Reasons for Bureaucracy in the Management of Portuguese Public Enterprise Hospitals – An Institutional Logics Perspective

Helena Costa Oliveira[a]*, Lúcia Lima Rodrigues[b] and Russell Craig[c]

[a] *Porto Business and Accounting School, Polytechnic of Porto, Porto, Portugal;* [b]*School of Economics and Management, University of Minho, Braga, Portugal;* [c]*Durham University Business School, Durham University, Durham, United Kingdom.*

*Rua Jaime Lopes Amorim, s/n, 4465-004 S. Mamede de Infesta, Porto, Portugal,

helena@iscap.ipp.pt, 0000-0001-5839-168X

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There is widespread perception that bureaucracy is omnipresent in Portuguese health care management. This is despite bureaucracy being heavily deprecated. This paper addresses this dissonance by studying the Portuguese Public Enterprise Entity Hospitals context. It seeks to understand how a bureaucratic approach prevails. The study is based on document analysis and extends the Institutional Logics Perspective to the health care context. Three institutional logics were observed: State, community, and profession. The need to resolve conflicts between the different logics induces a neo-bureaucratic approach to management. This paper contributes by identifying the institutional drivers of bureaucratic logic in health care settings.

Keywords: Health Care Management, Institutional Logics Perspective, Neo-Bureaucracy, Portugal.

Introduction

Portuguese public health care management is perceived overwhelmingly as being bureaucratic — a feature that is considered to hinder good management. However, for some, bureaucracy is still considered a proper management method in health care (Schofield, 2001).

The purpose of this paper is to understand how the institutional context justifies bureaucracy in Portuguese Public Enterprise Entity Hospital (PEEH) management and prompts a neo-bureaucratic culture. The paper explains how bureaucracy persists, in a neo-bureaucratic form, in the PEEH, by using the Institutional Logics Perspective (ILP) (Thornton et al., 2012). Such an approach is attuned to dealing with the heterogeneous and dynamic context of health care services.

The use of an ILP allows to go beyond strict institutional factors, pay attention to their particular logics and relationships and acknowledge the intrinsic ambiguity of any social reality. An ILP is based on the observation of several institutional orders and their

dialogical process. These orders have institutional logics that are shaped by cultural beliefs, goals, norms, rules, and practices that structure cognitive behaviour and decision-making (Friedland & Alford, 1991; Thornton et al., 2012). The ILP provides an interpretative institutional scheme that recognizes the individuality of social actors and avoids a deterministic view of any social reality. For these reasons, an ILP is understood as a metatheory and not as a theoretic framework to be tested.

The other concept used is bureaucracy. This management method was originally characterized by rationalization concerns, the division of labour, and the institution of rules and regulations defined by an organization's guiding authority (Weber, 1922). According to this view, bureaucracy represents a process of formalizing practices and anchors them in organization-specific rules and formal procedures (Stinchcombe, 1959). The original concept of bureaucracy has evolved to the concept of neo-bureaucracy (Farrell & Morris, 2003) — a bureaucracy in which there are informal means of communication and greater concern for the creation of a collaborative organizational culture.

This paper presents reasons for the persistence of bureaucracy in the PEEH and seeks to demystify bureaucracy. This study identifies the relevant institutional orders of PEEH context, characterize the institutional orders in terms of bureaucracy, and find that the most relevant is the State. In doing so, the paper contributes to the understanding of how institutional context explains the bureaucratic logic of the Portuguese PEEH with a more acute understanding of decisive socio-cultural variables and set points of comparisons for other hospital organizations. It also contributes by extending the ILP through a framework adopted to bureaucracy.

Next section presents a literature review. This characterizes the context of emergence of the PEEH, relates it to the subject of bureaucracy, and presents the ILP and its

application in the health care context. Then the study outlines the research method adopted. Thereafter, based on the ILP, the paper presents the relevant institutional orders and characterize their logics, as they relate to the bureaucracy. Then it is discussing the institutional reasons that justify bureaucracy in the management of a PEEH and conclude.

Literature Review

The emergence of Public Enterprise Entity Hospitals in Portugal

In the 1990s, bureaucratic culture in hospital management was identified as the main barrier to efficient administration. Public hospitals maintained a centralist culture of governance. This entangled them in a bureaucratic and command/control web that led to high spending and debt accumulation.

To face these shortcomings, the Portuguese State introduced enterprise management to public hospitals (Law 27/2002). Following the principles of New Public Management (NPM), hospital management was required to assume a higher degree of responsibility and accountability from managers (Harfouche, 2008). The intent of Law 27/2002 was to shake-up the established order by arranging the health care system in a network of health providers who were dependent on a state budget-funded contract (OPSS, 2003). This meant a separation between the financing agent (Ministry of Health (MH)) and the providing agent (hospital). Law 27/2002 was also intended to foster a market logic, based on hospital autonomy. This approach turned public hospitals into "joint-stock companies" with publicly-owned capital. However, in 2005, there was a legal change: hospitals would be known as "public enterprise entities". Hospitals were to have greater administrative, financial and patrimonial autonomy (Decree-Law 93/2005). This transformation prompted user and client interests above ministerial concerns (Egeberg & Trondal, 2009).

However, this approach failed to consider the unrepresentative nature of most clients (Peters & Pierre, 1998).

The financing model that was promoted depended on program contracts that set objectives and quality criteria. This aimed to regulate health demand by strategically distributing it among diverse public hospitals. Decision-making, service acquisition and hiring human resources became faster: these activities were no longer under the direct administration of the State (Rego et al., 2010), despite state regulation of them. Such autonomy implied managers acted according to the procedures outlined in the Statute of the Public Manager (SPM) (Decree-Law 71/2007). Regular accountability, such as through monthly publication of the "Tableau de Board", was required. Incentives linked to the performance of management practices were now considered a motivating tool. Thereby, this was claimed to contribute to increased quality, efficiency and user satisfaction.

The process of public hospital transformation into PEEH reflected a will to cut bureaucracy in hospital management. The change sought to reconcile management autonomy with government supervision and to strengthen the regard for economic rationality (Barros & Simões, 2007). However, for some observers, the health governance model has merely changed from a bureaucratic/administrative one to a business-centred one. The PEEH was perceived as representing a stricter guidance by the Ministry of Finance (MF) and the MH. This corroborated the idea that, apart from the legal status of the hospital, everything remained the same in hospital management (Abreu, 2003). The legal transformation of hospitals into the PEEH was not accompanied by decentralization at an intermediate level. The bureaucratic *modus operandi* continued, with little transparency, and with high dependence on different professional groups (OPSS, 2009). The governance system for the PEEH was still very central, with many decision-making

responsibilities retained by top management. There were no productivity bonuses. Nor was there freedom to hire. Though the government tended to move away from management and planning functions, this was countervailed by its reinforced role as health system regulator (Simões, 2004).

The main problem with the reform was the imposed rules that undermined management. This is a common problem of Portuguese public administration: too much bureaucracy at the level of practice, routine and procedure; and paradoxically, a lack of bureaucratic responsibility and ethics. Despite political efforts to reduce bureaucracy, legislation to change the behaviour of administration officials and agents has proved insufficient and ineffective.

The persistence of bureaucracy is not specific to the Portuguese public administration. In centralized political systems (e.g., France), power is an accepted fact and the role of bureaucracy in establishing and maintaining state power is recognized (Peters & Pierre, 1998). Despite the changes driven by NPM reforms, bureaucracy was reinforced (Kettl, 2000). For example, after NPM-type reforms, the Italian public administration remained a bureaucratic model (Tomo, 2019). In the UK, despite the transfer of many aspects of bureaucracy in service delivery agencies to auditing and control agencies, the overall system was no less bureaucratic (Barberis, 1998). In the British public service, competitive pressures and increased reliance on performance management and monitoring are new modes of central control and formalisation that depart significantly from the ideal of post-bureaucratic organization (Farrell & Morris, 1999). The PEEH, developed in line with the NPM, also reflects the persistence of bureaucratic logic. What has been observed is a "continued dominance of bureaucratic values within public sector organisations, despite the post-bureaucratic discourse of NPM and the changing political and economic context" (Parker & Bradley, 2004, p. 211).

Instead of a shift from bureaucracy to post-bureaucracy, what is observed is a neo-bureaucracy in which change is not associated with less control but with different mechanisms of control.

The Institutional Logics Perspective in the health care sector

The ILP goes beyond legitimation theories that characterize neo-institutionalism. Central to this development is the understanding of an institution as an objective reality. An institution has symbolic and practical expression and provides stability and meaning to social life (Thornton et al., 2012).

Core institutional orders are proposed. Each order has particular logics that shape organizational preferences, interests and behaviours. Five institutional orders were identified by Friedland and Alford (1991) (capitalist market, bureaucratic state, democratic regime, nuclear family, and Christian religion). Thornton (2004) considered six (market, corporation, profession, state, family, and religion). Thornton et al. (2012) added one more (community). Such institutional pluralism is justified by the need to understand concomitant practices and beliefs. It should consider distinct institutional orders, with their interrelated identities and logics, because they frame individual and organizational behaviour (Friedland & Alford, 1991; Thornton et al., 2012).

Thornton and Ocasio (1999) defined institutional logics as social constructs through which individuals produce and reproduce their material subsystems, organize time and space, and find meaning. Each institutional order promotes its logics, with organizing principles that enhance certain behaviours that may conflict with others. An institutional logic is an information filter (Prahalad & Bettis, 1986) and a provider of a particular rationality that has material and symbolic representation. Institutional logics should not be considered as "good or bad", just as a system of beliefs and practices that privilege certain practices and organizational adjustments (Styhre et al., 2016).

The ILP represents an integrative approach to social life in its structural, normative, and symbolic dimensions. In a plural environment, individuals and organizations develop different identities according to the institutional orders that prevail (Kraatz & Block, 2008). The ILP recognizes the coexistence of multiple social identities in individuals and organizations, and recognizes that individuals and organizations also affect the ruling institutions. This approach allows determination of whether the causes of institutional change are structural or results from social agency.

The ILP imposes itself as a metatheory that avoids a deterministic behaviour-based explanation, and addresses organizational cultural heterogeneity (Lounsbury, 2008). To this end, it outlines the relevant institutional orders of a socio-cultural context with the corresponding institutional logics, providing a method of interpretative analysis of reality. These orders are proposed as ideal types with a set of categories of analysis (such as sources of legitimacy, informal control mechanisms, sources of identity, root metaphor, basic norms, sources of authority, economic system, basis of attention and strategy) to understand institutional logic (Thornton et al., 2012).

Distinct institutional logics interrelate in various ways. Sometimes there is a relationship of complementarity; and at other times, of competition. Syntheses or transfers may arise between different logics, or a dominant logic may arise to overrule others. The contradiction between multiple institutional logics enables individuals, groups, and organizations to transform identities, organizations, and societies (Friedland & Alford, 1991). So, individuals and organizations can exploit these contradictions and mobilize different logics in favour of one that supports their interests (Greenwood et al., 2011). Moreover, not all individuals relate to these logics equally. Some individuals have different access to knowledge and information, or they activate this knowledge in different ways. The maintenance of a logic depends on the behaviour of people and

interactions in the organization (Lander, 2016). Thus, it is important to inquire about different modes of social interaction in the organization, mainly in decision making, training and collective mobilization (Thornton et al., 2012). Inconsistencies and contradictions can arise that cause institutional dynamism.

Hospitals are heterogeneous organizations with multiple actors. They have different backgrounds and interests, but share norms, routines and practices (Styhre et al., 2016). As hybrid organizations, they encompass different logics, such as in accounting and control practices (Busco et al., 2017). The study of hospitals has to acknowledge this heterogeneity and explain ongoing changes in the dominant logics (Waldorff, 2013). In this field of institutional plurality (Kraatz & Block, 2008), the complexity intensifies the uncertainty about the future evolution of management (Miller & French, 2016). The emergence of new logics (Waldorff, 2013) and their confrontation with current ones (Waeger & Weber, 2019), can be expected. So, the ILP seems to be an appropriate approach to study health organizations behaviour in different cultures (Xing et al., 2020; Mannion & Exworthy, 2017; Currie & Spyridonidis, 2016).

Research Method

Purpose and research question

The research question addressed is: *How does the institutional context of PEEH management justify a bureaucratic approach?*

Using the ILP, there are three preliminary questions:

(1) What are the relevant institutional orders in the socio-cultural context of PEEH?

(2) Are the institutional orders equally relevant, or is there a dominant one?

(3) How are the institutional logics of these orders characterized in terms of bureaucracy?

This paper characterizes the institutional logics relevant in the PEEH context in terms of bureaucracy. The paper then studies how they relate, to understand how the bureaucratic logic of PEEH management is formed.

Research design

The research follows four steps. The first three address the preliminary questions presented above. The fourth step uses the information collected in the previous steps to address the general research question. The outcome of the three first steps is presented in the Results section. The Discussion section analyses the outcome respecting the general research question.

The first step presents the relevant institutional orders in the socio-cultural context of PEEH. Among the seven hypothetical institutional orders proposed by Thornton et al. (2012), three are chosen as relevant: State, community, and profession. These orders represent the principal stakeholders, following an adaptation of a previous study in hospitals (Rodrigues, 2011).

The second step studies the relative relevance of the institutional orders, seeking to determine whether there is a dominant order among the three, and how influential each order is.

The third step characterises State logic, community logic and profession, in terms of bureaucracy. To do so, Thornton et al. (2012) proposed a set of orienting categories of analysis, suggesting that more pertinent and refined categories be used according to the subject of study. The paper considers three of Thornton et al.'s (2012) general categories: basis of attention (to understand the purposes and fundamental aims in each order); authority; and control. Because of the peculiar nature of the subject, two other categories were added: procedural rules and accountability.

So, the study focus on the traits commonly associated with bureaucracy — these are usually related to encumbering rules that hinder adaptive and flexible management. The study analyses authority, control, procedural rules, and accountability. These categories allow deriving the bureaucratic logic in each order.

The category of *authority* searches for the presence of hierarchies and investigate sources of authority. The *control* category explores the presence of mechanisms of formal and informal control of performance. The *procedural rules* category explores the presence of a work jurisdiction that defines competencies, responsibilities and the formation of formal regulation. The *accountability* category analyses the consequences of the control results. Overall, each order is analysed according to the presence of hierarchical features, power relations, regulation and procedural flexibility.

The fourth step proposes a bureaucracy-based explanation for the formation of the institutional logics in PEEH management.

Data collection

Data were collected from a variety of sources: legislation on health care and public hospitals, government documents, statutes of professional orders, and published works on the Portuguese public health care sector and public administration. All data were subjected to an active and continuous recursive process of reading, examination, speculation, search, selection, view, interpretation (Davie, 2008, p.1072).

Results

Relevant institutional orders: State, community, and profession

The *State* order is understood as the public sector administration and the government. Constitutionally, the health care service is a public responsibility (OPSS, 2008). As a public enterprise entity under the supervision of Regional Health Administration (RHA),

public-funded and with an administration dependent on the MH and MF (Decree-Law 18/2017), the institutional order of the State is central in the context of PEEH.

The mission of public health care services is to satisfy the health needs of the population in its influence area. The politics of health care should be oriented by the idea of the citizen-user of the health care system. Because of the social importance of public health care in a community, the institutional order of the community is very relevant. A central purpose in health care politics for the last twenty years has been to recognize the health care user as a central voice in the development of services (Serapioni, 2016). Thus, the community is understood as all the users and expected beneficiaries of public health care services, including civil associations.

Autonomy of a professional identity domain is very important for work satisfaction and personal development. This paper considers that the professional order includes all organized professional classes whose efforts assure the public sector health care service: that is, mainly physicians, nurses and managers. Physicians and nurses each have their professional associations (known as "Orders" in Portugal) and union representation too. Although professional hospital managers are not organized in a professional Order, the study extends attention to them. This is because the management of PEEH is entrusted to an autonomous board of directors that includes professional managers represented by the Portuguese Association of Hospital Managers.

The relevance of each order in PEEH management

Public health care access and quality needs to be balanced with public expenditure. This is reflected in the subordination of PEEH management to the MH and MF (Decree-Law 18/2017). The PEEH depends on external approval of annual business plans, budgets, and accountability documents. The superintendence power of the MH is evident in the stipulations of article 6 of Decree-Law 233/2005 that establishes and approves objectives

and strategies of the PEEH. All this stresses the overwhelming presence of the State. Despite the attempt to make PEEH management more autonomous, it is a public sector organization whose authority is centred in a hierarchy that makes the most important management decisions (Bilhim, 2013). Additionally, notwithstanding new forms of hiring, PEEH administrators and most employees are best regarded as public servants. Also, the purchase of goods and services and the contracting of works are subject to the rules of public law contained in the Public Contracting Code. These features reflect the dominance of the State order in the PEEH context that constrains the autonomy of managers.

Governance practices in the health care sector no longer depend solely on the auto-regulatory movement of the medical Orders. Professional medical power and autonomy are more constrained by a managerial logic of control. Conflicts arise between the State order and the medical professional order. State bureaucracy is considered to constrain good medical practice by overwhelming them with administrative rules and strict cost control. The pursuit of efficiency by management sometimes clashes with medical practice. Physicians and nurses complain that they are constrained by management functions limiting their activities as health professionals.

The business model developed by the PEEH has led to tensions among health care professionals. When medical practice is required to satisfy management requirements rather than attend to patients' questions, inevitably ethical problems and discomfort arise among medical practitioners (Ribeiro, 2017). Despite bureaucratic constraints, the medical professional order is capable of reacting, since their professional deontological code allows them the right to disobey hierarchical technical orders (Article 13, Regulation 707/2016). However, clinical and management organizational legitimacy must coexist and contribute to an organization's survival. Through the administrative and management

process, the State order is now the principal authority in the PEEH. However, professional orders are still crucial. Conflicts between professional orders and the State order have to be addressed.

The community order is the least influential. Despite the government's attempts to have major participation by civil society in the setting and accomplishing of public health care goals, this is incipient (Barros & Simões, 2007). Nonetheless, the community order exerts influence mainly through the political judgement that health care politics produces in elections (Rodrigues & Silva, 2016).

In sum: The State institutional order is the ruling order. The professional order assumes a very relevant role in the PEEH context. The community order is the least influential. Furthermore, the conflict between the State order and the professional order is ongoing.

Characterization of the institutional orders regarding bureaucracy

Category of basis of attention

In the State order, the focus is the public service and funding issues. This focus emphasises a set of fundamental values, such as human dignity, equity, ethics, and solidarity (as stated in article 64 of the Portuguese Constitution).

Regarding the community order, in a population increasingly aware of its rights, civil society demands quality public sector health services. There is a concerted effort to change the attitude of the community in respect of the provisions of public health care services, and to encourage the community to actively participate in the development of these services.

Concerning the professional order, physicians and nurses aim to strengthen their status. Management aims to deliver health care services efficiently.

Category of authority

The health care sector in Portugal is supervised by the MH and the MF. Thus, the authority that guides public administration is sourced in the legislative power of the Assembly of the Republic. The public institutions that have effective power over health care services include the Directorate General of Health, the Central Administration of the Health System, the Shared Services of the MH (SSMH), and the National Authority of Medicines and Health Products. State authority is also evident in the manuals that rationalize procedures in hospitals. The State is the decisive authority in the health care environment.

Responsibility for planning and resource allocation in the Portuguese public health system, at the regional level and sub-regional level, has remained highly centralized despite the establishment of the five current RHAs in 1993. Strategic guidance is provided by the MF and the MH (Amador, 2010) so that public hospital budgets continue to be defined and allocated by a central authority. There is a strict hierarchical organization constrained by the superior authority of the MF and the MH. They rule over intermediate institutions, such as the SSMH and the RHAs. This is consistent with the view of Portugal as one of the most centralized countries in Europe (Magone, 2010).

At the community level, there is no formal authority since this order is not part of a planned organization. However, common values and interests are recognized and reflected in diverse associations that represent various users of health care services (Law 44/2005). These associations arise as informal sources of authority in the community. They assume greater importance because they promote interactions between the health care services and the community (Serapioni, 2016).

At the professional level, the sources of authority for physicians and nurses are their Orders and associated rulings. Since hospital managers are not ruled by a specific Order, they do not have such professional ruling authority.

Category of control

With the State institutional order, formal mechanisms of control are present. The Secretariat of State for Administrative Modernization established the Integrated System for Evaluation of Public Administration Performance (ISEPAP) in an attempt to introduce management driven by measures and controlled objectives, rather than by bureaucratic regulations. This meant the introduction of formal and objective processes of control by the State for all public services and servants, including public health care services. Furthermore, commencing in 2010, the Centre for Controlling and Monitoring the National Health Service (CCM) manages all activities related to invoice processing, and fighting corruption and fraud within the health care sector. Also, in 2010, the SSMH was founded to centralize purchasing for the Portuguese public health sector, with a view to achieving more controlled and efficient expenditure. These are formal mechanisms of control of the public health care system.

Among the community, public politics foster interest and demand for transparency and control of the public health care service. Public participation and patient empowerment are major health care goals that have been inscribed in key legal documents in Portugal over the last two decades. Users have the chance to evaluate the quality of public hospitals in satisfaction surveys or through feedback on the National Health Service website.

Regarding control actions, Law 46/2007 establishes that every person has the right to access administrative documents (art. 5). There is an online database where anyone can access every public contract and the performance results of public health institutions. This

allows better questioning of administration practices. However, although civil society has a formal means to monitor the performance of public services, especially in the health care sector, these means are used infrequently.

The community is not prone to formal ways of control. However, the user's judgement is valued more today and the medical professional authority has to be sensitive to the user's perception and control. Public health care users tend increasingly to be more aware and demanding of services.

In the professional order, there is an informal dimension of control by peers and a formal dimension by the Orders, as legislated in the Order statutes applying to nurses (Law 156/2015) and physicians (Law 117/2015). Managers are under the SPM. The control mechanisms are exercised by the MH and MF (Decree-Law 71/2007, article 6).

Category of procedural rules

Looking at the state institutional order, the public administration executes its functions in a way similar to that of a bureaucratic-type of organization (Tavares, 2019). It formally establishes tasks and procedures and creates work jurisdictions that define competencies and responsibilities. This is reflected in the regulatory management mechanisms of the Portuguese health system which is highly normative and has extensive legislative provisions (Simões et al., 2017). The MH develops and regulates formal procedures that are to be implemented in public sector health care management (as is the case with the CCM or creation of SSMH). As such, all health professionals must understand the technical procedures relating to the acquisition of medicines. Public health care services seek to achieve greater formalization of management procedures, in line with the bureaucratic organization of all public administration.

At the community level, procedural rules are commonly belittled. Citizens feel impotent when dealing with heavy administrative regulation. To speed up system

response, informal mechanisms are used and accepted. That allows citizens to overrule the heavy formality due to the regulations (Tavares, 2019).

Regarding the professional order, physicians and nurses have a protocol that regulates medical intervention across all the health care system, even the duration of a medical consultation (Regulation 724/2019). The protocol configures the bureaucratic feature of jurisdiction, with clearly defined competencies and responsibilities. This professional culture produces, collectively, trans-national regulations that establish conventions and standards of medical models. Management is subject to the SPM. Its proceedings are set and constrained by political decisions. Regardless of the autonomy of management (Decree-Law 133/2013, article 25), the activities of managers have a strong bureaucratic and administrative component.

Category of accountability

In the State order, ISEPAP evaluates public services and public workers. ISEPAP attempts to guarantee accountability of the public services, including health care. Every public service has a complaint procedure. The State order attempts to create a culture of accountability as a means to counter the long-standing public perception that public administration is involved in secrecy (Moreira & Maças, 2003).

The community order can use juridical and political channels to argue for responsible health care services. The rule of law allows an appeal to the court's sovereignty so that the civil responsibility of the medical practice can be claimed. Additionally, there is political accountability because public health care services are subjected to political judgement by the electoral process (Rodrigues & Silva, 2016).

In the professional order, medical practice has its disciplinary and ethical rules enforced and controlled by the respective Order. Physicians and nurses are responsible for their actions towards their respective Orders as detailed in disciplinary regulations

(Regulation 631/2016; Regulation 340/2017). Managers respond to the MH and MF (Decree-Law 133/2013, article 25).

From the categorical analyses, an understanding emerges of the institutional logic relating to bureaucracy that is present in each order. The State logic reflects a purely administrative management model. Power is centralized within a hierarchical sense of authority. There is concern for objective control of the management of public health care, standardization and rationalization of procedures, and public concern for the accountability of politics and services. All this implies a strong bureaucratic logic with strong formal constraints. This logic, and its shortcomings, has been recognized historically. By resolution of the Council of Ministers, the National Day of De-bureaucratization was established, in 1990, on the last Thursday of October. The digitalisation of administrative processes has been implemented with the intent of de-bureaucratization (Law 82-A/2014). However, these initiatives have proven to be symbolic and have not yielded practical benefits.

Contrary to the other orders analysed, the community is a socio-cultural expression with no formal hierarchy. It is characterized by a dynamic informality and non-bureaucratization. The community is critical of the bureaucracy for encumbering good public services.

The Orders of nurses and physicians adopt a bureaucratic logic in which every professional is subject to a deontological and discipline regulation and is accountable for every professional act. Furthermore, to ensure security and predictability in medical action, professional procedures are standardized and regulated by professional codes that are developed collectively and reviewed continually. Thus, this professional logic shows a peculiarly bureaucratic trend in which regulation and formalisms do not depart from a central and hierarchical authority. Rather, they arise from a collectively developed

consensus of the organisational field. Accordingly, Mintzberg (1979) considered the hospital a professional bureaucracy, since professionals tend not to act according to hierarchical authority, but to their values and codes. Medical professionals do not regard themselves to be bureaucrats, despite the organization of the profession having evident bureaucratic traits. Under the SPM the managerial profession develops its activities mainly under a bureaucratic State logic.

Discussion

Consistent with Goodrick and Reay (2011), the PEEH is classified as having three institutional logics with the State logic dominant, but conflicting with the professional logic.

The State logic is dominant for political and legislative reasons. Nonetheless, professional logic is very influential. Community logic is the least influential. State and professional logics are bureaucratic whereas the community works within an informal logic in which disregard for bureaucratic rules prevails. However, community logic presents some reasons that favour the development of bureaucracy, as the call for transparency and citizen participation in public health care services increases. This reflects the increasing social concern for equity and efficiency in public health care services, consistent with the view that the bureaucracy is a predictable way of achieving them (Meier & Hill, 2005). So, even though the community works under an informal logic, its demands for public health care services are conducive to a bureaucratic managerial logic. Additionally, mindful that medical practice can be referred to civil court, and to prevent civil responsibility, hospital regulation has increased. This has stiffened bureaucratic processes as a measure of defensive reaction to medical practice.

There are reasons within institutional contexts that favour bureaucratic logic. There are other good management-related reasons for bureaucratic logic. For example,

systematic constitution of multidisciplinary teams requires more efficient control and formalization of rules. However, these seem secondary in the broad institutional context.

The bureaucratic logic observed is affected by a conflict between State and professional orders: professional medical power and autonomy are constrained by a managerial logic of control. The relative influence of these orders is likely to vary over time, depending on the evolving institutional logics. They certainly have opposite interests and look for compromises. The conflicts that undermine management should be addressed by fostering a collaborative and participative environment in which health care professionals are involved to achieve efficiency gains and cost control. This is conducive to a bureaucratic approach in which managers are more open to intra-organizational dialogue and the bureaucratic process is developed accordingly. Because medical staff have a special status, efforts should be made to engage them in PEEH management.

Health care organizations which invest in budgetary participation affect the sense of commitment of clinical personal. This, along with role clarity, motivates better managerial work attitudes and better performance of clinical managers (Macinati & Rizzo, 2016). Non-managerial controls, such as those coming from a participative culture, help to moderate the tensions that emerge from coercive use of managerial controls (Nyland et al., 2017). This is the way to lead in bureaucratic environments: to improve management quality through major accountability and ethical demands. Professional qualification reflects this trend by seeking to assist and support staff in developing their skills. This means a new stage in the development of bureaucracy: neo-bureaucracy, that is, a type of bureaucracy that calls for a collaborative environment. The political intention to involve civil society in the improvement of public health care services is also a factor that favours such a bureaucratic approach because it fosters collaboration among the different stakeholders. Thus, the institutional context of PEEH justifies the bureaucratic

logic. Interest in managing conflicting orders, together with the political intention to involve civil society in the health care services, marks an evolved approach to bureaucracy.

There is a will to evolve from a simple bureaucratic logic of management to a logic that integrates and coordinates the several stakeholders under a model of services centred on the quality of decentralized management leadership. Nevertheless, the prevailing institutional context still appeals for use of bureaucratic logic.

Conclusion

This exploration of the justification for the presence of bureaucracy in the PEEH has identified three institutional logics relevant to the institutional context of PEEH: the State, community and professional logics. The first two are eminently bureaucratic logics. The third is non-bureaucratic.

In the PEEH, State logic prevails, but professional logic is a decisive force. Community logic is, by far, the weakest and least influential. The three institutional logics coalesce in the formation of a bureaucratic logic of management. The bureaucratic features of the two major logics in this context conform to the PEEH logic of management. Community logic, though non-bureaucratic, presses health care services towards bureaucracy with increasing demand for transparency and responsibility.

The conflict between professional and State orders induces a bureaucratic approach that values the particular status of physicians and nursing staff — one that involves all staff in a collaborative and supportive regime that engages them in management. The need to manage the relationship between the different interests and to foster community participation in the health care organization tend to prompt a collaborative regime. This bureaucratic regime conforms to the neo-bureaucracy approach.

To the best of our knowledge, this paper presents the only study of the application of the ILP in the Portuguese health care context. This paper depicts the PEEH context with a novel approach using the institutional drivers of bureaucratic logic in management. Further research could be directed beneficially at investigating how to disrupt the prevailing institutional logics and their relations to break or change the bureaucratic rule in the management of the PEEH health care settings.

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