created. This manual was mandatory in any service and there was a statement that all services received: "How to organize HOSO's Policies and Procedures Manual". According to this statement, the manual had to be organized and in a visible and accessible place to all service's collaborators. This manual was a compilation of all HOSO's 28 General and Sectorial policies and procedures (cf. Table 5.3). The manual was divided in General Procedures and Sectorial Procedures. There were several "document read statements" (cf. Table 5.4) so that all collaborators sign it every time they read a document. Each time a new document was annexed the service director should announce it so that collaborators read and sign the statement referring the document that was read. It was also referred that Accreditation and Quality Improvement Commission would visit the services regularly in order to clarify any doubts that might arise on the manual.

Table 5.3 – HOSO's 28 General and Sectorial policies

	Policies	Initials
1	Quality Policy	QUA
2	Document Management Policy	GDC
3	Communication Policy	COM
4	Clinical Administration Policy	ADC
5	Investigation Policy	INV
6	Infection Control Policy	CIF
7	Risk Management Policy	GRI
8	Incident Management Policy	GIN
9	Waste Management Policy	GRE
10	Resuscitation Policy	RRE
11	Admission Policy	ADM
12	Stay Policy	EST
13	Discharge Policy	ALT
14	Health and Safety Policy	SSG
15	People and Goods Safety Policy	SPB
16	Human Resources Policy	RHU
17	Occupational Health Policy	SOC
18	Nursing Policy	ENF
19	Volunteer Policy	VOL
20	Information Systems and Technologies Policy	STI
21	Accounting and Financial Functions Control Policy	CFC
22	Purchase and Sale of Goods and / or Services Policy	CVB
23	Clinical Information Management Policy	GIC
24	Patrimony Management Policy	GPM
25	Restoration Policy	RES
26	Clinical Analyses Laboratory Quality Control Policy	CQL
27	Training Policy	FOR
28	Waiting List Management Policy	GLE

Source: HOSO

Table 5.4 – HOSO's Document read statement

Document Read Statement

Collaborator's Name	Code of the documents you have read (see code in the document header)	Date and signature of the colaborator
Exe: Maria Silva	GDC Proc. GDC.01 Proc. GDC.02	

Source: HOSO

5.4. How resistances were mitigated

Physicians are traditionally the professional class that offers more resistance to change and HOSO was not an exception (cf. section 2.4.1). When service's meetings started it was needed to bring people together. The most difficult actors to pursuit were the Service Directors. The full-time activity as physicians plus the service director responsibilities left little or no time for a new assignment. Dr. P. explains this reality:

"*This is also a cultural defect of us in terms of organization: we always find that people "can do it" because in this house the service directors operate, see patients, and do not have a time attached to the direction of the service. They are on an equal footing with the other doctors, but accumulating the function of service director, without time attached to it. Often it is by personal option, because they do not want to stop exercising but other times it is by necessity, due to lack of resources. And implementing such a process as this, was is a huge burden for people.*"

It took a lot of awareness campaign, a lot of "*pull on the white coat*" and a friendly speech for physicians to understand that Accreditation and Quality Improvement Commission was there to help in whatever they needed.

According to what the researcher could collect from interviews there were two concrete factors that acted in physician's resistance, reducing it, and allowed the process to proceed. Those factors were the two people that led the process – the President of Board of Directors and Dr.P, who led the Accreditation and Quality Improvement Commission and the accreditation process. It was previously referred that the involvement of top management is crucial to the success of the program and that happened in HOSO with the President of Board of Directors leading the Risk Management Commission and promoting the program. The President even took the auditing course and became part of the IQS's auditor portfolio.

*"The success of such a program has a lot to do with the organization's leadership and also has a lot to do with good project management. But back to the same ... good project management is also better if you have the support of the leadership. Leadership is important and when the Board of Directors is involved, we have better results. So, it's the lead because if project management was not working, we talked to the Board of Directors and they had the power to replace or get someone to help. This commitment of the Administration is, in fact, essential." (*IQS's Director 2005/06*)*

DUQuE's project conclusions in 2014 also highlighted the importance of leadership on the success of these quality programs.

"A common factor responsible for catastrophic failures in health care is the lack of leadership involvement. This is a decisive component that affects patient care even where patient care in clinical units is pursued by competent and dedicated professionals. Simply put, research suggests that hospitals in which leaders are involved in quality, reach better quality of care outcomes. Causal mechanisms for this are not fully understood but cover elements such as leading by example, non-blaming culture, adequate sourcing of key clinical areas, pro-active monitoring of quality and safety indicators, and early interventions when problems arise. Leaders should realistically assess the performance of the organisations they represent, be aware of the quality metrics available in the organisation and engaged with the clinical teams who are aware of the difficulties of quality improvement." (Groene *et al*., 2014: 12)

This was what happened in HOSO, as a member of CHS's quality commission states:

"*A process like this will always have an engine, and it can never be just one person. The President of Board of Directors at the time turned out to be that engine and then called some key persons so that the engine worked. We have to recognize the people who initially constituted the quality commission in the Outão, especially Dr. P., who played a key role. When we move to the clinical area, and accreditation manuals always have this aspect, the President of Board of Directors has not the knowledge to decide. There has to be a person (the President of the Accreditation and Quality Improvement Commission) who has to analyze and say what clinical aspects have to involve service directors and the chief-nurses*."

The "*leading by example"* is mentioned by an HOSO's Service Director:

"The President of Board of Directors was always an administrator that I, as a doctor, perceived that he saw HOSO as his second home, he gave himself up to this hospital, it was good for us, as doctors, to see the strength and commitment that he had to get that hospital accredited. That was good for us. He helped us and when there were the final meetings he tried to reconcile and see what could be improved, either he or Dr. P. They were two pieces that I, as a doctor, orthopedist and HOSO's friend, consider to be people who had much merit in the accreditation of the hospital. They were both very involved. The President of Board of Directors had been there for many years and HOSO was what he liked, he had that great commitment. Things had to move forward, and they did. In a way there was collaboration from us by seeing the hard work they had; we felt that we should try too."

Two physicians interviewed in the hospital's urgency (and for that reason, impossible to be recorded, although the researcher was able to write down some of their answers) described the relation with the President of Board of Directors as being close to all professionals and of great empathy. This relationship was classified as a facilitator in the introduction of this process. Due to the relation of respect and proximity physicians had with the President of Board of Directors, a proposal from him would always be considered.

"*When the President of Board of Directors is in the main events relating to this process and when he is the main motivator that takes the whole pyramid behind him, it is very different than if it was an intermediate level to do so."* (Dr. P, Physiatrist - HOSO)

The President of Board of Directors, over the years managed to create a reputation, a respect and trust among the other professional classes that made him the key person to give credibility to this process. This was transversal to all the HOSO's professionals interviewed.

"*It is not very usual for a President of Board of Directors, to go through all the services, at the end of the day, to greet the professionals, and to have a relationship of proximity; never refused to receive a person, to share the meals in the same cafeteria as the other professionals. It brings people together. The President of Board of Directors was not closed in his room*." (Nurse Director, member of the Board of Director's)

"*The President of Board of Directors was a very present person. He would often visit the services, every day*." (Chief-nurse 2 - HOSO)

"*The President of Board of Directors has a very characteristic form of management, of great involvement, of going through the services, of being present. Every day, from morning to night the President was present. It is recognized by all that the President of Board of Directors had a way of being and a way of conducting the processes that is very particular. He has this characteristic, this capacity of when he wants something done, he can "take water to his mill", involving everyone, even those who do not want, with his conversation, his knowing, his almost "affection", disguised, but that is there, with his calm. A great ability to gather and distribute work – to see who he puts in certain areas for this to work*" (Quality Commission - CHS)

"If it was another type of administrator, there might have been a medical barrier." (Physician3 –HOSO)

"We felt that the "orchestra boss up there" really had a great commitment to the hospital being accredited and encouraged us by saying that "hospital X was already accredited ... ours is going to be too". To see the President of Board of Directors fighting for that hospital was a reason for me to fight. To see my directors to give themselves with eagerness to work… that hospital was a stimulus. It was what I later tried to instill in the younger ones. Leadership: when we have a leader, who gives everything so that the hospital is a reference, we can do it!" (Service Director - HOSO)

"*The President of Board of Directors was always an open-door person for us, physicians. He visited daily the services and talked to people*." (Physician2 - HOSO)

The other key person was Dr. P, the physiatrist that the President of Board of Directors chose to lead the accreditation program and the Accreditation and Quality Improvement Commission.

"I think that if it was not a physician leading the process, if it was another professional but a physician, the resistance from medical class would have been much greater. Dr. P. was extremely motivator and always available to answer our questions and help." (Physician 4 - HOSO)

Nevertheless, there were some resistances mainly in the passage from a verbal culture to a writing culture. "Write what you do and do as you wrote" was one of the slogans of the program and a major transformation in HOSO's practices. The fact that HOSO was a traumatology and orthopedic hospital was considered as a major difficult. The problem dwells in the fact that specialties with lots of surgery, such as orthopedics, usually did not write, did not register. This program presupposed that the clinical history of the patients had to be written daily in clinic diaries. This was a practice that was already usual for nurses, and even physicians confess that to know the patient's condition they would look at nurse's record.

"*Nurses are different from doctors. They are much better organized than doctors. They are accustomed to schedules, records, and write everything. We, doctors, do not. That was why it was more difficult for us than for them. They are accustomed. They have meetings when they leave the shift, they get together, and everything is written. Many times, we, doctors, to know the patient's clinical condition, see the note of the nurses because if we look to our clinical journal very little was written. We had a lot of support from the nursing team and from other professionals who were more accustomed to this type of procedure than we were. For us physicians, it was very difficult not only to communicate but to accept*." (Service Director - HOSO)

"*The fact that HOSO is an orthopedic hospital has had a lot of influence on the quality of clinical records information, because traditionally medical doctors write something in the processes, write down the history, what the patient did in the hospital. However, the more we migrate to the specialties within surgeries the fewer records are written, because they are individuals trained to sew, and to tear and to cut ... not to write... writing is given to internals. A good surgeon wants to operate, does not want to write, and last of this scale is orthopedics. For all this I think I had more difficulties here, in HOSO, in the quality of the clinical information recorded. It was one of the areas where we had to work harder*." (Dr. P, Physiatrist - HOSO)

"*One of the rules was that the clinical processes had to be perfectly filled and the orthopedic doctor was against writing and on our visits to the ward, our diary was minimal. I,*

as service director, often wrote in the clinical diary of patients of my ward." (Service Director - HOSO)

Besides the clinical record it was necessary to write in the paper all the procedures that the manual required. And many of them, as referred previously, had to do with clinical procedures, and required the physician's involvement. It was necessary to think about the current practice and compare it with the best practice. If it was necessary to change, the change should be done. Nonetheless, many times the best practice was already a reality, but it was not visible because it was not written.

"*This all entailed an enormous amount of criteria that had to be discussed, had to be operationalized and we had to find evidence that the hospital was in accordance with the standard. Much document had to be done through this multiplicity of meetings that were taking place where all were involved, still the most difficult to convoke was the service director*." (Dr. P, Physiatrist - HOSO)

"*And make people think… "Why do you do that? Why don't you do it any other way?" "I do not do it any other way because I know I should do like this." "No, but if you do it in other way, by the best practice, you will do it better." Sometimes it is not easy to listen to another person saying that there is a better way to do what we have always done. But I think it was peaceful afterwards*." (HOSO's Quality Commission)

This question of not writing clinic records was related with a habit that was general in medicine a few years from now: the organizational culture centered on "I": I know what I know, I do what I do and I don't have to share it with nobody, eventually with my closest colleagues. The challenge was to change this "I" culture to a "Us" culture. This was not easy but the advent of internet helped changing minds and spreading knowledge.

"*The story of the "I'm the one who knows" is over. A long time ago …Ok, you know what you know, but you must know what is proven to be good, you must know what others do and what others know. The fundamental is: aligned practices, based on scientific evidence, is proven!, what is done on the other side of the world is perfectly accessible, the works are published and are well-founded studies. The experience that each one have is valuable, but it has to be framed within good practice, of what is done in 90% of the world*" (Dr. P, Physiatrist - HOSO)

"*This process was an added value to us, physicians. For example, in relation to hospital infection prophylaxis, it already existed, it continued to exist but, to a certain extent, it evolved because other types of standards were arranged to complement this process and doctors learned from it. But there was no change in the procedure of the medical act. The clinical act was done correctly but was not written.*" (Service Director - HOSO)

"*I was lucky because my service director was a super-available person, he dedicated himself entirely to HOSO; he worked exclusively at HOSO. He was able to coordinate both, although he did not like working with papers, he understood perfectly what it was necessary to do and what advantages that process would have for us*." (Chief-nurse 2 - HOSO)

It was referred by two physicians that the writing of procedures was seen as an added value for physicians, still there were barriers that they justified by the great amount of bureaucratic work it implied and not by personal reasons. This corroborates the justification so stressed by the President of Board of Directors, that the doctors offered no resistance; their availability of time was what conditioned their attitude.

"*There is this idea that these processes are better accepted by nurses and Diagnostic and Therapeutic Technicians than by physicians. I, honestly, have doubts here. I never realized that there was resistance; there might have been less availability. The doctors, more than the nurses, realized the importance of this process of continuous improvement in hospitals. Resistance in my view is found transversally in all areas, from the administrative, technical, nurses, etc. It will be more correct to call it "less availability". Even the clinical departments of the services, demonstrated no resistance. As we have a higher number of nurses and Diagnostic and Therapeutic Technicians it is easier to make those professionals available to work in these processes at full or part time; this is almost impossible with doctors. Some nurses even prefer to be working in this area than with patients. It's a matter of motivation. It is difficult for a doctor to be separated from patient care*." (President of Board of Directors - HOSO)

These obstacles were not felt by nurses, who took a preponderant role in the implementation of this program, involving their professional class, but also other professionals. Their academic training approaches organizing techniques and their daily routine was already based on written procedures, team group and lots of information being shared. Physicians had neither of those. Dr. Larcher, Sta. Marta's hospital Administrator and accreditation project manager refers this limitation and its recognition by physicians:

"*doctors are the first to be aware of the limitations of the basic medical curriculum, and the Order of Physicians itself has recently organized a" significant number of management training*." (IQS, 2004b: 16)

"*Once the accreditation process requires an internal thought of the service, it is natural for chief-nurses to lead the process, especially at the beginning of the accreditation process, when the first manuals were much focused on the organization internal services*" (Quality Commission - CHS)

"*Nurses were a very important class in the implementation of the program, with a lot of work done*" *(*Dr. P, Physiatrist - HOSO*)*

This preparation work, based on establishing procedures and writing down what was done, was not strange to nurses who, as stated previously, due to their academic background, are very aware of these issues and base their practices on procedures and clinical records. It was nothing new, but it was a significant addition of work. It was also importance the presence of a nurse in the Accreditation and Quality Improvement Commission.

"*Even from nurses there was some resistance in the beginning. This had only to do with the increase of work. Nurse S. joined Accreditation and Quality Improvement Commission as a Chief-nurse and then became very interested and enthusiastic. She had an excellent photographic memory and was so excited about the process that she ended up being invited by the Board of Directors to be part of this quality commission (until today). It ended up being a 100% on the Commission. It was a great help to have that element there. Language is easier within pairs*." (Chief-nurse 2 - HOSO)

Physicians recognize that this program was easier for nurses than for them due to their registry habits and organization.

"*Nurses are different from doctors. They are much better organized than doctors; they are accustomed to schedules, records, and write everything. We doctors do not*" (Service Director - HOSO)

"*Doctors have a lot of autonomy. We have our hierarchy in the hospitals but then each one is responsible for the acts practiced and standardization is not easy. We have acting standards, and every physician has to know the good practices for his profession and his actions - but that did not mean having a script, the organizational part running differently.*

Doctors manage their time very at "naked eye" ... planning, organization ... this is more for nurses, they are used to it." (Dr. P, Physiatrist - HOSO*).*

In the field, researcher was able to attest that nurse's professional class is responsible for several new procedures: "*They keep creating and feeding the process. It's to be praised. Sometimes people say that they are trying to have more notoriety. But what is true is that they do, they show work and this is to be praised*" (Radiology Technician (TR) and Quality Enhancing Element - HOSO). This was also referred by the two physicians interviewed in urgency who emphasized the fact that nurses are the engine that still feed this process by continuing to produce procedures, to update others, and to remove those that do not make sense.

Another obstacle to overpass was the description of the job. The program required it and it was different from the description of functions. The description of functions is stated in the law and it refers to each professional class but it is extremely vague and general. But what was asked was to write down what concrete actions each one had to do. It was needed to say how many patients they had to see/per day, time of entry and departure time, if they had to tell the helper to clean the service in a certain way, etc. It was difficult to pursue every single collaborator to write it down, but it was concretized.

"This [description of the job] raised a class struggle because they said that this was all in the law. There was a fear of getting this commitment. People live much more comfortable with generalities, which is what is in the law, and which does not correspond minimally to what is requested in the workplace. One thing is description of functions and another thing is the description of the job" (Dr. P, Physiatrist - HOSO*).*

Another battlefield was the organograms. It was difficult to define responsibility lines. They were not clear in the hospital nor were they in the law. A class struggle settled in because nurses depended hierarchically on the Nurse Director but functionally depended on the Service Director. Although all nurses depended on the Nurse Director hierarchically because she is the one who evaluates them, they functionally all depend on the Service Director. The assistants were also in the same situation, as well as the secretaries. The way they managed to solve this issue was by using, in the organizational charts, the solid lines to hierarchical dependencies, and the dashed lines to functional dependencies.

Some standards were common to every service (as explained previously) – the operating standards. Working those standards raised many questions and discussions. Every service had

to design an organization chart where responsibilities of each collaborator were defined. This organization chart should be in a visible place and all the people in the service should have descriptions of their jobs, so that everyone become aware of what they were asked to do. The service had also to prepare an internal regulation were service's schedules were disclosed.

*"There were responsibilities not vertically but horizontally. This all had to be reconciled .... there were a lot of complaints, a lot of discussion. It was a difficult process: job description and organizational charts because of the definition of responsibilities" (*Dr. P*,* Physiatrist - HOSO*).*

Another huge challenge was the architectural features of the hospital, installed in a fort. In addition to the absence of fire or signage doors, the notion of risk and training on risk and safety were non-existent. It was necessary to transform two block-operating rooms and three sixteen-bed wards with orthopedic patients.

"*Many works were done, operative block, wards. When we came to the conclusion that certain situations had been authorized and the auditors had liked .... it was very good for us! It was the recognition of the work done, and because of the needs of that hospital, because that hospital was not a hospital, it was a fort and it became an orthopedic hospital. Orthopedics is a specialty in which the danger of infection is the worst of any kind of specialty, bone infection. And it was a fort turned into an orthopedic hospital*." *(Dr. P,* Physiatrist - HOSO*).*

*"There were things that were in compliance, others were not in compliance because HOSO is a very old hospital, the wards have a huge tall foot, the windows are very old, the block was outdated, and everything had to be modified to be accredited. And that was difficult. At first, we had a certain fear of these norms being not accepted since the hospital did not have the physical conditions to carry out everything that was planned. But we did! Hard work, but we got it." (*Service Director - HOSO)

Thanks to the works made in the operative blocks, within the framework of the accreditation program (financed by QCAIII), physicians stated that, nowadays there is no difference between the HOSO block, a general hospital block or a private hospital block. In the case of the wards, things are different. As HOSO was a fort, the adaptation to a hospital implied very large wards with very high ceilings. For reasons related to the aseptic and temperature-comfortable environment a ward should not have this kind of large wards with many beds and with high feet.

5.5. The first audit

The HOSO accreditation project began on 16 September 2003 and from October to December of the same year the internal disclosure of the project was made and the evaluation standards were distributed through the different levels and services (IQS, 2004b). The date of the final audit was scheduled for October 2005, but only took place in November 2006. This delay was related with the transformations that hospitals suffered in late 2005, regarding their transformation in business public entity [EPE]. HOSO and S.Bernardo's Hospital [HSB] originated Setúbal's Hospital Centre, EPE. This situation was an aspect that slowed down HOSO's accreditation process. Notwithstanding, the junction with HSB turned out to be an added value for HOSO in the accreditation process. There were general areas where HSB was more developed (e.g. infection control and clinical risk) and eventually synergies were created.

Audits were peer reviews. Dr. P highlights the importance of a peer review:

"*The audits are done by pairs; they are experts in the areas they are going to audit. Sometimes they do not even need to talk, they go by and they see, they're doctors, nurses, and hospital managers. The person who will audit the block is an anesthesiologist. It is a peer review. They have teams well aware of the good practices that should exist*."

Another added value of this choice was the interaction that existed with English auditors. The Joint Commission model was extremely professional, which meant that "*they behaved as auditors, and an auditor should not interfere or interact with the client*" (IQS's Director 2000/05). But King's Fund's Health Quality Service's auditors had a different way of interact. Some of their auditors were the most respected people, from managers, surgeons, people who knew a lot about hospitals and it would be inconceivable for them to work just as auditors, without sharing their knowledge, as stated by IQS's Director 2000/05, IQS's Director 2005/06 and Dr. P, Physiatrist from HOSO).

"*It was much more than a mere auditing process, when someone comes in, sees what was done, fills in the reports and leaves. There was this sharing, which, let's face it, is not very orthodox, but it was a shame to waste all that know-how*" (IQS's Director 2000/05).

The audit consisted in three phases: (1) the audit to document management phase, "*where they consulted documents that were mandatory e.g., infection control policy, documents that*

are considered important in terms of written documents"; (2) the interview phase, "*where auditors interviewed the people responsible for the project, service directors and the various commissions"* and (3) the observation phase, "*where the auditors circulate in the hospital, walking through each service and observing what was really happening, and talking to patients, employees, anyone*" *(Dr. P,* Physiatrist - HOSO*).*

The phase of audit to document management presupposed that the Accreditation and Quality Improvement Commission's had to prepare a file with all the documents that attested the measures implemented. "*We had a documental system with all the procedures, policies, everything was documented*" (HOSO's Quality Commission). In that file the documents that corresponded to standards were coded. At the same time all those documents were available, and properly coded, so when the auditors arrived, they would divide the standards among them and check if the documents responded to the standards, or not.

In the interview phase auditors met with people responsible for the project, service directors and the various commissions and there was a triangulation of information from different sources: "*For example, the risk commission had created its own system to manage the reports of risk incidents. The auditors asked for two examples of incidents that had occurred. Afterwards, they were going to confirm with documentation what had entered as a risk report, what actions were taken and if there was a correction to prevent the risk from occurring again*." (HOSO's Quality Commission)

In those meetings besides auditing, "*they also did a kind of consulting, sharing with hospital elements how their hospitals were organized, what they did well, what had been successful, what had not gone so well*" (IQS's Director 2000/05). According to the interviewees the researcher talked to it was much more than just the accreditation process. They shared what was best done in the UK that could be applied here.

In the observation phase, auditors would walk around the hospital, in the services, and they observed and asked. It was common for auditors to ask to collaborators, even if they were passing in the hall questions like "*Are you aware of this accreditation process? Are you aware that a quality process is in progress? Do you know the policy manual and do you know where it is in your service?" (*HOSO's Quality Commission)

Usually they asked to confirm something they had already read and they wanted to confirm if it was implemented or if it was just in the paper. "*Everyone in the hospital knew*

that in those days we were going to be auditing. Everyone knew auditors could approach to ask something, whatever they wanted." (Dr. P, Physiatrist – HOSO)

"*Sometimes we were still doing procedures in the week previous to the audit, but in those cases as we had no documents to prove its concretization, we said that it had only been approved in the previous week's meeting and was not operational yet.*" (Administrative of quality commission -CHS)

After the final audit the auditors meet and issue a report. This report, as stated before (section 5.2), details the findings of the investigation compared with the standards. Therefore, the report was written in the form of a plan of action in order to facilitate the development of the organization and the ongoing developments in the services to meet the requirements of the standards.

"*When the report is presented to the Board of Directors, there is always the care to know the opinion of the Institution. This is what we think, what do you think? Is it far from reality? Were you counting on this report? In the background there is the spirit of a team work and the assumption of a continuous improvement. The report comes very flowery, that's right, but everything is there, everything is there!*" (Dr. P, Physiatrist - HOSO)

An aspect pointed as an advantage extremely important in this process was the pedagogic character of audits. These programs are formative, they do not have the purpose to punish. The aim is to grow as a quality organization as CHKS's client manager stated: "*Accreditation is an educational process, pedagogical; the idea is to do it because it is a good practice*." A chief-nurse confirms that characteristic: "*I think it always had a pedagogical character. It always makes me nervous, we are being evaluated but never felt like they were police. I felt they were a help. They did not come with the aim of punishing, they came with the purpose of educating, teaching, guiding and helping us to grow in quality. I felt it.*" (Chief-nurse 2 - HOSO)

Dr. P also highlights the non-punitive character of this program: "*It is by no means punitive. They are very cordial in the interviews that they make, they give suggestions; it's a brainstorming too. The fact that the auditors arrive and we already know what they are going to audit there is nothing wrong. Even so, there are things that are still not right. We must have the humility to say, we are not well, we have to improve*."

Posteriorly a meeting with all the staff and each auditor (responsible for three or four areas) took place to present the result of the audit. *"It's a general meeting for everyone to know the results (people like to know the result of the work they've had for months and months). There's always praise, things went very well, and there's always a list of things to improve*"(Dr. P, Physiatrist - HOSO)

Then the official report was sent to the hospital. In HOSO's case, there were still nonconformities in essential areas. When this happens, an action plan must be conceived in order to overcome that situation and achieve accreditation. HOSO had to demonstrate that all pending actions would be completed within 12 months counting from the first audit. Therefore, HOSO's focused audit took place in November 2007, precisely one year after the first audit. Despite the effort, it was not possible for HOSO to achieve the intended goal in 2007. In April 2008 and in June 2008 HOSO had to present two progress reports. Progress reports is a way for the hospital to demonstrate the evolution of its work, usually related to some criteria that may have been classified as "partially compliant in an earlier audit." Thus, the hospital demonstrated that it has been able to change the conditions (it may be a pending work, a document that did not exist and that it came to exist, a work group that started to produce information, etc).

"*In the first audit we had 80% of the patients that did not have informed consent to the act .... This is something that is in the law! We had to create an informed consent format, created barriers in the course of the patient: consultation of orthopedics is it to operate? If yes: inscription in the operation list. Did he get informed consent? If ye: he may register, if not: return to the doctor. We had to put barriers in the process to make informed consent mandatory. It was a fight! But now it is a common practice*!" *(Dr. P,* Physiatrist - HOSO*).*

In 16th July 2008 HOSO reaches its first accreditation. This Accreditation was valid for three years from the date of the survey and not from the date of the grant and is subject to positive monitoring results. In October of the same year HOSO had a monitoring by King's Fund's Health Quality Service to ensure that the standards that led to the granting of accreditation were still being followed and accreditation was maintained. This was the first and only accreditation for HOSO, as a single hospital. In 2005, HOSO and São Bernardo's hospital got together and originated Setúbal's Hospital Centre [CHS]. São Bernardo's hospital signed the contract with King's in 2006 and after two focused audits achieved the accreditation in April 2010. In 2010, also, Setúbal's Hospital Centre signed the contract with

King's Fund's Health Quality Service and after the final audit in March 2012, a focused audit in the same year, November, and a progress report in April 2013, the Setúbal's Hospital Centre got accredited in 17th April. It has been re-accredited in 2016 and the last re-accreditation audit happened in October 2018, when on almost 3000 criteria, 150 returned to improve some things. A focused audit only for these criteria occurred on July 2 and 3, 2019 and the re-accreditation was achieved for 3 years counting from October 2018. Figure 5.2 resumes the evolution of this accreditation process which started in 2003 in HOSO.

Figure 5.2 – HOSO's accreditation's process evolution

	HOSO			HSB			CHS		
2003	1st contract	**2003**	**Signing of 1st contract**						
2004		2004	WIP						
2005		2005							
2006		nov/06	Final audit	1st contract	**2006**	**Signing of 1st contract**			
2007		nov/07	Focused audit		2007	WIP			
2008		april/08	Progress report		feb/08	Final audit			
		jun/08	Progress report						
		jul/08	**Accreditation 16/07/2008 to 30/11/2009**						
		out/08	Monitoring						
2009					mar/09	Focused audit			
					dez/09	Focused audit			
2010	2nd contract	mar/10	Canceled contract		**abr/10**	**Accreditation 28/04/2010 to 30/04/2011**		**2010**	**Signing of 1st contract**
					out/10	Monitoring		2011	WIP
2011					out/11	Monitoring		mar/12	Final audit
2012								nov/12	Focused audit
2013							1st contract	abr/13	Progress report
								abr/13	**Accreditation 17/04/2013 to 31/03/2015**
								jul/13	Progress report
								nov/13	Monitoring
2014								nov/14	Monitoring
2015							2nd contract	**2014**	**Signing of 2nd contract**
2016								jul/15	Final audit
								mar/16	**Accreditation 16/03/2016 to 31/07/2018**
2017								abr/16	Progress report
								jul/16	Monitoring
2018								jul/17	Monitoring
2019							3rd contract	**2017**	**Signing of 3rd contract**
								out/18	Final audit
								jul/19	Focused audit
								jul/19	**Accreditation Oct2018 to Oct2021**

31/12/2005 HOSO and HSB give rise to CHS, EPE

Source: original, based on information collected in interviews and hospital documentation

5.6. What changed in HOSO

The King's Fund's Health Quality Service program forced the hospital to bring people together, get them to talk to each other in order to organize the services so as to ensure the patient's safety during hospital journey. It is worth emphasizing that this study reports to the beginning of the 21st century when Portuguese hospitals had no fire plans, where there was no signage, where there was no care for waste separation, i.e. where a series of practices that are now taken as an acquired fact, did not exist. In fact, and it was referred by most of the people the researcher talked to, especially the top-level management:

"*the important thing here is not the medal or the sticker that is out there, it is for embed and for alerting people to the need for this culture of safety and quality, which is fundamental in a health institution. The program is the vehicle*." (Dr. P, Physiatrist - HOSO)

*"The procedures and policies of the hospital were created by multidisciplinary teams, there were many people involved ... they had to think ...It was a process that improved the collective consciousness, people often do because it is the routine, and here they were forced to sit and to think about the course. What is considered the standard? The good practice? Ok, but we do differently ... so what do we have to modify to get to the standard? The process by itself is worth it." (*Dr. P, Physiatrist - HOSO*)*

*"The Manual was a document that involved several services and various areas, we all got to talk to each other. There were procedures that involved several services, for example, sending a patient to physical medicine and rehabilitation: the process, knowing what is best for that patient, the patient going to physical therapy to do a certain exercise: what exercise? What do I need to keep doing? The communication between the service and the physiotherapy is an extremely important communication channel for patient improvement. It was important for people to see that we all worked for it and all parts of the work of all services were important for the recovery of that patient." (*Chief-nurse 1 - HOSO*)*

One of the great areas of change was the risk management, which was a utopia until then. There were no Emergency Plan; no one knew what to do in a fire or catastrophe scenery. In terms of signage, the change was visible. Before accreditation nothing was marked, after accreditation, everything had the correct signage. Fire extinguishers were installed in all services and training was given to collaborators.

"*All employees had to do training in resuscitation - a basic life support course. Some took the advanced course. But the basic course was done by everyone. There were also fire drills - where the exits are, how to react in the situation, who evacuates first, where to go. That was very important. This part was very important and a very important asset that accreditation has brought us.*" (Chief-nurse 2 - HOSO)

"*There is another key factor here: the training factor. One thing is the basic training that each one brings, but training at the institution level is very important. At the institutional level, it is necessary to understand the needs of the staff and to create training courses so that they can gain skills in these areas*." (CHKS's auditor)

Emergency schemes began to exist throughout the hospital, something that did not happen before, and which involved the planning of circuits, as IQS's Director 2005/06 states: *"When we started working, the hospitals did not have an emergency plan nor did they have a disaster plan".* This was Portuguese hospitals' reality and these changes were occurring in other hospitals that were passing through the same accreditation program implementation, as in Santa Marta's hospital: "*Nothing was signed before and now everything has correct signage. In addition, there are also emergency plants on each floor, something that did not exist and that involved the planning of circuits*" (IQS, 2004b: 18).

*"Before we were accredited, we had a fire at the Serra da Arrábida and HOSO was almost to be evacuated. Fortunately, Secil's cement plant, which is very close to the hospital, had a South American firefighter team that acted promptly and got the fire out of the hospital. After the accreditation process was done there was an employee who did not turn off the ATM machine - one of the standards is to shut down – it heated up, and caused a fire. But then we've already knew how to proceed, the intermediate floor was evacuated, it was controlled and we knew how to act." (*President of Board of Directors - HOSO*)*

*"Even now, there are still those who do not understand why, if I am a nurse or a doctor, do I need to know how to work with a fire extinguisher? Why do I have to know how to evacuate a service? There has to be an order, an organization. Often, after training, they tell me that now they understand why they have that material in the service room and what it is needed for." (*Chief-nurse 1 - HOSO*)*

The standardization of procedures was something that was already part of the nurses' routines, much due to their basic training. Notwithstanding, the majority of procedures were not written. There was a verbal culture and it had to be transformed into a written culture.

Many things were already done, and correctly done, but they were not written anywhere. There were no clinical records of what was done and how it was done. It was important that every procedure became written and, as a good practice, became also available to all professionals. The culture of not sharing the knowledge was a reality that ended and the knowledge of best practices recognized worldwide became mandatory. The web gave a huge boost making available studies and investigations, and putting people connected, from as far as they were.

"Standardization is very important. We do not immediately see the advantages because the initial process was hard but then we began to see. For example, we needed to have the emergency car in order. Before the accreditation process we did not have the checklist, we saw more or less, but something could fail. After the accreditation process no. We followed the list, it was faster and safer. Normalization saves a lot of time. We spent a lot of time at the beginning but then everything was easier. Even the integration of new elements has become easier. It is not only the aim of the hospital to be accredited, to the outside, with quality; in terms of services there was, in fact, an improvement!"(Chief-nurse 2 - HOSO)

Physician's, in this particular case, orthopedists, had no written culture. The clinical diary was almost inexistent, and this was an important criterion for accreditation. The written culture was perceived by all professionals and, despite some difficulties in turning it into a practice to physicians, it was achieved.

"*Although it could be much more filled with information, there is a huge distance from what we have now and what we had when we started.*" (Dr. P, Physiatrist – HOSO)

Until the implementation of this program the visits of the doctors to the wards, happened whenever the doctor wanted and the doctor only visited "his patients". From a certain point on, it became a team composed by the medical team, the nursing team, the anesthesiologist and the physiatrist, who visited the ward one or two days a week and saw all the patients who were in their service.

"*It was a good thing that was created at that time. I went to internships where this was done and I had already tried to implement it in HOSO; this process helped. I explained to my colleagues that this was already happening in other countries. In what concerns to the clinical diary and the team visits, this process was very good.*" (Service Director - HOSO)

It is important to enhance that all these procedures and standardizations do not enter the medical act, respecting physician's autonomy and identity. This is a very important factor that has to be taken into consideration when analyzing how this new logic was introduced in the institution, how it gained its space and how it coexists with existing logics - professional and management's business-like logics.

As stated previously, the President of Board of Directors had a major contribution to the dissemination of this new logic. He was an extremely considered and respected person by every professional class in the hospital. This was due to his conduct, proximity and "affection" (as mentioned by some interviewees). In this process he got personally involved assuming the leadership of the Risk Management Commission and taking the IQS's training for auditing, becoming an auditor. This attitude of proactivity transmitted to collaborators (doctors, nurses, DTT, medical assistants, etc.) made them see this process as important for the hospital and motivated them to participate. They trusted their leader and if he was so involved in this process, if he truly believed that it was a good thing for HOSO and it was reachable, they had no way but to support him. This does not mean it was an easy way. It was not easy, mainly from physician's class but it was always justified not as a resistance to change, but a consequence of the busy time physicians had, with no time left to other tasks. Nevertheless, all physicians that were interviewed recognize, unanimously, that it was a beneficial program for HOSO.

"*It involved a lot of time in meetings. Good practices were already a reality, but they were not written as procedures. At first, people refused to participate in committees because it was not mandatory, it was just a group of people, volunteers who worked on it. Although we believed in the process, we thought it already existed. However, when at the end we met and presented our proposals, we came to the conclusion that it had been a good and valuable work for HOSO because those standards existed but were not written. From now on, when we needed, we just had to go to the dossier and everything was contemplated there. It turned out to be a good process for HOSO*" (Physician1-HOSO)

"*This process was good to us, doctors. For example, in relation to the prophylaxis of hospital infection, it already existed, but evolved because other types of rules were arranged to complement this process and doctors learned from it. But there was no change in the procedure of the medical act. The clinical act was done correctly, although it was not written. The added value was, for example, the medical team meeting, weekly or once-daily meetings,*

that occurred not in the ward, but in the doctor's office, with a presentation of clinical cases. This was already done but this process boosted it" (Service Director - HOSO)

When the process began it took six months to the release of the first procedure in HOSO but after that, the speed of releases highly increased. To be released, the procedure had to be elaborated, rectified and publicized. The program had several speeds.

"A turning striking point was when people saw that someone had done a procedure and that it was disclosed and the people to whom it was intended saw it. The speed of procedures and policies gained a boost." (Dr. P, Physiatrist - HOSO)

In the beginning of this process, all professionals were very oriented by the book but then professionals tried to make the leap: abandon the book, take advantage of the mindset change that occurred in the meantime, and create a more stable and permanent structure that did not comply to an obligation or to the idea of doing the right thing to respond to an audit.

"All these important good practices that must exist in institutions, health institutions (more than, perhaps, any other area, because it plays with people's lives) resemble the image of a cockpit of an airplane. Whoever is in the cockpit of an airplane has to know perfectly what procedures are to do, and have to repeat them, have to announce them ... and this resembles an operating room. But it does not only apply to the operative rooms because the accidents and the risk exist since the patient enters the hospital until he gets out. There are a lot of risks when you cross the hospital. And it was one of the key parts of the program, the risk assessment and the implementation of a general accident reporting system." (Dr. P, Physiatrist - HOSO)

This accreditation program was a very arduous process because it implied the involvement of all professionals to work on the standards. But only working the basis with everybody it is possible to interiorize this logic. This was, mainly, a change of mindset.

"*It did not change the day-to-day actions but there were certain things that were not usually done and became a practice, e.g. there was a mistake in any service: people got used to report. It is online, in a non-punitive way, then it is analyzed in a non-punitive way, let's see what failed. Another example, at the entrance of the block the nurse who receives the patient has a checklist (like an airplane cabin) and there is someone who repeats what she says: the name of the patient, the name of the doctor, what will be operated, what is the side and the side is marked with pen. Some routines were introduced, but the nurse who received*

the patient already had them, but she had not a checklist that helps her not to fail, turns out to be a security for her." (Dr. P, Physiatrist - HOSO)

Moreover, the major transformation that happened was in these little (but major) details. The hospital did not hire more people, nor had collaborators to do extra work (after the first preparation work). What happened was that each service started to have a person who is the liaison with the quality Commission, as HOSO's Chief-nurse 2 resumes: *"We planted little trees in each service to spread the quality culture."*

Another aspect which was a novelty with this process, in terms of organization, was the creation of a documental system with a collaborator working only for this purpose. The Quality Document Management System remains until nowadays and it still is an important piece of this puzzle. This department standardizes the style and format of the Quality documents in the Setúbal's Hospital Centre, creates a system of classification and numbering of documents. It also defines the indexing mode and compilation in central file of all the policies and procedures of the Setúbal's Hospital Centre, so that all staff members are required to read the relevant policy documents and procedures for their work area. Additionally, it defines the mode of documentary control in order to ensure that the end user has the correct version. In the CHS's Quality Improvement Strategy, dated July 2010, and revised in April 2017, the manual remains mandatory in the services as well as the employee rubrics when they read a new procedure. However, when the researcher questioned how the new procedures came to the knowledge of the collaborators, the answer was that it was available on the computer and, in some occasions, interviewees didn't know what to answer. It was again pointed out that, due to the fact that the nurses meet whenever the shift ends, it facilitates the flow of this type of information. The fact that all the information is now concentrate in the computer, although without a system that automatically validates when the collaborator reads the procedure, creates a situation of uncertainty in this question, which is crucial for the continuous spread of quality logic. Dr. P shares his opinion on this subject: "*I know how it should be, with meetings. I know that in some services this happens. All professionals have access to the manual and all the procedures online, and a circular comes out".*

A crucial factor for this logic to gain its space within the organization was the training that occurred and still occurs, in specific areas. As stated previously, there are four areas of mandatory training for every professional to attend: (1) occupational health; (2) risk

management; (3) infection control; and (4) basic life support. Notwithstanding, training is still seen as something that is not assumed as mandatory. It should be but "*in these last years the most heard justification that came from the Service chiefs was that if people go to training, the service would be left alone*" (CHKS's auditor). And for that reason, professionals miss training that is crucial to spread this quality logic.

"*The training rates should be 100%, which is impossible, because of the turnover, lack of personnel ... by several factors*" (Quality Commission - CHS)

"*Trainings are still not respected. They must be seen as something mandatory, that you cannot miss.*" (CHKS's auditor)

5.7. The accreditation process in HOSO today

In the beginning, the manual was more oriented to the general risk, not getting much into the clinical area, as explained by HOSO's President of Board of Directors:

"*At the outset, this program was not so focused on continuous improvement of clinical risk, but more on general risk, i.e. there was a set of general risk procedures we thought about but were not structured (for example, if there was a fire in the hospital, how the hospital would respond to a storm at night - many things like that happen in HOSO). It was necessary to create a set of organizational structures that responded to a number of issues in the area of risk management and which were not structured. And this process was born was directed, essentially, to the part of the general risk management, the fires, the infections.... with the evolution of the times these processes emphasized the area of the clinical risk (accidents with the patients in the wards, checklists in the blocks*".

Nonetheless, the manuals have evolved to more clinical aspects. "*For example, the weight of clinical auditing has only begun to be noticeable in the manual we had for 2013. It did appear before; but in 2013's manual clinical auditing began to have more weight"* (Patient Quality and Safety Committee - CHS)

And it was a turning point for the clinical aspects of care because it is also understood that there was an evolution. "*In the first stage we have already organized our organization, now we are going to take the next step in terms of the quality process, following the process of continuous improvement*" (*ibid*).

The actual Caspe Healthcare Knowledge Systems [CHKS], the old King's Fund's Health Quality Service, works with an on-line platform – Accreditation on-line [AO].

"*The accreditation manual has 65 standards, but Accreditation On-Line has 60 - it is an electronic platform with the standards that apply specifically to that hospital - it is a tailor-made manual (e.g., the transport of patients in Portugal is not done by the hospital, it is done by INEM, by the firemen, therefore this standard has no meaning in Portugal)*" (CHKS's client manager)

When a standard or criteria does not apply to the hospital the non-application must be justified online and the client manager in London accepts (or not) the justification.

"*When hospitals say that some criteria do not apply, it may signify that the hospital does not do it because they never did, or because they are not used to it, but the criteria can and should be applied*." (*ibid*)

With Accreditation On-Line the process can be started in London, with the documentation analysis, the first phase. The services should fill online and attach all evidence that is requested for their service. If 30 services exist, the 30 services should apply the platform individually, and fill their information. However, what happens, in Portugal, is, according to CHKS's manager, "peculiar": the person responsible for the documental system (and who gives administrative support to the Quality Commission) still continues to prepare the "Caderno de Encargos" for each service (as if the on-line platform did not exist), exporting the forms to an excel sheet with the information each service has to fill in. Each "Caderno de Encargos" is saved in pens and distributed by each service. The service fills their excel worksheet and return the pen to the quality administrative member who will input in Accreditation On-Line all the information, from all services. In London, the client manager sees all inputs with the same profile – the profile of quality administrative member. "*This only happens in Portugal*", assured CHKS's manager. The client manager analyses the information and attaches. If some information is missing there is a chance for services to fill in and attach evidences. Six weeks before the audit, the access to Accreditation On-Line is closed. In Portugal the limit is also different from the usual: it had to be shortened to 3 weeks before audit, due to the constant delays. When Accreditation On-Line access is closed, only auditors have access to data. The next phase is the survey where "*six principal auditors (four English and two Portuguese) plus four "shadow" auditors which facilitate communication with English auditors*" (Quality Coordinator 2005/2013 - CHS) will interview basically all employees they want as well as patients (these later, with previous permission). Interviews will start with superior managements, followed by service directors and middle direction and

finally auditors will be in the services where they can observe the environment and conduct more informal interviews with staff about relevant standards - for example participation in training, staff assessment, knowledge of safety and health problems, rights of patients and so on. At this level, the inspectors ask for permission to speak with patients and with informal care providers (CHKS, 2016). "*Within 40 days the auditors produce the report comparing the observed with the standards*" (Quality Coordinator 2005/2013 - CHS). The following procedures are still the same that was described previously.

CHKS's client manager highlighted another particularity that occurs in Portugal: "*Audits with mixed teams (i.e. with English and Portuguese auditors) only happen in Portugal. In no other country this happens: the auditors are exclusively English. And Caspe Healthcare Knowledge Systems still trains Portuguese auditors. Last year four more Portuguese auditors concluded the training*". This is the result of the intense relation that was established with IQS, at first, with the aim to train Portuguese auditors so it was possible to have know-how to create a national accreditation agency. This objective vanished but the relation with CHKS remains.

In Setúbal's Hospital Centre the process continues: "*An accreditation process is an extremely dynamic process. The re-accreditations are every three years but we don't just wait for the next one. The Commission for Quality and Patient Safety (usually termed by the researcher "Qualiy Commission") meets biweekly, and we oscillate between HSB and HOSO. Currently is composed by Dr. P., the coordinator, four physicians, four nurses, infection control representative, pharmacy representative, imaging technicians, management communication, training, technical assistants. We totalize seventeen members.*" (Chief-nurse1 - HOSO). The main difficulty reported nowadays is to keep the motivation alive. It is not an option to let go. It is a daily work to keep the project alive and people motivated. Nonetheless, the reality is completely different from the year 2000. Mentalities changed, routines changed and that's the major success of this project – the quality logic became intrinsic in the daily life of professionals.

"*There is already a huge set of clinical guidelines for everything. The elaboration phase has been long overdue. The standards are elaborated, rectified and approved. They're already out there and people know where to find them. These programs are not made from one day to the next, it is step by step; we sow to harvest later. If we are already in the phase of "if you did not meet the standard you have to justify"? No, we are in a time of awareness, of consciousness.*" (Dr. P, Physiatrist - HOSO)

CHAPTER VI – DISCUSSION

In this chapter the researcher discusses through the findings resulted from the interviews, direct observations and documents. First the researcher justifies the choice for a cross-level dynamic analysis (Thornton & Ocasio, 2008). Then the researcher presents an analysis on societal changes that determined health field changes and the emergence of the New Public Management movement, which introduced in public administration a new business-logic. The next section presents how this new logic gained space in Portuguese public administration discourses and narratives and how that impacted health field. The chapter continues with the discussion of how these changes introduced the quality concern in health field and how that leaded to the expansion of accreditation programs in hospitals, introducing in the field, and in organizations, a new logic: the "bureaucratic-quality" logic. The specific case of HOSO is analyzed: the particularities of the hospital, the actors that were crucial in this process and all the institutional work that was developed towards this new logic. Finally, the institutional logics perspective is used to analyze the introduction of a new logic in HOSO, and how this multiple coexistence was managed.

6.1. A cross-level dynamics study

Greenwood *et al.* (2011) consider that health sector is a field that is portrayed as more predestined to present enduring competing logics due to the great variety of occupations, each one conditioned by different logics.

In this study the researcher opted for a cross-level dynamics study in order to be able to study the changes that occurred: (1) at the societal-level, by analyzing the global movement NPM, that brought to public administration a new business-like logic; (2) at the field-level, explaining how this new business-like logic was assumed by regulatory entities (WHO, EU, Portuguese Government) and how it raised a new concern with quality in health field, and how this new concern was assumed through policies and advices; (3) at the organizational-level (hospital) by exploring how a new logic ("bureaucratic-quality" logic), associated to an accreditation program, emerged; (4) and at individual-level, by analyzing how different actors reacted towards the introduction of this new logic and the important role that some of them played in this process. This cross-level analysis grounds on Thornton and Ocasio argument that "*work on institutional logics is inherently cross-level, highlighting the interplay between individuals, organizations and institutions*" (2008: 120). (Appendix II summarizes all the interactions among different levels)

In so doing, the researcher draws on more than one theoretical approach to offer a more nuanced and balanced view of the institutional processes she observed. With the aim to analyze the cross-level institutional work done by several actors in the process that led to the emergence of the new "bureaucratic-quality" logic in HOSO, the researcher used the institutional work perspective (Hampel *et al*., 2017). The study on how the new logic ("bureaucratic-quality") was assumed within the organization, and gained its space, was framed by the institutional logic perspective (Thornton *et al*., 2012). The researcher also investigated if the introduction of this new logic resulted in an institutional change in the hospital studied.

Hospitals are examples of complex organizations, either horizontally (with multiple institutional orders) and vertically (with multiple categories for each institutional order) (cf. Greenwood *et al.*, 2011; Thornton *et al.*, 2012). The majority of the empirical studies that address the subject of institutional complexity assume some assumptions: the existence of only two logics, the incompatibility between them and the implicit idea, when analyzing logics shift, that

the older logic should be replaced by the new one, due to their incompatibility (Thornton *et al*., 2012; Scott, 2008; Greenwood *et al*., 2001; Thornton & Ocasio, 1999).

This study addresses the analysis, at a micro-level, of how the introduction of a new logic, that is inherent to an accreditation program – a "bureaucratic-quality" logic - in a specific organization - a specialized hospital - penetrated and gained its space within the existing logics - the professional logic (that emphasizes the quality of care and it is prosecuted by physicians and nurses) and the business-like logics (that is occupied with efficiency and it is Board of Directors concern) (cf. van den Broek *et al*., 2014). Therefore, this study challenges the assumptions mentioned above by analyzing a third field-logic emergence, its relation between the already existing field-logics and the reasons that explain the long-term coexistence of this "*trio of logics*".

6.2. Pre-existing logics in HOSO

Field-level logics are embedded in societal-level logics and subject to field-level processes (Thornton *et al*., 2012). Health care field has been dominated by the professional logic ever since, creating a relatively stable field (Reay & Hinings, 2005: 356): "*Physicians were actively involved in the governance of hospitals and other health facilities, and quality of services was assessed through a strong reliance on medical opinion*."

This professional logic is related to special knowledge that is acquired with effort, which makes it an elite knowledge and, for that reason, an instrument of power (Freidson, 2001). Professional logic respects closed expert occupations and is characterized by "*autonomy, discretion, and trust*" and differentiates medical professionals from other workers (Sirris, 2019: 1). Physicians have been seen as the paragon professionals (Freidson, 1986; Abbot 1988), not only due to the control they have always had in their professional work but also due to the dominance that they have had [and still do] among other occupations in medicine groups (nurses, laboratory technicians, X-ray technicians, etc.). This professional autonomy and clinical freedom have been important in the construction of physician's identity. Professional identity "*is exclusive because of long-term academic training and socialization*" (Sirris, 2019: 1). This identity, with the emphasis on their exclusive right to decide treatments and have access to medical

professional knowledge, explains the reactions from physicians towards the efforts to control their clinical practice and behavior (Doolin, 2002). According to Noordegraaf (2007), this professionalization of the field aimed to establish professional control (cf. Freidson, 2001), as well as occupational closure (Abbott, 1988), creating conditions to professional workers govern themselves and mitigate outside interference. This occupational closure was a particular characteristic in HOSO, but it was not just related with physicians. Due to the fact that it was a specialized traumatology and orthopedic hospital that worked almost exclusively with insurances, it offered its professionals better conditions than the rest of hospitals offered, creating a unity in workers, stimulating the closure and the "almost" defense of the organization.

"*I have no doubt that those who worked at HOSO had a sense of belonging, for a variety of factors. Big teams imply more complex management. This sense of belonging may also be explained by another factor. HOSO, as a central orthopedic hospital, had access to different funding and to an extraordinary source of funding that came from insurers. HOSO had a financial willingness to invest in certain things that most hospitals did not have. All that was orthopedics went to the HOSO and the insurers paid what they said. It was a source of human resources cohesion*." (CQSD member and GIARC coordinator - CHS)

"It was a hospital that reached the end of the year with a surplus. We worked a lot with insurers, because we had a lot of patients that were accidents, and that had influence. The professionals who came to work for the institution felt recognized for their work because they were able to manage and provide care so that by the end of the year we had no debt. We all worked towards it and felt good. We were like a big family. We had certain kinds of conditions that gave us added value, even though it was a very specialized hospital, orthopedics and traumatology. There were no restrictions as "you cannot do this now because there's no money" but we had the feeling of taking care of the hospital as if it were ours. We felt like a family, we all knew each other, and we all helped each other." (Chief-nurse and member of CAMQ - HOSO)

Physician's professional logic dominated the Portuguese hospital's institutional logic's until 2002 when Portuguese public hospitals were corporatized and splits between the purchaser and the supplier of health care services ensued. This business-like logic was "*itself an instantiation of societal-level logics, as specific historical, cultural and material contingencies in the field lead to field-specific variations in practices*" (Thornton *et al*., 2012: 149). The business-

like logic in public administration was a consequence of the NPM movement which appeared as a result of "*some social and economic problems that developed states faced in the 1970s and 1980s*" in Western countries (Bevir, 2009: 143).

"*New public management reforms, it is said, are a common response to common pressures — public hostility to government, shrinking budgets, and the imperatives of globalization*." (Polidano, 1999)

Change in logics is usually seen as a "*period effect*" by scholars and NPM was the exogenous force that ushered this "business-like" logic into Public Administration, separating effectively "*a relatively stable period of beliefs from another*" (Dunn & Jones, 2010: 114). NPM reforms started to emerge in Portugal since the 1990s, albeit the fact that the integration in European Union, in 1985, being considered a factor that "*allowed NPM to permeate the health system in a politically correct manner*" (Simonet, 2014: 57) as Portugal started to be "*eligible for European funding for social and economic infrastructure development, including the health sector*" (Bentes *et al*., 2004: 89). As Thornton *et al*. (2012: 150) explain, the societal logics of the interinstitutional system – in this case, this new business logic – are "*available building blocks for the formation of the field-level institutional logics*" that may exert effects cross-nationally. The emergence of this new logic was shaped both by the societal-level market logic of the EU and the market logic in the field of Portuguese corporate governance (which is shaped by EU through the process of Europeanization – see section 4.2.2) (cf. Thornton *et al*., 2012). In Portugal this new business-like logic was introduced in health sector by the new health basis-law (1990) which opened doors to several changes that occurred in health sector. This business-like logic introduced narratives and rhetorical that were not usual in public administration (much less in public health sector), such as "*performance*", "*entrepreneurial*" and "*delivery*". The main idea was that Governments became smaller, more entrepreneurial, and capable of produce more public value using limited resources. In Portugal, the new Basis-law and the new statutes of NHS – 1990/1993 – opened doors to experiences of quasi-market in four hospitals.

"*The effect of NPM in our country is related to the relaunch of a hospital management reform program, under the responsibility of the state for the provision of health care established by the Constitution, which resulted in several innovative management experiences, such as the granting of the management of the Hospital Fernando Fonseca (Amadora / Sintra) to private*

hospitals in 1996, the almost entrepreneurial experiences of the São Sebastião Hospital in Santa Maria da Feira in 1996, the Local Health Unit of Matosinhos (1999) Hospital de Barlavento Algarvio in 2001 and the attempts to delegate competencies in organic intermediate management structures through the creation of the Integrated Responsibility Centers (CRI) in 1999." (OPSS, 2009: 86).

These experiences opened the door to business logic in NHS; however, it is not possible to talk in business logic throughout the healthcare field until the year 2002. In Portugal, and trying to understand how this new logic affected the narratives and rhetoric of governments, the researcher analyzed the government's programs between 1991 and 2002 (cf. Appendix V).

"*The health minister defends a business management for any institution and a sense of competition among them, namely through the annual publication of a ranking based on indicators. Articulated with this new form of management, quality is a tool to be deepened and disseminated throughout all institutions and a task to be pursued by IQS and to be disseminated in the future."* (IQS, 2003: 3)

Although this study does not explore the introduction of this logic in HOSO, it was with the pressures coming from business-like logic and the NPM values that were beneath it, that in Portugal, in the late 1990's, the quality of public services became a major concern.

6.3. The emergence of a new logic

The NPM movement, acting at a societal level, introduced this new business-like logic in public administration, and emphasized "*the centrality of competition and performance measurement*" (WHO, 1995: 52). The idea was that this new logic would enable the "*delivery to all of high-quality essential care, defined mostly by criteria of effectiveness, cost and social acceptability*" (WHO, 2000: xiii). In order to achieve higher quality on health, more and better information was required and "*supporting mechanisms as clinical protocols, training, licensing and accreditation processes*" should be used (WHO, 2000: 137). Information on health systems performance must be comparable and meaningful to enable analysis, explanation of variations and the strength of the "*scientific foundations of health policy at international and national levels*" (Murray & Frenk, 2000: 717). This benchmarking of health system's performance raised

the question of delivering high-quality care services and put on the agenda the question of quality in health services. Accreditation programs for hospitals started to disseminate, becoming mandatory in some countries (e.g., France).

In Portugal, the priority for health had been prepared since 1996, with the creation of a Health Reflection Council, which studied and submitted proposals for health reform. The result of those years of preparation and analysis culminated with the disclosure of a new strategy for health "*Saúde, Um compromisso: uma estratégia para o virar do século (1998-2002)*" by the MoH which originated the Saúde XXI program, at the beginning of 1999. This program was created within the framework of III Community Support Framework (QCA III) and the Health Minister in 2000, considered that it was *"a measure of great political significance, highlighting the priority given by the Government to health reform and that it is seen as a fundamental axis of the country's economic and social development strategy*" (Ministério da Saúde, 2000: 2).

This emergence of health quality concern is resumed in Appendix I. Appendix I is a cross-level analysis, created by the researcher, to resume, in a framework, the raise of health quality concern in the world (Societal-level), in Europe and in Portugal (Field-level, concerning the health sector).

Within this strategy, that considered quality as a priority, IQS was created in 1998 and established a protocol with King's Fund with the aim to accredit Portuguese hospitals (IQS, 2000). This protocol considered also the transfer of all knowledge and technology to the Portuguese government with the ultimate goal of creating a national accreditation agency (Ministério da Saúde no dated). These accreditation programs, which were not compulsory (but voluntary), introduced in hospitals a new logic: the "bureaucratic-quality" logic. The process is categorized as bureaucratic mainly due to the obligation to hold meetings and to complete the standards manual (cf. Pomey *et al*., 2004).

IQS introduced the new "bureaucratic-quality" logic in Portuguese health organizations, mainly hospitals. This was made through the use of discourse, narratives, rhetoric, symbols and training. The IQS magazine was a symbol which materialized the quality concept in health. These magazines were constituted by the presentation of examples of hospitals that were doing their accreditation process, presenting their difficulties, their main struggles and how they arranged ways to be successful in the program. It was a detailed description of processes with physicians, nurses, hospital administrators and presidents of Board of Directors stating their points of view.

By presenting these real statements these magazines embodied cultural ideas, but also enabled agency by how experience and knowledge was channeled (Jones & Massa, 2013).

Through this artifact (magazine) IQS drew on narratives, discourses and rhetoric (cf. Chapter III) to persuade the field's constituencies about the importance of quality in the health care sector. By telling stories on how the processes developed in several hospitals, IQS "*communicate[ed] collective values, beliefs and feelings*" (Yanow, 2006: 42). Similar stories and narratives were part of the discourses employed during the implementation of the quality program in HOSO. As an example, this discourse of a Chief-nurse from HOSO (that was part of the Quality Commission) and that in 2018 stated:

"In this accreditation process everyone is involved, all services, no one is left behind. We all work for a common good, for the Institution. This was information that was passed. We held meetings for all, opened to all. For me, in this process it is essential to show each person that it is important, that it is part of the process, that without him/her, the puzzle is not complete."

This latter discourse, that took place in 2018 in an interview for this research, is similar to a statement that the researcher found in a 2004 IQS' Magazine where a member of the Board of Directors in Santa Marta's hospital stated: "*it can be said that no service or hospital sector was left out, as well as guarantee that no professional class was relegated to second place*" (IQS, 2004b: 16).

These similarities were also identified in subjects such as the main resistance to the program: the resistance to move from verbal culture to written culture. In an IQS' magazine it was possible to read in a report about the implementation of the process in a hospital that:

"*It was necessary that the professionals internalize that they would have to pass from a verbal culture to a written culture, which would allow to give visibility and continuity to the work developed. Although we knew there was a good performance there was no culture of writing. It was necessary to demonstrate to the professionals that their actions resulted in improvements, i.e., that the project was not only the production of procedures, but something that aimed to contribute greatly to the improvement of the health care provided in the Hospital*." (IQS, 2004b: 17)

Dr. P, in 2018 also referred this resistance, mainly from physicians:

"*The fact that HOSO is an orthopedic hospital has had a lot of influence on the quality of clinical records information, …. the more we migrate to the specialties within surgeries the fewer records are written, because they are individuals trained to sew, and to tear and to cut ... but not to write .... writing is given to internals. A good surgeon wants to operate, does not want to write, and last of this scale is orthopedics. For all this I think I had more difficulties here, in HOSO, in the quality of the clinical information recorded. It was one of the areas where we had to work harder*."

The accreditation program that IQS protocolled with King's Fund and implemented in hospitals (the ones that expressed their will to do it) is itself, and according to Lawrence & Suddaby's (2006) framework, an example of definitional work, as it [accreditation programs] engage actors in processes that (re)define boundaries and frameworks, creating new institutions. The protocol with King's Fund had also the objective of legitimating this accreditation program. It is necessary powerful actors in the field to demonstrate the cause-effect relations and give surrounding actors templates for action (Lawrence & Suddaby, 2006). These powerful actors, are powerful because are the ones who possess resources and legitimacy to educate relevant actors to organization (*ibid*). For Perkmann & Spicer (2008) they must be professionals with technical, technocrat or expert competences, attributing rigor to institutions. In this case study it was referred by HOSO's key actors, that King's Fund was an English Foundation with the best experts in some areas and that fact was seen as an added value for the program, it was even referred that it transmitted an "aura" to the program. For three times in researcher's interviews it was referred that some of the auditors were the most respected people, from managers, surgeons, people who knew a lot about hospitals and that it would be inconceivable for them to work just as auditors without sharing their knowledge. The audits were much more than that; they were a share of experiences (IQS's Director 2005/06, IQS's Director 2000/05, Dr. P, Physiatrist - HOSO).

6.4 The institutional work in HOSO

The institutional work was investigated at the organizational and individual level although, during the research work, it was possible to identify the institutional work taken at the field level (Appendix II). As Gawer & Phillips (2013) argument, to change field-level logics it is

necessary to act at the organizational level, doing internal work (which is going to be explored below); but it is also necessary to act at field level, doing external work, changing the spread practices of the field which is achievable by building legitimacy (*ibid*). In this particular case of Portuguese health field, this legitimation was achieved by an "adaptive emulation" (Jones & Massa, 2013) that seeks legitimation through the prestige of stablished solutions. By choosing a well-known program from a prestigious English organization [King's Fund], it was easier to get hospital's attention and acceptance. The program was legitimated by King's Fund prestige which worked also to the theorizing of the concept. As Greenwood *et al.* (2012) argument, theorizing is connected to the "*conferring of legitimacy*" (*p.*61) and it is particularly relevant in highly professional settings, as hospitals, where boundaries and templates of appropriated organizational forms are well defined. An important issue to theorizing – naming - was worked and spread through the sector by IQS. By giving names to the new concepts they became part of the cognitive map of the sector. Accreditation, standards, criteria and compliance are examples of new concepts that became part of daily routine in hospitals that went through these programs. By spreading these concepts in a specialized magazine, IQS assured theorizing's narrative component. Theorizing is associated with powerful actors in field – the ones that possesses resources and legitimacy to demonstrate the cause-effect relations and give surrounding actors templates for action. This institutional work was assumed by King's Fund and, although this technical work attributes rigor to institutions it does not create a relation between actors and institutions (Perkmann & Spicer, 2008). This relation [between actors and institutions] was achieved by the construction of normative networks between IQS and the hospitals. IQS was the link, the facilitator, between King's Fund and hospitals. It was composed by a group of people who believed in the program and stablished and nourished cooperation relations within the hospitals.

At this point of discussion the researcher narrows the scope of the investigation to the organization [HOSO], frames the acting of key actors in the implementation of the program in HOSO and interprets it through the lens of institutional work perspective. Voronov & Vince (2012: 16) argue that "*individuals may engage in institutional work to attain emotional or symbolic goals, rather than in the pursuit of material needs*". Individuals have (unconscious) desires and aspirations that are institutionally conditioned by social and power relations and professional experiences (*ibid*). This approach considering fantasies that influence institutional

work complements prior research that assumed institutional contradictions (Seo & Creed, 2002) and the position that individuals occupied in the field as sources of motivation (Battilana, 2006). The researcher aimed to apply this research direction to this investigation in order to understand the inner motivations that made Dr. P suggest this accreditation program to HOSO's President, and his leading the project.

In Chapter V, it was described how Dr. P, a physiatrist, brought the idea of hospital accreditation program to HOSO and presented it to the President of Board of Directors. He also headed the Accreditation Commission, created with the aim to implement the program. In field interviews it was possible to understand (by the discourse and by the motivation demonstrated when talking about this theme), that it was something that was important for him. Some statements from Dr. P justify this idea:

"*This is a matter of faith. Or you do have faith and get something in life or you do not have it and you do not leave the same place. This is a matter of faith.*"

"*What these manuals bring us, I call it the Bible, is that each procedure was worked with a huge set of professionals around the world, to reach a standard, that evidence had to be much tested. Each procedure of the manual has a cycle, with expertise, with clinical evidence, studies, etc ... that is what makes it incontestable. This was explained to the doctors. That has a lot of strength. This is an awakening to walk towards the quality of health, with a script that helps immensely*"

In late 1990's, Dr. P was a physiatrist in HOSO. The researcher found important to understand the position of such a medical specialist in the organization, in order to try to understand the motivations of this professional behind the good willingness and apparent total belief in the program, as it was stated for more than once in the interviews, as transcribed previously. At hospitals, in the top of the medical hierarchy are surgeons. They are the ones who lead the surgeries, and because of that, they are the ones who can get the fastest feedback of their performance on the patient. They are seen almost as "gods" because they solve the patient's problems quickly and visibly. Surgeons also give the indication, by prescription, if a patient needs to be seen by a physiatrist. Therefore, a patient is only seen by a physiatrist when indicated by the orthopedic surgeon, which puts the physiatrist immediately at a level of subservience to the orthopedic surgeon. In addition, physiatrists do not treat: they only prescribe for

physiotherapy; and it is the physiotherapist who establishes a relationship with the patient and who is directly associated with the recovery of the patient.

"*Dr. P, as a physiatrist, although he had his hospital work, was more available than us orthopedists. And thankfully he was chosen and was always in the process* "(Physician4, Service Director)

"*In Outão, Dr. P was a physiatrist, does not operate, he has no inpatients, maybe only needs 4 or 5 hours a week to make physiology consultations, to stay connected to his profession."* (President of Board of Directors - HOSO)

Consequently, it became clear to the researcher that physiatrists, in the organization, are in an (almost) invisible position. By assuming the leadership of this program Dr. P gained a projection in the organization that would not have gained being only a physiatrist. This assumption made by the researcher is based on the idea defended by Voronov & Vince (2012: 16), that institutional work should not be classified as "*necessarily rational*" and defend the distinction between intentionality and rationality. This assumption was also based on Lawrence and Suddaby's (2006) belief that creating institutions by changing abstract categories of meaning presupposes the involvement of powerful actors on the field but also can be an enormous opportunity for entrepreneurs that are less powerful actors. Although actions may be oriented to personal desirable objectives [strategic actions] they may not be consciously reflected by individuals. Institutional work cannot be classified as totally rational because it is conditioned by institutions and by "*unconscious processes that cannot be reduced to rational thought.* " (Lawrence and Suddaby, 2006: 16) The researcher assumes the difficulty to prove empirically this deduction; it is an aspect that may be unconscious, therefore difficult to prove. It was from the direct observations in the interviews and from crossing emotions with ground observations that this explanation arose. Nevertheless, an unconscious aspiration will always be very difficult to prove empirically unless the actor in question assumes his personal intention (which may not even be conscious).

Whether Dr. P was instigated by unconscious (or conscious) desirable objectives (i.e., achieving a more visible role in the hospital) or if he just simply believed in the program, it is unquestionable the major role he played in the implementation and maintenance of the accreditation program. His dedication, enthusiasm, willingness to help, willingness to captivate

all employees, especially his peers – physicians - are characteristics that all interviewees, without exception, attributed to him.

*"Dr. P. was extremely motivator and always available to answer our questions and help." (*Physician2 - *HOSO)*

"*We have to recognize the people who initially constituted the quality commission in the Outão, especially Dr. P., who played a key role. When we move to the clinical area, and accreditation manuals always have this aspect, the President of Board of Directors has not the knowledge to decide. There has to be a person [Dr. P] who has to analyze and say what clinical aspects have to involve service directors and the chief-nurses*." (CQSD member and GIARC coordinator - Setúbal's Hospital Centre)

"*We saw from the part of the President and Dr. P., a huge willpower for our hospital to be accredited.*" (Physician1, Service Director)

"*I think the group that started the process was also very committed and was very good at getting everyone behind. We had a doctor, who was the coordinator, who is Dr. P*." (CAMQ – HOSO)

"*These were two "pieces" [Dr. P and the President] that I, as a doctor, orthopedist and friend of HOSO, consider being people who had much merit in the accreditation of the hospital. Both had a very big involvement.*" (Physician4, Service Director)

In this discussion the researcher opted to use the term "actor" instead of "entrepreneur" responding to the shift that institutional work agenda has suffered moving away from "*the personal traits of heroic entrepreneurs*" (David *et al*., 2017: 671) and of inefficient markets and focused on "*more social image of actors and agency*" (Hampel *et al*., 2017: 24). Dr. P exerted his institutional work mainly through narratives, rhetoric, identity and community. Dr. P used narratives to explain situations, "*selecting, combining, editing and molding*" situations to construct a story, as Zilber proposed (2009: 208):

"*There was a whole work of initiation to a new logic in quality that went on to explain the concept of quality in health, benefits, failures, resistances, in order to raise people's awareness for this logic, which in essence is also a culture's change.*" (Dr. P, Physiatrist).

Dr. P also used persuasive language to legitimate the process within the professional class of physicians, as defended by Suddaby & Greenwood (2005):

"*What these manuals bring us, I call it the Bible, is that each procedure was worked with a huge set of professionals around the world, to reach a standard, that evidence had to be much tested. Each procedure of the manual has a cycle, with expertise, with clinical evidence, studies, etc... that is what makes it incontestable. This was explained to the doctors. That has a lot of strength. This is an awakening to walk towards the quality of health with a script that helps immensely.*" (Dr.P, Physiatrist). Alvesson & Willmott (2002: 622) concluded that discourses of quality management promote "*passion, soul and charisma*".

As argued before, medical professionals are characterized by having autonomy, independence and control of their work, and because of their specificities it is more difficult to influence this class. A central finding of this research was that physicians proved to be the most resistant class and to have Dr. P [a peer] as the leader of the project, was an enabler factor due to the particularities of this professional class.

*"I think that if it was not a physician leading the process, if it was another professional but a physician, the resistance from medical class would have been much greater." (*Physician2 - *HOSO)*

"*It was good, because Dr. P., as a doctor, collaborated, helped us in setting the standards. Every time we had questions, we turned to him. I think that choosing a doctor to lead the process was a good choice from the Board of Directors.*" (Physician4, Service Director)

"*It has always been said from the beginning - I myself attended several training sessions, in King's Fund, in which they defended that the program coordinator should, preferably, be a physician to be a facilitator element with the clinical staff, increasing the receptivity of colleagues.*" (Dr. P, Physician)

The work for gaining physician's trust, attention and adherence to the program was highly reinforced by the active and respectable President of Board of Directors who legitimized this process. Researchers defend that legitimation often takes a discursive approach, making use of rhetoric and narratives (David *et al*., 2017; Suddaby & Greenwood, 2005). Yet this legitimacy was also achieved by a combination of two additional factors: (1) the solid image of a

respectable, straightforward, always present and always available President; and (2) his personal involvement in the program, leading the Risk Commission and attending the IQS's auditor course, becoming therefore, an auditor. These two strands can be confirmed in the following quotations that also show the impact these attitudes had on the medical profession:

"*The President of Board of Directors was always an open-door person for us, physicians. He visited daily the services and talked to people*." (Physician2 - HOSO)

"*The process was always led by the Board of Directors, otherwise it would not succeed. The main success factor is the involvement of management, and this is what happened at HOSO*." (Dr. P, Physiatrist - HOSO)

"If it was another type of President, there might have been a medical barrier." (Physician3 –HOSO)

"*And we had a lot of support from the Board too. I think, on the one hand, the team was able to motivate and motivate the hospital very well. And then the board itself framed this philosophy very well in its way of management*." (CAMQ – HOSO)

"*When the President of Board of Directors is in the main events relating to this process and he is the main motivator that takes the whole pyramid behind is very different than if it is an intermediate level to do so."* (Dr. P, Physiatrist – HOSO).

The great attention in the choice of the people who composed and headed the commissions that were created for the implementation of the program, revealed the concern on legitimating the accreditation program. The purpose was, on one hand, to have multidisciplinary teams, with the aim to have all the areas involved in the elaboration process, and on the other hand, to pass a message that the program was something important for the hospital, otherwise the people involved would not be participating in the process in a so visible way. The choice of the members for these commissions was a responsibility of the Board of Directors, but the Board asked Dr. P. to suggest the names of the elements that should be part of those commissions, namely, the Risk Management Commission (General and Clinical) and the Clinical Administration Commission, exerting agency, a central concept in institutional work (Hampel *et al.*, 2017). For the researcher, and according to what she could observe directly from the interviews with Dr. P and the references from other interviewees, this agency was exercised in

social stage, based on the idea that individuals as sole, rarely turn into social actor (Abdelnour *et al*., 2017). Based on Ashforth & Mael's (1989) classification of individual's motivations for agency, crossed with Abdelnour *et al*.'s (2017) perspective of agency, the researcher considers that Dr.P was guided by individual's identity and identification through a "*perception of oneness with a group*" (p.35).

To implement the program the Board of Directors created a multidisciplinary Accreditation and Quality Improvement Commission [CAMQ]. The choice of a physician to lead this process was intentional, as explained previously. And the fact that it was a cross-functional team, involving several professional categories, was extremely important to reach all professional classes. Indeed, this multidisciplinary commission was also a way to promote the dialog between different professional classes, creating conditions to different opinion's convergence (Grant *et al.*, 2004). These professionals would be the drivers of this new logic, doing an institutional work through narratives and rhetoric (Grant, 2004; Suddaby & Greenwood, 2005), explaining the accreditation process and what needed to be done in their services - they were the connecting link, the stimulating elements; and being a peer facilitated the interaction, as Chief-nurse 2 recognized

"*It was a great help to have that element [a chief-nurse] in the Quality Commission. Language is easier between peers*".

"The members of the Commission were the people who connect the commission with those responsible for the services. The Quality Commission held meetings, initially, with the service director, the responsible nurse or coordinator and the service person who liaised with the quality committee. We held meetings with these people and said, this is your specifications, these are the documents to prepare, we have to have evidence to show when the external auditors come. And then we helped people work." (Chief-nurse 1 – HOSO)

"We all work for a common good, for the institution. This was information that was passed on. We held meetings for everyone, open to everyone. Then we held meetings with the services. Fortnightly meetings of the Quality Commission were scheduled to take stock of each other, as each one was doing. We had to have all the documents to show in the audits and for the services themselves to know what they were doing. From policies, procedures, job descriptions,

action plans, it was all worked out and tailored to the needs of the services themselves." (Dr. P, Physician)

"*How did we make the new procedures known? The head nurse had meetings with nurses on shift change or specific meetings to talk about it. Then, within the services themselves, there was a nurse that was the link to the quality commission. And that was good, because boss is boss and having a peer to communicate these changes becomes easier." (Chief-nurse 1)*

This commission [CAMQ] established a Quality Improvement Strategy that defined the creation of the Risk Management Commission (cf. Chapter V), which embraced clinical and general risk. The coordinator of this Commission was the President of Board of Directors, and many top elements, such as, the Hospital Administrator's Representative, the Infection Control Representative, the Director of the Pharmacy Services, all related areas of the Ethics Committee, and the Occupational Health Service also participated, legitimating, once again, the program.

"At the time, the coordinator of the commission was the President of Board of Directors. This was intentional, with the purpose to show the importance of this commission. With hospital's top elements involved, it was noticeable that it was something that had importance." (Chief-nurse 1-HOSO)

Professionals only accept guidance and supervision when it is from a respected peer (Freidson, 2001), who engage in institutional work, conferring legitimation to the program. Findings showed that Quality Improvement Strategy defined also the creation of the Clinical Administration Committee [CAC] – responsible for clinical quality. The members of this commission were also carefully chosen. The Clinical Director of HOSO led the Committee together with HOSO's nurse Director and Dr. P, as the liaison member to the Quality Commission. The choice of the Clinical Director and the Nurse Director had the purpose to involve physicians and nurses and to demonstrate the importance of the accreditation process.

In this investigation the researcher found that making visible what was invisible was part of the strategy followed by the institutional actor (entrepreneur) to materialize some concepts and ideas in the hospital. This accreditation process presupposed a major slogan "write what you do; do as you wrote", an expression used by Dr. P.. This entailed major resistances (that will be addressed in the next section concerning multiple institutional logics) although this shift to a

written culture was considered to be one of the greatest added value of this process. The process of writing down all the procedures that HOSO did to accomplish all the manual's standards is a result of the institutional work undertaken by Dr. P because it materializes quality. Indeed, the manual turns good practices visible. These findings reflect Friedland's (2012) perspective that symbolic – ideas, beliefs and schemas – must be made material to signify.

"*It was a way of showing the value we had and of saying abroad that CHKS demanded and we did it: it was necessary to move to paper*." (Chief-nurse 1)

"*Although we knew there was a good performance there was no culture of writing. It was necessary that the professionals internalize that they would have to pass from a verbal culture to a written culture, which would allow giving visibility and continuity to the work developed*" (IQS, 2004b: 17)

Furthermore, this program considered as mandatory the daily clinical record, which was a practice that was common to nurses but not to the professional medical class (the orthopedic surgeons) who worked in HOSO. To the researcher, this shift from a *had*-hoc culture to a writing culture should be considered a materialization of practices, and therefore an important outcome of the institutional work undertaken towards the new "quality" institution (Friedland, 2012).

This shift towards a writing culture meant also a shift on the organizational culture centered on "I" (I know what I know, I do what I do and I don't have to share it with nobody, eventually with my closest colleagues), to a new organizational "Us" culture. This was also potentiated by the innumerous multidisciplinary meetings, which brought together professionals who usually did not sit at the same table or exchange opinions with one another and promoted dialogue, which is considered very important in institutional work's dynamic (Lawrence Suddaby, 2006). Dialogue enables the identification of change necessity may it be organizational, political or environmental, and by doing it, dialogue may be considered the beginning of organizational change (Grant *et al*, 2004). These dialogues occurred as a way to respond to all the procedural writing obligations that the program required.

"*Yes, it was usual to have doctors on the one hand, and nurses on the other, but with this process we often had to join nurses with doctors and with other hospital professional classes.*

There was an approach and a sense of team spirit, even with other professionals." (Service Director-HOSO)

"*This process brought greater team unity as it put people who spoke by circumstance sitting at a table discussing these issues.*" (Chief-nurse 2)

Halasa *et al.* (2015) also concluded that accreditation improves the level of completeness of medical records. Based on Donabedian's theory which considers quality of care dependent of structure, process and outcomes, improving a structural measure, as complete medical records, will improve the likelihood of a good process (contents or courses of services) which will determine the likelihood of good outcomes (results of service).

6.5. HOSO's institutional logic change (?)

The first intent of the researcher when analyzing the findings through the perspective of institutional logics was that Reay and Hinings' (2009) study mirrored the reality she had found in HOSO. The authors concluded that the coexistence between multiple (and conflicting) logics could last for long periods of time without one being the dominating logic; the key was collaboration among actors. The authors highlighted the idea that collaboration is possible when one part has a specific knowledge that is crucial to reach the objectives, and holds strong identities and power to maintain its independence. In this case study, physicians were this part; they are characterized by a strong identity based mainly in their autonomy and in their clinical freedom (Doolin, 2002), preserving their independence. Reay and Hinings (2009) defend that in these types of collaborations the maintenance of identities is essential for collaboration to happen. The introduction of the new "bureaucratic-quality" logic in HOSO did not enter the medical act, thus not affecting physician's autonomy and identity. Notwithstanding, Reay & Hinings (2009) presupposed that when this type of long-time co-existence and rivalry between logics occurred, this determined also a change in institutional logics. However, this conclusion [in HOSO] was not clear to the researcher. Perchance this new logic did not change in fact the institutional logics that existed in hospital, considering Scott's definition of institutional logics, as the "*belief systems and related practices that predominate in an organizational field*" (2001: 139).

Analyzing the characterization of multiple practices that co-existed in HOSO (see figure 6.1) the researcher can demonstrate how the new logic did not change overall goals from the previous existing logics. The overall goal of medical profession is to provide all "medically" necessary services while the business-like logic's overall goal is to provide effective and efficient services. The "bureaucratic-quality" logic has continuous quality improvement as the overall goal and this enhances both the "medically" necessary services, by improving the medical services; and ensures better services. Analyzing the impact that this accreditation program had on belief systems, the researcher concluded that it did not change the belief systems of the health professionals – the professional logic of physicians. It enhanced it, bringing the theme of quality of care to the day-to-day concerns, while that logic was already intrinsic in all health care professionals. This is validated by Pomey *et al.'s* quotation when explaining that the patient and family became to be at the heart of all processes: "*Although such a principle should have been present prior to self-assessment, the accreditation manual made it possible to better understand how to actually put it into practice*" (2004: 121). Pache and Santos (2010: 459) also refer that "*the nature of demands is an important factor when studying organizational responses to conflicting demands because it allows us to predict the degree to which these demands are negotiable*." These demands may involve conflict at the goal's level.

Figure 6.1 - Characterization of multiple practices co-existing in HOSO

	Medical professionalism logic	Business-like health care logic	Bureaucratic-quality logic
Belief Systems (what goals or values are to be pursued within a field)	'Doctor-patient' relationship is most important component of system	Consumer' relationship is appropriate model for service provision	Patient and their families at the heart of all processes
	Services should be provided under the direction of a physician	Services should be provided by the lowest cost provider	Services should be provided respecting the "Good Practices"
	Overall goal is to provide all "medically" necessary services	Overall goal is to provide effective and efficient services	Overall goal is Continuous quality improvement
Associated Practices (means for pursuing the goals and values)	Physicians are the only gatekeeper to the system, and decide how all services are provided	Physicians are one of a team of health care providers, and consumers choose which provider to access	Decisions should be made based on Good Practices; Clinical acts are not considered in the manual
	Physicians hold the authority to make decisions	RHAs determine the extent of services available; physicians make decisions within this constraint	

Source: Adapted from Reay & Hinings (2005: 358)

Regarding practices, the researcher concluded that some may have been introduced, but the majority were already a routine and considered as good practices. Thus, the accreditation program brought the materialization of those practices, through the mandatory writing of procedures and clinical diaries: "*The hospital also learned the importance of a writing culture and the place it should hold. Until then, the organization's memory was transmitted essentially by word of mouth. Few things were committed to paper, including information regarding the patient.*" (Pomey *et al., 2004*: 121) Practices of professional logic (cf. Figure 6.1) consider autonomy and independence of physicians as fundamental. The new ("bureaucratic-quality") logic did not pinch the freedom or identity of doctors – especially in the implementation phase, when it was more focused on general risk than on clinical risk. This can be perceived by the observation of figure 6.2, which shows the index of 2016 manual - norms for specialized and clinical services. It is possible to understand that regarding orthopedics there are no specific standards. Therefore, this seems to indicate that these programs do not "invade" the space and autonomy of physicians in HOSO; this explains the maintenance of their identity. "Bureaucratic-quality" logic does not interfere with business-like logic's practices (cf. Figure 6.1).

Therefore, and balancing the findings from the ground analysis, the researcher concluded there was not a change in institutional logics (that was characterized by a duality between professional and "business-like" logics). This "bureaucratic-quality" logic introduced by the hospital accreditation program did not contradict professional logics or business-like logics. Contrariwise, it blinked an eye to the quality of the service that was provided (in line with the professional logic), and the other to the efficiency of the services once it organizes and systematizes processes. This new logic was not a conflicting logic with the existing ones (as already explained and demonstrated). Based on these findings the researcher aimed to understand how this new logic was introduced in HOSO and how co-existed with the already existing logics. As the majority of studies offered mainly "*conflicting perspectives on their consequences for organization and field-level processes and outcomes*" (Besharov & Smith, 2014: 374) and were one-level studies, neglecting that cross-level analysis is essential on institutional logics studies, as it enhances the connections between individuals, organizations and institutions (Thornton & Ocasio, 2008), the researcher focused on the study of Besharov & Smith (2014). In this study the

authors "*theorize about the heterogeneous ways in which multiple logics manifest within organizations and their implications for organizations*" (Besharov & Smith, 2014: 365).

Figure 6.2 – Specialized and Clinical Services (CHKS 2016 Manual for HOSO)

Section 6 : Specialized and clinical services

Source: Accreditation Program for Health Care Organizations - Specialized Accreditation Standards (2016: v)

Regarding that, they present a framework to analyze the question of the multiplicity of logics through two dimensions: the compatibility between logics and their centrality. As mentioned in Chapter II, compatibility refers to the consistency between two logics and how they reinforce the actions of the organization. This consistency is linked to the organization's goals (cf. Figure 6.1); it is not related to the means organization uses to achieve them. Centrality respects the existence of one or more logics that are core to the organization.

Besharov & Smith (2014) defend that close relationships create motivation to face multiple logics in more compatible ways, even when logics may continue to be incompatible at the field level. This close relationship referred by the authors, existed in this hospital, and was highlighted by all interviewees, becoming clearer to the researcher that it was a factor that enabled the compatibility within logics. Focused on understanding the factors that influenced a well succeeded implementation program, the researcher concluded, after had interviewed several professionals from HOSO, that it was a hospital that had particular characteristics. And those particular characteristics acted as enablers in this accreditation process, facilitating the introduction of this "bureaucratic-quality" logic in a complex organization where two logics were already co-existing. The fact that it was a small hospital (rounding 300 employees) situated in the middle of Arrábida's mountain, by the sea, created an atmosphere and ambience very different from what it is considered a "normal" hospital. The sense of belonging, of unity and team spirit was referred unanimously by each and every interviewee from HOSO. They considered the hospital as their family, and there was the attempt to get people together in meetings post-work.

"I worked in many public hospitals, but HOSO, since I got there in 1979 until I left, in 2011, was a "family" hospital. There was an attempt of meetings between people even outside the hospital, to fraternize, with all kinds of professional classes (maintenance, nursing, doctors): it was a family." (Service Director - HOSO)

"*I think that we felt this process differently than S. Bernardo's hospital [an hospital of the same hospital center of HOSO]. As we were a smaller hospital, a family, we had a sense of unity, of teamwork, of "let's work towards a common end*". (Chief-nurse 2 - HOSO)

"Outão was a hospital far from the city, had a very particular culture, the human sense that existed was ... was different from what exists in these large organizations (hospital centers). People did their best for the organization because there were about 300 people, people felt the hospital… in my view, small hospitals have higher levels of humanization" (President of Board of Directors - HOSO).

Findings highlight another factor that was repeatedly pointed as a factor that contributed to the unity of HOSO's collaborators: the figure of the President of Board of Directors. The President was a person that went everyday through all the services to greet the professionals, creating a close relationship with them; knew everyone by the name; shared meals in the cafeteria

as everyone and never refused to receive an employee; the door was always opened. And he was the first to say yes to the accreditation program, assuming the leadership of the Risk Commission and attended the IQS's training for auditors, becoming a CHKS's auditor.

"*We had a very big support from the board of directors, mainly from the President of Board of Directors. He was the one that was most connected to us. I think that on one hand, the team was able to motivate itself and motivate the hospital very well. And also the board itself fit very well this philosophy in its management."*

"We felt that the "orchestra boss up there" really had a great commitment to the hospital being accredited and encouraged us by saying that "hospital X was already accredited ... ours is going to be too". To see the President of Board of Directors fighting for that hospital was a reason for me to fight. To see my directors to give themselves with eagerness to work… that hospital was a stimulus." (Service Director - HOSO)

"If it was another type of administrator, there might have been a medical barrier." (Physician3 –HOSO)

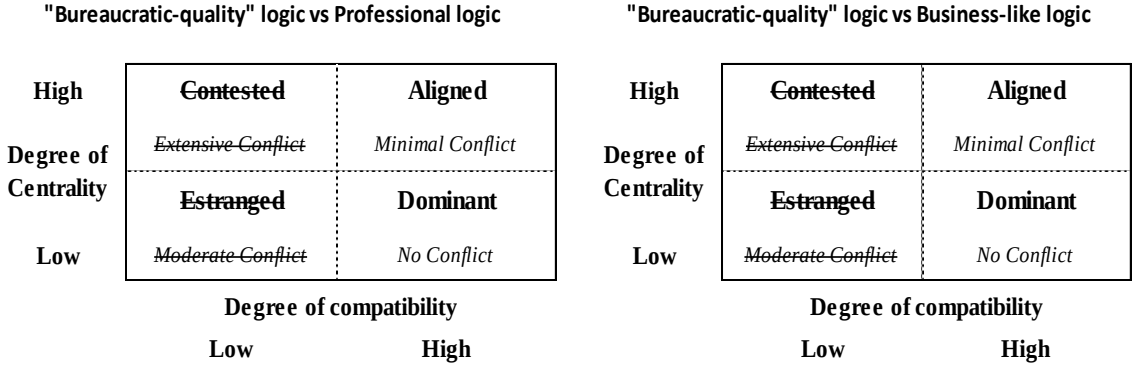
"*The President of Board of Directors was always an open door person for us, physicians. He visited daily the services and talked to people*." (Physician2 - HOSO)

There is evidence that this involvement was extremely important for the adherence of collaborators to the program, and to the success of its implementation. These findings are supported by Groene *et al.* (2014: 12) who refer that hospitals with leaders involved in quality processes present better quality care outcomes, and relates those results with "*leading by example, non-blaming culture, adequate sourcing of key clinical areas, pro-active monitoring of quality and safety indicators, and early interventions when problems arise*". This leader was, thus, a factor that fostered unity and group cohesion, increasing "*logic compatibility within the organization*" (Besharov & Smith, 2014: 368). Hospitals present a highly compartmentalized structure with several "*cellular, self-sealing and institutionalized*" boundaries (Ferlie *et al.*, 2005) 129) and such organizations need leaders who understand multiple logics – ambidextrous leaders - leaders who also have communication skills to vanish any skepticism and who have the authority to interfere and minimize resistances (*ibid*). The President of Board of Directors was always described by HOSO's collaborators as this type of leader, who got personally involved,

who was interested, and who motivated all around them enabling the implementation of this program.

Drawing on Besharov & Smith (2014: 377) framework and responding to the call made by the authors, the researcher applied their framework "*to pairs of logics*" (suggested when more than two logics co-existed). The researcher did not focus on the relation between the pre-existing logics in the organization, but on the compatibility between the professional logic and the "bureaucratic-quality" logic and between "business-like" logic and "bureaucratic-quality" logic. Compatibility concept, as mentioned earlier, refers to the consistency between two logics and how they reinforce the actions of the organization. Previously, the researcher demonstrated that the new "bureaucratic-quality" logic's goals were not conflicting with the other two logics (professional and business-like) (cf. Figure 6.1.). Therefore, there is compatibility within the two pairs of logics that are being analyzed. Furthermore, findings have demonstrated that HOSO was characterized by a familiar ambiance, a sense of belonging and unity (stated for several times by transcriptions of interviews). This factor creates motivation to face multiple logics in more compatible ways, even when logics may continue to be incompatible at the field level (Besharov & Smith, 2014). The researcher considers that, therefore, the degree of compatibility is high, which eliminates two types of logic multiplicity in HOSO: contested and estranged (cf. Figure 6.3)

Figure 6.3 – High degree of compatibility between logics



Source: Adapted from Besharov & Smith (2014: 371).

The structure of the field is particularly important for centrality (Besharov & Smith, 2014). As addressed previously in Chapter II, health care is a highly fragmented field where several logics coexist, namely the professional and business-like logics. Analyzing the centrality of these two logics, professional logic (emphasized by physicians) vs business-like logic (emphasized by the state and management), both logics became central to the organization, as both actors hold power in the field, presenting therefore a high centrality (Besharov & Smith, 2014). Nonetheless, the objective of the researcher is not to analyze the centrality within these two logics but within each of these logics and the new "bureaucratic-quality" logic introduced by the accreditation program.

When analyzing centrality between the professional logic and the "bureaucratic-quality" logic the findings show that in this relation there is a dominant player – physicians. This dominant role is maintained because "bureaucratic-quality" logic does not overlap with professional logic, i.e., the principles of this new logic - continuous quality improvement - were already present in professional logics; this new logic highlighted a focus on it and developed them. The fact that the principles of this new logic were intrinsic to medical profession and the fact that the accreditation program did not entered in clinical acts preserved the identity of physicians, explain the dominance of professional logic.

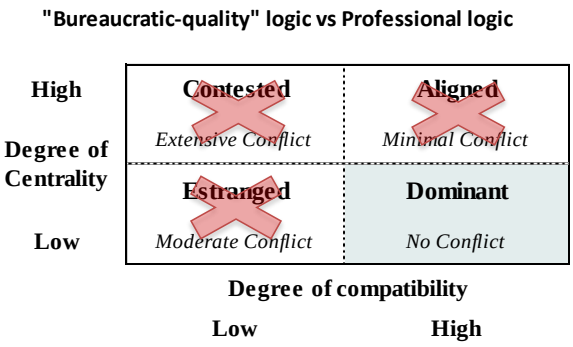
"This process was a good thing to us, physicians. For example, in relation to the prophylaxis of nosocomial infection, it already existed, continued to exist and somehow evolved because other types of norms were arranged to complement this process and physicians learned from it. But there was no change in the procedure of the medical act. The clinical act was done correctly. It was not written, it is true, but it was done and the patients were well treated. The added value was for example the medical team meeting, or weekly or once-daily meetings, not in the ward but in the doctor's office with presentation of clinical cases. This was already done but from then on it was done more regularly." (Service Director – HOSO)

"*It did not change the daily life but there were certain things that were not done and that started to be done, as for example: at the entrance of the block the nurse who receives the patient has a checklist (like an airplane cabin) and there is someone who repeats what she says: the name of the patient, the name of the doctor, will be operated on what, which side, the side is*

marked with pen. Routines were introduced but the nurse who received the patient already had them, but she hadn´t all the questions, it turns out to be a security too for her. The change was made in these small (big, I would say) details." (Dr. P, physiatrist – HOSO)

Therefore, the findings on analyzing this relation between professional logic and the "bureaucratic-quality" logic demonstrates that the degree of centrality is minor, as professional logic players dominate. This takes us to conclude that for the relation between professional logic and "bureaucratic-quality" logic the type of logic multiplicity in HOSO is Dominant (Besharov & Smith, 2014) (cf. Figure 6.4).

Figure 6.4 – Dominant type for professional and "bureaucratic-quality" logics relation



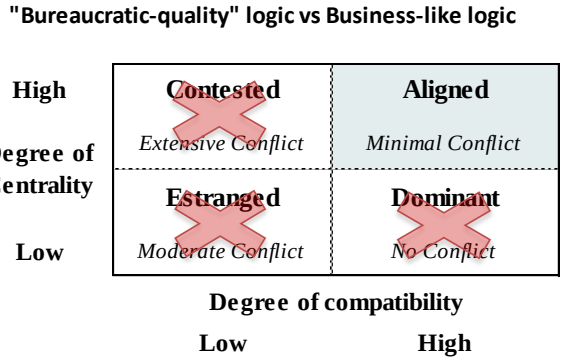
Source: Adapted from Besharov & Smith (2014: 371)

The combination of high compatibility between logics with low centrality, as occurs in this relation, results in the reinforcement of the prevailing logic. Ultimately it can appear that organizations embody a single logic. It is researcher's belief that, after the (natural) initial resistance to a new logic, the high level of compatibility enabled a pacific coexistence that led to the assimilation of the peripheral logic ("bureaucratic-quality") with the dominant logics (professional and business-like) (Besharov & Smith, 2014). The researcher emphasizes that this pacific coexistence is mainly due to the fact that this program did not pinch this professional class's identity, thence not invading clinical actuation. Researcher believes that if the program entered the area of clinical practice, even if the objectives of the two logics were compatible, conflict would be inevitable because the identity of this professional class based on autonomy and independence, would be undermined. Reinforcing this idea, Ryan & Hinings (2009) defend

that in the presence of a logic that is addressed by one part that has a specific knowledge which is crucial to reach the objectives, holds strong identities and power to maintain their independence - as physicians in this study - the maintenance of identities is essential for collaboration to happen (Reay & Hinings, 2019). Therefore, the researcher questions Besharov & Smith's framework because it considers that when the objectives are compatible the types of conflict considered are "minimal" (aligned type) or inexistent (dominant type). As the authors considered three factors that influence the degree of logics' compatibility, the researcher would add the factor identity as a key factor that could block this compatibility between logics.

Analyzing centrality between the business-like logic and the "bureaucratic-quality" logic, the researcher concluded that this relation presented a higher centrality than the previous pair of logics. This is related to the fact that HOSO's administration was extremely involved in the implementation of the program, balancing the two logics. With business-like logic occupied with efficiency and being of Board of Directors concern (cf. van den Broek *et al*., 2014), and with the active contribution that the President of the Board of Directors had in the implementation of this program, the researcher can conclude that these two logics exerted strong influence on organizational functioning. These findings lead the researcher to conclude that in this relationship (between business-like and "bureaucratic-quality" logic) there was a high centrality, and the type of logic multiplicity is Aligned (Besharov & Smith, 2014) (cf. Figure 6.5).

Figure 6.5 – Aligned type for business-like and "bureaucratic-quality" logics relation



Source: Adapted from Besharov & Smith (2014: 371).

In this type of relationship the logics present consistent organizational goals with the two logics exerting strong influence on organizational functioning (*ibid*). As Besharov and Smith

predicted, conflict is minimal, and there is potential for logic blending (i.e, combining multiple logics into a new one). Yet, the researcher cannot guarantee that this blending has already occurred between the business-like logic and "bureaucratic-quality" logic. To accomplish that it would be needed another study focusing on business-like logic in HOSO.

CHAPTER VII - CONCLUSIONS

This chapter presents the main conclusions and implications of this study, its limitations and suggestions for future research. It begins with a general summary of the thesis, and then presents the main theoretical and practical contributions of this study. The chapter ends with the discussion of the limitations of research followed by suggestions for future research.

7.1. Overview of the Study

This investigation focuses its attention at the beginning of 21st century, when Portuguese public sector was starting to feel the impacts of NPM reforms. The Portuguese hospitals were characterized by the existence of two main logics: the professional logic (that exists ever since in health field level) and the "*business-like*" logic that was introduced in Portugal in 1990's, as a result of the societal level movement referred previously [NPM], but that was not felt in health field until 2002. Each of those logics was associated with different organizing principles, which presuppose different behaviors from actors in the field (Reay & Hinings, 2009). Nevertheless, this investigation had not the intent of studying the relation between these two logics (professional and business-like logics). Many studies have already reflected on the introduction of the new business-like logic on Public Administration, mainly in health sector, and the conflicts that it generated (Witman *et al.*, 2011; Llewellyn, 2001; Meyer & Hammerschmid, 2006; Pache, & Santos, 2010; Reay & Hinings, 2005; Scott *et al*., 2000). Notwithstanding, this NPM movement acting at a societal level, emphasized "*the centrality of competition and performance measurement*" within public administration, with hospitals being included in this benchmarking (WHO, 1995: 52). This raised the question of delivering high-quality care services and put on the agenda the question of quality in health services. As a consequence, accreditation programs for hospitals began to be advised as a tool to better quality and better information (WHO, 2000)

In Portugal, this societal trend had its repercussions consubstantiated on field level in 1998 with the disclosure of a new strategy for health "*Saúde, Um compromisso: uma estratégia para o virar do século (1998-2002)*". This strategy assumed quality as a priority and, supported by the European Union (also influenced by the societal trend), originated "Saúde XXI" program,

at the beginning of 1999. This program was financed by the EU funds and there was a specific verb to support hospital accreditation programs. Within this health strategy, IQS turned out to be a field actor extremely important in the dynamics that occurred between the health field and the organizational level. A protocol between IQS and King's Fund was established with the aim to accredit Portuguese hospitals, which gave rise to the Hospital's National Accreditation Program. This accreditation program, which was not compulsory (but voluntary), introduced in hospitals a new logic: the "bureaucratic-quality" logic. The process is categorized as bureaucratic mainly due to the obligation to hold meetings and to complete the standards manual (cf. Pomey *et al*., 2004).

The hospital studied [HOSO] was a specialized hospital that had special features, which made it a "special hospital" (an expression used by all HOSO's collaborators interviewed). In 2003 HOSO volunteered to implement the King's Fund's accreditation process, which was mediated by IQS. Notwithstanding the preparation for this implementation started a few years before by the hand of a physiatrist, who introduced this program to HOSO's President of Board of Directors. These two actors revealed to be key factors for the success of this program implementation.

Framed by this reality and inspired by the literature review on institutional logics perspective the researcher intended in a cross-level dynamics study (Thornton and Ocasio, 2008) in order to be able to understand: (1) how the new institutional logic ("bureaucratic-quality") emerged and developed in the Portuguese public sector of health care (societal level-field level); and (2) why and how was the new logic introduced in HOSO and what were the dynamics associated with the introduction of the new logic at the intra-organizational level (field level – organizational level – individual level).

The first cross-level dynamics analysis (societal level-field level) refers to the pilot study and it was already resumed previously in this chapter. The second cross-level dynamics (field level-organizational level) refers to the main case study and a brief summary of the findings will be addressed hereafter.

Accreditation processes are examples of 'defining work' (Lawrence & Suddaby, 2006) a form of institutional work to create institutions that is related to the activity carried out by actors in order to construct rule systems. In this investigation two actors were studied regarding the institutional work they engaged in this process: Dr. P, the physiatrist and the President of Board

of Directors. Findings demonstrate that Dr. P incurred in institutional work, assuming institutional work as the role actors play and their efforts to interact and influence institutions (Hampel *et al.*, 2017). Dr. P introduced the program in HOSO and led the implementation process by taking the leadership of the Accreditation and Quality Improvement Commission, created to implement the program. By assuming these roles he engaged in a process of effective leadership. He was also the responsible for the choice of the members for the commissions created within this process. These actions reveal the agency role this actor played in this process (Hampel *et al*., 2017; Lawrence & Sudabby, 2006). Nevertheless, the findings indicate that this agency was exercised in social stage (Abdelnour *et al*., 2017), guided by a "*perception of oneness with a group*" (Ashforth & Mael 1989: 35). Dr. P exerted his institutional work also through narratives and rhetoric. He used narratives to explain situations, "*selecting, combining, editing and molding*" those situations to construct a story (Zilber, 2009: 208). He also used persuasive language (rhetoric) to legitimate the process comparing the accreditation manual to the Bible. Dr. P remains as the responsible for the Quality Commission in CHS (the hospital center that congregates HOSO and Setúbal's hospital).

The present investigation also demonstrated that the President of Board of Directors carried out his institutional work through the legitimation of the process. The President was a high respected figure and it was consensual how all interviewees referred to the President as being a person with unusual characteristics in a Director: every day he visited all services, knew all employees by name, and had the door always open and a close proximity to all the employees. These characteristics created in collaborators a sense of recognition, admiration and respect. As many doctors assumed, if this program had not been fully taken over by the President, they might have been able to show some resistance. But when the President takes the lead of one of the committees (Risk) and has an active role in the process, employees believe in the process and follow their leader. He engaged in an effective leadership and stimulated the cohesion among collaborators and promoted close relationships. These findings are in line with literature which argue that leadership is important to the willingness of staff to undertake improvement (Groene *et al*., 2014; Ng *et al.*, 2013; El-Jardali *et al*., 2008; Ferlie *et al.*, 2005)

Professional classes – physicians and nurses – reacted differently to this new "bureaucratic-quality" logic. This investigation demonstrated that physicians were the

professional class who presented most resistance to the program. This is explained both by the scholar formation and also by historical context of the relation between the two classes. Nursing is based on procedures, records, and nurses' education approaches that. Doctors are rarely faced with the need or awareness of clinical records (or at least at the time of this investigation focus – the beginning of 21st century). The other argument to justify the different reactions from these two professional classes is related to the different roles (dominant/ subordinated) of these two classes. Although nursing has reached more autonomy, the subordination of nurses to physicians is a reality in health services (Gadolin, 2017). And these different roles (dominant/ subordinated) create in these two classes a totally different predisposition for managerial approaches that influence the control they have on their work (*ibid*). Nurses did not see it as a threat to their (relative) autonomy, but physicians, in the early days of implementation might have seen this program as illegitimate, due to its strong identification to the professional logic. The findings demonstrated that nurses played a facilitator role in this process, in procedures creation and almost assuming the pulse of this process in services. Although procedures had to be signed by a physician, the service Director, the Chief-nurse played a crucial role in procedures creation. This is explained also by the nature of procedures, mainly in first accreditation, which was related to hospitals structural organization. It did not enter in the medical act.

This question of not entering in the medical act was also the justification this investigation identified for physician's position towards this program. In the early days there were reports of some resistance, especially with regard to the transition from a verbal culture to a written culture. In this hospital there was the aggravation that the doctors are all orthopedic surgeons which conditions the receptivity to administrative / bureaucratic processes. However, the fact that this process did not enter the medical act preserving the identity and autonomy of these professionals facilitated the process of acceptance. Reay and Hinings (2009) explain that collaboration can exist even when one of the parties is characterized by a strong identity based on their autonomy and clinical freedom, as with physicians (Doolin, 2002). This collaboration is only possible when the independence of these professionals is assured. That is what happened at HOSO, as this accreditation process did not pinch the doctors' independence.

Findings demonstrated also that this new "bureaucratic-quality" logic presented goals that were compatible (if not intrinsic) to the other two dominant logics – professional and business-

like. Even if the means were not the same, they do not condition the compatibility among logics when goals are compatible. This reality enabled a relation between logics with minimal or non-existing conflict (Besharov & Smith, 2014). The special features that HOSO presented, such as special leadership and group cohesion enhanced the degree of compatibility between different logics *(ibid)*. According to Besharov and Smith recommendation the co-existing logics were analyzed in pairs: "bureaucratic-quality" logic and between "business-like" logic and "bureaucratic-quality" logic. It was demonstrated that in both relations there was no conflict.

The next section discusses the main theoretical and practical contributions and implications of the present investigation.

7.2. Theoretical and Practical Contributions

7.2.1. Theoretical Contributions

Firstly, most empirical studies focus on one level solely, emphasizing the individual agency, for individual level, the internal organization dynamics, for organization level, or the dynamics at the field or societal level, for field/societal level analysis. As this investigation contemplates the study of institutional logics, the researcher opted by a cross-level dynamics study as it enables to study the relations between the different levels (individual, organizational, field and societal) (Thornton and Ocasio, 2008). By taking a cross level analysis researcher was able to explain how institutions both enable and constrain action (Thornton *et al*., 2012) and by bridging these different levels of analysis this study responds to the numerous calls for cross-level research in institutional theory (Thornton *et al*., 2012; Battilana & Dorado, 2010). By taking this approach in this investigation it was possible to understand the dynamics between the different levels. As Thornton *et al*. (2012) argue it is essential to understand how actors change institutions in the context of being conditioned by them. This study showed how the organization features conditioned the implementation of the accreditation program and the institutional work accomplished by Dr. P and the President of Board of Directors, but is also demonstrated that those features were a result of actor's work. The group cohesion that was referred and the strong feeling of unity was a result of actors work. By taking this cross-level analysis it was also possible to understand how a societal trend gets embedded by field-level and how this is

transmitted to organizations in micro-level. By doing this exercise of interaction between levels this investigation contributes to get a fuller understanding about the interactions and dynamics between the societal, field and organizational levels.

Secondly, this investigation contributes to institutional logics perspective by suggesting the inclusion of identity in explaining the co-existence of multiple logics over time. When analyzing and using Besharov and Smith's (2014) framework, and crossing it with Reay and Hinings (2009) findings on collaboration, the researcher identified that the framework should consider a situation where compatibility between logics is not possible, even if the goals of the two logics are consistent and coherent. Reay and Hinings (2009) concluded that in the presence of a logic that is addressed by one part that has a specific knowledge that is crucial to reach the objectives, holds strong identities and power to maintain their independence - as physicians in this study - the maintenance of identities is essential for collaboration to happen. The researcher suggests the following condition to be added to the Besharov & Hinings (2014) framework: in the presence of a logic that is addressed by one part that has a specific knowledge that is crucial to reach the objectives, holds strong identities and power to maintain their independence, compatibility between logics is only possible if identities are maintained and preserved. In this investigation it was clear for the researcher that, if physician's autonomy and independence - identity - had not been preserved, i.e., if the accreditation program had procedures concerning the medical act, physicians would have resisted/ block.

Thirdly, this investigation by combining two important streams in institutional theory - institutional work and institutional logics - makes a theoretical contribution to the knowledge on how logics change with the institutional work carried by actors, as Gawer and Phillips (2013) call for. This study contributes to the knowledge on "*how actors work to influence shifts in the logics of their fields and how they are affected by those shifts*" (Gawer and Phillips, 2013: 29). Although in this particular case there was not a change in logics, due to the fact that the new logic had goals that were intrinsic in the already existing logics, this study addresses the main call made by the authors when investigating the dynamics between individual-level and field-level. This study also contributes to a theme that Hampel *et al*. (2017) consider as not well explored in institutional work which is the field-level logics.

Forthly, the researcher hopes that this case study provide insights into how the politics associated with the NPM movement impacted hospitals and individuals, answering to calls from Hood & Peters (2004), Kurunmaki (2009) and Cruz (2013). This investigation has shown that these accreditation programs were a result of the NPM movement and described how those pressures were internalized by the organization and collaborators. Most of empirical studies on this area regard the emergence of the business-like logics in hospitals.

Finally, this study is related to the theme of standards and institutional work. Slager *et al*. (2012) highlight the fact that despite the major role standards play in today's society, assumed by the generality of scholars and public, institutional work on their formation is almost inexistent. Standards offer a rich context to investigate institutional work due to the contestation and debates that usually rise around them, exposing different actions and strategies used by different actors. This study exposes the reaction of a hospital to an accreditation program, based in standards. Therefore it contributes theoretically to this theme.

7.2.2. Practical Contributions

Some practical implications have resulted from this investigation.

The first one is addressed to hospital professionals as this study demonstrates that accreditation programs in hospitals do not interfere with physician's identity, respecting their autonomy and independence. It should be noted that this study focuses at the beginning of the 21st century. However, and according to the recent manuals to which the researcher had access, this requirement remains. With regard to the nursing class, these programs can be a challenge for professionals who accept to actively participate. The researcher had access to several current procedures, most of which were authored by nurses. This accreditation process, ultimately, may give visibility to these actors.

The second practical contribution comes from the resistance demonstrated in the implementation of the program by physicians. In their academic training doctors are never exposed to or sensitized to topics such as quality and patient safety in general. They have contact with the issue of infection control but are not aware of issues that will later be important in their daily lives. The study suggests that it might be important to incorporate in the training of doctors,

a curricular unit that addresses these themes, so that the awareness begins to be made during the scholar years. This would help to prevent major resistance in hospitals towards the implementation of quality programs.

Finally, the study revealed that the role of planning and programming the national policy for quality in health care sector as well the evaluation and certification of the quality of those services should be allocated to different entities. In fact, currently, the DGS accredits hospitals through the ACSA model, concentrating on itself all these range of activities. Yet this does not give any sense of guarantee and impartiality. Thus, an impartial organism, independent, should be created with the contributions and representations of professional orders and associations with the aim to ensure the transparency and guarantee of quality patient care.

7.3. Limitations of the Research

The researcher is aware that this study presents some limitations.

The first one derives from the fact that it is an intensive and single case study (cf. Yin, 2018). For that reason, the researcher did not undertake a comparison with other accredited hospitals. This was not possible within the time limit that the researcher had to conclude this thesis. For this reason, the findings from this study do not provide basis for generalization (*ibid*). Therefore, more cases should be replicated, although the sense of union that this hospital achieved in those days seems to have vanished. The transformations that this sector had gone through, especially with the corporatization of hospitals, generated large center hospitals, where the sense of belonging that was so much reported in the interviews is difficult to find. Replications should be done with similar cases of hospitals that were accredited at the beginning of the century.

The second limitation of this study concerns the fact that some of the people who experienced this accreditation program in HOSO were no longer working there and some were already retired. Fortunately, the researcher was able to contact and meet some of the key actors that, even though retired or working in other organizations, were available to contribute to this study with their precious knowledge and experience.

7.4. Suggestions for Further Research

In this study the researcher partially uncovered a theme that has been absent from literature - the role that emotion has on institutional dynamics (Jarvis, 2016). The approach was made in an attempt to justify the reasons that led Dr. P to take this process as a mission and why he was always at the forefront of the process. The researcher argues that more studies about emotions related to institutional actors with a social position (that may be) less recognized in organization life are needed to account for sustained conclusions. This suggestion is aligned with the vision that Hampel *et al.* (2017) present on institutional work considering that it evolved from a concept to a perspective. In the beginning the aim was to capture actions that institutional research described but now, institutional work focus on understanding the relationship between institutions and actors. The authors believe that innumerous possibilities are arising with individual-level studies, and give special focus to the unexplored role that emotions play in the interaction between actors and institutions

A second suggestion is related to the gap the researcher identified in Besharov and Smith's (2014) framework. The researcher suggested that this framework should contain a condition when one of the parts has a specific knowledge that is crucial to reach the objectives, holds strong identities and power to maintain their independence. This condition is the preservation of identities. Without this preservation compatibility between logics is not possible. The researcher suggests further research to validate her assumptions.

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DL nº35/ 2012, February 15th - Redefines Health System Central Administration's (ACSS) assignments

Despacho" nº 69/2009, August 31st – Adoption of ACSA as "national and official accreditation model"

Despacho nº 14223/2009, June 24th - Approves the Health Quality National Strategy

DL 234/2008, December 2nd - first amendment to DLs Nos. 212/2006, of 27 October, which approves the Organic Law of the Ministry of Health, and 219/2007, of 29 May, which approves the organic of the Central Administration of the Health System, Transferring the competences attributed to the Central Administration of the Health System, IP (ACSS), in quality matters, to the Directorate-General of Health (DGS) and setting the way to terminate the Partnerships

DL nº 219/2007, May 29th - Approves the organic of the Central Administration of the Health System, I. P. (ACSS)

DL nº 212/2006, October 27th - Approves the Organic Law of the Ministry of Health and the Dissolution of IGIF

DL 233/2005, December 29th – Creation of three new hospital centers assuming an EPE legal status

DL nº 93/2005, July, 7th - Turns SA hospitals into public business entities (EPE)

DL nº309/2003, December 10th - Creates the Health Regulatory Authority (ERS)

Ministry Council Resolution nº15/2003 -Creates a mission unit called "Hospitais SA" to coordinate the global launching process and hospital business strategy with the legal nature of exclusively public limited companies

Law nº 27/2002, November 8th -Approves the new legal regime for hospital management and makes the first amendment to Law 48/90 of 24 August

DL nº 185/2002, August 20th - Frames the establishment of public-private partnerships under a private management and financing regime, in which the forming principles and instruments are established

Ministry Council Resolution nº 27/2000, May 16th - Defines QCAIII management structures

Portaria nº288/99, April 27th- Creates, within the Ministry of Health, the Institute of Quality in Health (IQS).

Ministry Council Resolution nº 13/96, February 8th – Created the Health Reflection Council (CRES) with the aim to study and submit proposals for health reform

DL 308/93, September 2nd -Approves the organic of the Health Informatics and Financial Management Institute (IGIF)

DL nº10/93, January 15th - Approves the Organic Law of the Ministry of Health

DL nº11/93, January 15th - Approves the Statute of the National Health Service

Law nº 48/90, August, 24th - Health Basis Law

DL nº 254/82, June 29th - Establishes Regional Healthcare Administrations

DL nº.704/74 of December 7th, determined that the hospitals from 'Misericórdias' started to be managed by commissions that were appointed and responded to the Secretary of State

DL nº 584/73 of November 6th, the MoH became autonomous in relation to Assistance

DL nº 414/71 of September 27th, established the legal regime that would allow the progressive structuring and the regular operation of professional careers for the different differentiated groups of employees who were working in the Ministry of Health and Care

DL nº 413/71 of September 27th, the right to health for all citizens was recognized for the first time, but limited, to the human, technical and financial resources availability

DL Nº.48358/ 68 of April 27th stablished the General Regulations of Hospitals

DL Nº.48358/ 68 of April 27th stablished the General Regulations of Hospitals

DL Nº.48357/ 68 of April 27th created the Hospital Statute

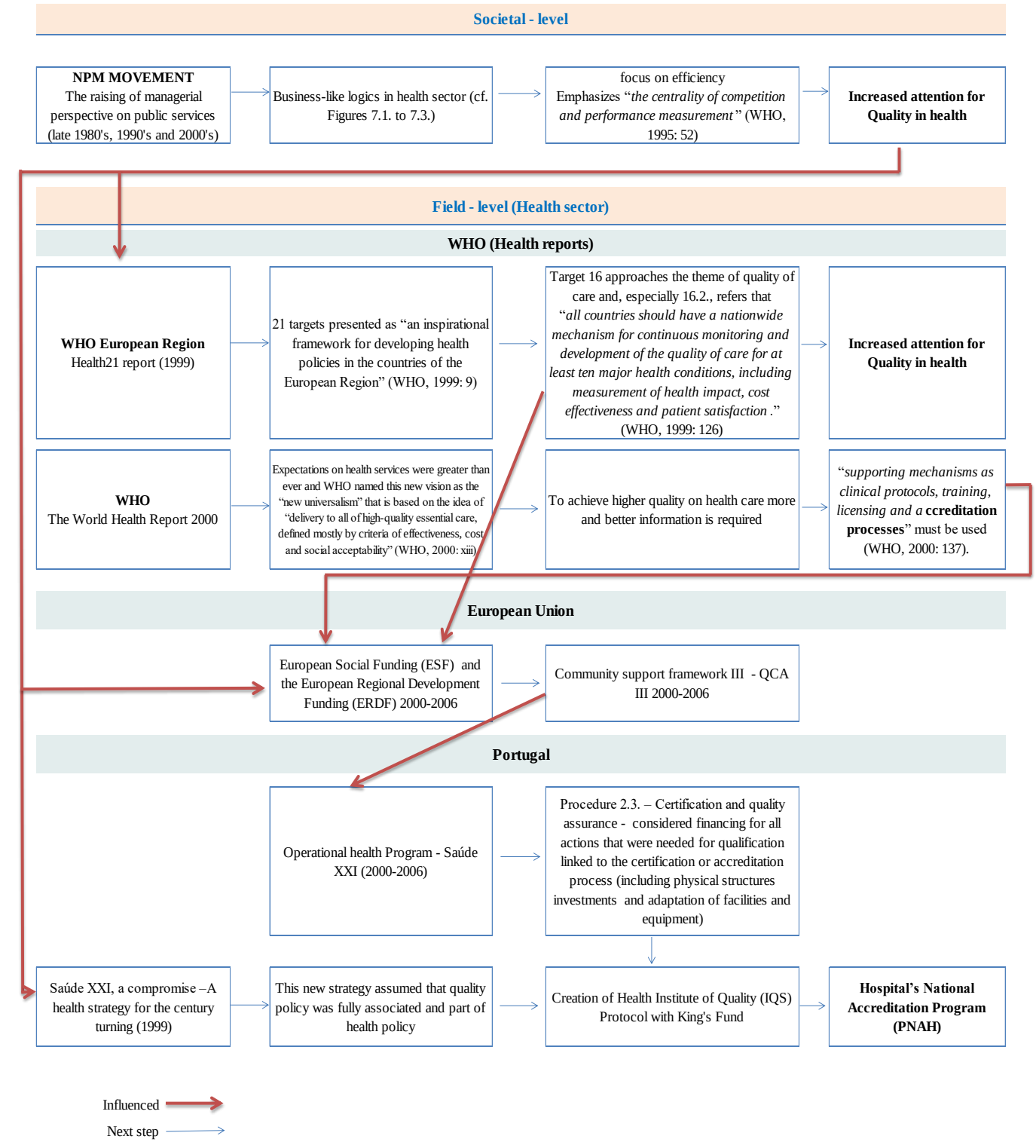
Law No.2120/ 63, of July 19th, promulgated the bases of health and care policy, assigning to the State, organization and maintenance of services that could not be delivered to private initiative

DL No. 41825, of August 13th (1958), the protection of public health services and public assistance services are transferred from the Ministry of the Interior, to the newly created Ministry of Health and Assistance

Law no.2011 of April 2nd (1946), establishes the organization of the existing health care services, laying the foundation for a hospital network

APPENDICES

Appendix I - The raise of Health Quality concern in the world (Societal-level), in Europe and in Portugal (Field-level, concerning the health sector)



Appendix II – Theoretical Framework of study

Theoretical Frameworks to be used in this investigation

How the new "bureaucratic-quality" logic was introduced at the field level (Health) and at organization level (Hospital)

Theoretical Framework: Institutional work theory

Field level	**Organization/ Individual level**	
Health sector	Hospitals	
Pressures applied by institutions to individuals and organizations, which result in conformity and compliance (e.g., DiMaggio&Powell, 1983)	Ways institutional entrepreneurs transform institutions (e.g., DiMaggio, 1988)	Materialization (Jones & Massa, 2013)
WHO Reports and advices	Dr. P (Physiatrics) – IW	"heroic institutional change agent" (Voronov&Vince, 2012)/ "actor" ("more social image of actors and agency" (Hampel et al., 2017: 24)
	Dr. P (Physiatrics) – Emotions	justifies assuming control ?
	President of Board of Directors – IW	Legitimacy
EU Funds - QCA III		
PT - Saúde XXI		
IQS		
Protocol Kings Fund		
Hospital's national accreditation program - PNAH		

Through the writing of procedures; the (good) practices that were done in HOSO became visible through the writing
The security signing, information visible (organograms, service scales, etc...), praise and criticism, accreditation seal
Posters

How the new "bureaucratic-quality" logic co-existed with the professional-logic (physicians and nurses) and the business-like logics (introduced by NPM movement)

Theoretical Framework: Institutional logics perspective

Societal level	NPM global movement	**Business-like logics** in Public Administration and in Health sector
Field level Health	WHO reports	**Business-like logics** and increased attention for quality in health assuming that "supporting mechanisms as clinical protocols, training, licensing and **accreditation processes**" must be used, introducing the **"bureaucratic-quality" logic** in the field
	EU Funds	QCAIII - considers financing for accreditation processes - **"bureaucratic-quality" logic**
	PT	Saúde XXI strategy - **"bureaucratic-quality" logic**

Organization level Hospital	Health Professionals	Professional logic	**Multiple Institutional Logics**	Besharov & Smith Framework (2014)	Professional logic vs "Bureaucratic-quality" logic	Dominant	**Assimilation** (Besharov & Smith, 2014)
	Board of Directors	"Business-like" logic					
	Whole organization	Introduction of a new "bureaucratic-quality" logic			"Business-like" logic vs "Bureaucratic-quality" logic	Aligned	**Blending ?** (*ibid*)
Individual level Professional classes	Physicians	Most dificult professional class: Physicians		first impact: resistance to the process due to disbelief	Close relationships and interdependency between members (Beshavov & Smith, 2014)		Creates motivation to face multiple logics in more compatible ways (Besharov & Smith, 2014)
		their autonomy was preserved as the program did not enter the medical act		resistance due to the lack of time, to writing in diary - Surgeons Orthopedists don't like to write			
	Nurses	Major allied of this process. Used to procedures, writing diaries.		Some resistance at first, due to the amount of bureaucratic work needed			

Appendix III – Resume of the interviews conducted in this research

Date	Duration	Referencein thesis
08/03/2012	2	Finance Director -HOSO
21/03/2013	2	Profª ENSP
28/03/2012	2	Finance Director -HOSO
10/04/2012	1,5	CHS's Quality Coordinator 2005/2013
24/10/2012	2	Finance Director -HOSO
20/11/2012	1	Dr.P, Physiatrist - HOSO
06/12/2012	1,5	Dr.P, Physiatrist - HOSO
02/04/2013	1	IQS's deputy director 2000-2005/ Director 2005/06
23/12/2013	1,5	Health Ministry (2001/02 - XVII Government)
10/11/2017	2	President of Board of Directors - HOSO
21/11/2017	3,5	Chief-nurse 1 - HOSO
22/11/2017	1,5	HOSO's Quality Commission
23/11/2017	2,5	Coordenadora do Modelo de Acreditação do Ministério da Saúde de Portugal/
23/11/2017	1	DGS's Accreditation program Operational
24/11/2017	1	DGS's Quality Director
29/11/2017	2	CHKS's client manager
06/12/2017	2	IQS's Deputy Director 2000/05 IQS's Director- 2005/06
07/12/2017	2	IQS's Director (2000/05)
18/04/2018	2	Administrative of quality commission -CHS

Date	Duration	Referencein thesis
09/05/2018	2	Quality Enhancing Element - HOSO
21/5/2018	2	President of Board of Directors - HOSO
28/05/2018	2	Dr.P, Physiatrist - HOSO
07/06/2018	2	CHKS's auditor/ Quality Responsible - Almada's Hospital
12/06/2018	2	CHKS's auditor/ Nefrologist in HSB
05/09/2018	2	Radiology Technician (TR) and Quality Enhancing Element - HOSO
07/12/2018	2	Physician1 - HOSO
12/12/2018	1	Physician2 - HOSO
12/12/2018	1	Physician3 - HOSO
23/05/2019	1,5	Quality Commission - CHS
17/06/2019	1,5	Board of Directors - Director nurse - HOSO
17/06/2019	1,5	Physician4, Service Director - HOSO
19/06/2019	1	Chief-nurse 2- HOSO

Total/hours	**55,5**

Appendix IV - Main laws in health sector analyzed

29/06/1982	Decree-Law n.º 254/82, June 29th	Creation of ARS's
24/08/1990	Law nº 48/90, August, 24th	Lei de Bases da Saúde
15/01/1993	Decree-Law nº11/93, January 15th	new NHS statutes
15/01/1993	Decree-Law nº10/93, January 15th	Extinguish of SIMS and DGFSS (que deram origem ao IGIF)
02/09/1993	Decree-Law 308/93, 2nd September	Creation of IGIF
27/04/1999	Portaria nº288/99	Creation of IQS
16/05/2000	Ministry Council Resolution nº27/2000, May 16th	QCAIII
08/11/2002	Law nº 27/2002, November 8th	31 SA Hospitals
05/02/2003	Ministry Council Resolution nº15	Hospital Mission unit creation
10/12/2003	Decree-Law nº309, December 10th	Creation of ERS
07/07/2005	Decree-Law nº 93/2005, July, 7th	SA turn into EPE Hospitals
27/10/2006	Decree-Law nº 212/2006, October 27th	Extinguish of IGIF and IQS
29/05/2007	Decree-Law nº 219/2007, May 29th	Creation of ACSS
02/12/2008	Decree-Law 234/2008, December 2nd	Creation of Health Quality National Strategy

Appendix V – Narratives, rhetoric and "business-like" terms analysis of government's programs between 1991 and 2002

Statements in XII Government Program (1991-1995) indicating business-like logics in Public Administration

Representative statements in XII Government Program (1991-1995)	How business-like logic is sustained by Government statements
*Administrative modernization will take place with the **market economy in mind**. There will be a reframing of the Public Administration missions in the light of the **decentralization, regionalization, deconcentration and privatization processes** in order to make it possible to bring services closer to citizens and provide a **better product at a lower cost** to society.*	The use of "business" narrative, that was inexistent in health sector: decentralization, regionalization, deconcentration and privatization; Market economy in mind Services seen as products that should be provided at a lower cost
*Coordinated **deconcentration measures** will also be deepened in the Public Administration, in a coherent articulation with the **policies of regionalization and decentralization**, bringing services closer to the population.*	The use of "business" narrative, that was inexistent in health sector: decentralization, regionalization, and deconcentration
*The government action will address a permanent, gradual, **decentralized** and selective **reform of the state, reducing its weight, providing competition between private entities**, humanizing their services and establishing **mechanisms to ensure control of the quality and cost of services to be provided**.*	The use of "business" narrative, that was inexistent in health sector: decentralization, weight reduction, and competition; control of quality and costs
*It is intended a more **decentralized Health System**, organized according to Functional Health Zones that respect the institutional interrelationships, and enhance the existing means.*	The use of "business" narrative, that was inexistent in health sector: decentralization

Source: Original, elaborated with information from XII Government program (Portugal, 1991)

Statements in XIII Government Program (1995-1999) indicating business-like logics in Public Administration

Representative statements in XIII Government Program (1995-1999)	How business-like logic is sustained by Government statements
Budgetary rigor will lead to more careful expenditure management, with increasing economy, effectiveness and efficiency, achieving better quality and productivity in service delivery and meeting collective needs.	The use of "business" narrative, that was inexistent in health sector: efficiency, effectiveness, budgetary rigor, economy
Replace controls "a priori visas" by reinforcing management audits and "ex post" controls, both on the legality of acts and on the optimization of management processes and the results achieved.	The use of "business" narrative, that was inexistent in health sector: management audits, optimization of management processes and the results achieved
Creation of an entity directly responsible for the debureaucracy and modernization of the public administration, whose immediate task will be to conduct a debureaucracy action,simplification and administrative reform according to priority areas, with institutional or mission structures of the smallest size and high operability;	Creation of an entity to conduct debureaucracy of public administration
Promoting effective public management based on the sector's effectiveness, efficiency and productivity;	The use of "business" narrative, that was inexistent in health sector: effectiveness, efficiency and productivity
Increasing objective and results-oriented participatory management, motivating productivity and combating waste through the creation of cost-benefit assessment processes	The use of "business" narrative, that was inexistent in health sector: objective and results-oriented participatory management
Improve the functioning and increase the efficiency of hospitals and health facilities by providing them with new management models based on their administrative and financial autonomy and establishing, in parallel, accountability mechanisms for their management bodies.	Increase the efficiency of hospitals; New management models based on autonomy and accountability mechanisms
Achieve effective decentralization in health service management and local care planning by transferring broad competences to regional health administrations, which will tend to function as funding entities, endowing them with financial resources fixed on a capitalization basis, varying according to demographic and regional mobility criteria.	The split between provider and financier functions (regulator State)
Review the status of hospitals and health centers for greater management autonomy, including the organizational model, financing and accountability to the community;	New management models based on autonomy and accountability mechanisms
Realize an effective decentralization in the management of health services and local planning of the care to be provided to the population, by transferring broad competences to the Regional Health Administrations, which will tend to act as financier	The split between provider and financier functions (regulator State)
Studies should be regularly published on the costs of providing healthcare versus their effectiveness, including assessing the quality of benefits.	Measurement is a caracteristic of NPM

Source: Original, elaborated with information from XIII Government program (Portugal, 1995)

Statements in XIV Government's Program (1999-2002) indicating business-like logics in Public Administration

Representative statements in XIV Government Program (1999-2002)	How business-like logic is sustained by Government statements
The foundations of health reform are laid, based on the profound and structuring modernization of the organization and ***management*** *of the NHS, with* ***substantial support for the good functioning of*** *the social and* ***private sectors****, framed by explicit objectives and by consensus to improve health*	The explicit support to private sector that was seen as essencial for the good functioning of NHS
The current and proposed work of the Government requires a thorough ***reform of the Public Administration in health,*** *a* ***new working relationship with*** *the social and* ***private sector****, a policy for the health professions.*	Reform of Public Administration in Health that opened doors to private partnerships, aligned with the NPM idea of less State, more entrepreneurial State
Only then will it be possible at the same time to guide the country's effort to guarantee everyone access to health and to have a ***financially sustainable health system,*** *given the* ***country's current economic and budgetary conditions***	The use of "business" language, that was inexistent in health sector; the efficient use of resources (regulator State)
The NHS is not simply an element of the health system. It is certainly its structuring component. However, the social and ***private sectors are also of fundamental importance.*** *High* ***priority should be given to newly launched initiatives*** *which clearly and transparently define their role and support their effective implementation*	Reform of Public Administration in Health that opened doors to private partnerships
Distinction between financier entity*, already set,* ***and entities providing health care,*** *with the* ***creation of a public institute*** *of finance that will have the specific task of overall management of the funding system*	The split between provider and financier functions (regulator State)
Autonomy of management of hospitals, *health centers and local health systems, allowing* ***effectiveness, accountability*** *and humanization, acting in parallel with non-profit institutions or* ***private companies*** *that provide services to the NHS*	The use of "business" language, that was inexistent in health sector; private sector seen as a partner to public health

Source: Original, elaborated with information from XIV Government program (Portugal, 1999)