

MANAGING THE RIVALRY OF ANTITHETIC INSTITUTIONAL LOGICS: A QUALITATIVE STUDY IN THE SCOPE OF TURKISH HEALTHCARE FIELD

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ZİT KURUMSAL MANTIKLAR ARASINDAKİ REKABETİ YÖNETMEK: TÜRK SAĞLIK ALANI KAPSAMINDA NİTEL BİR ARAŐTIRMA

Öz

Bu alıřmada, örgütsel aktörler tarafından yönetilen kurumsal mantıklar arasındaki rekabet Türk Sağlık Alanı kapsamında ve niteliksel araştırma yöntemleri ile incelenmiştir.

Bu bağlamda, kurumsal mantıklar arasındaki rekabetin yönetilmesi açısından “manipülasyon eğilimi” ve “kurumsal talepleri uzlaştırma” başlıkları altında iki farklı stratejik kategorinin toplanan verinin kodlanması sonucunda ortaya çıktığı ifade edilebilir.

Anahtar Kelimeler: Kurumsal mantıklar, kurumsal mantıklar arasındaki rekabet ve bunun yönetimi, Türk Sağlık Alanı

Abstract

In this study, the rivalry between the institutional logics being managed by the organizational actors was analyzed within the scope of the Turkish Healthcare field in parallel with the qualitative research methods.

In this context, it can be expressed that two strategic categories were developed under the titles of “inclining towards manipulation” and “reconciliation of the institutional demands” in terms of managing the rivalry of the institutional logics and coding the data obtained from the interviews.

Keywords: Institutional logics, rivalry between institutional logics and its management, Turkish Healthcare field

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1. Introduction

While Friedland&Alford (1991:223) suggest that the most important current institutional orders¹ within the contemporary western societies have a central logic that forms the organizational principles, they have also brought meaning to the concept of logic which has found a place for itself as a ‘set of material practices and symbolic structures’. In terms of structuring of the organizational environment, the mention DiMaggio&Powell (1991:278) forward for the institutional logics is ‘cultural elements that consist of wide spread rules and beliefs that are taken for granted’, and that it is particularly noteworthy in terms of having the concept set in a specific context.

In this direction, the institutional logics that can be conceptualized as indicator of main principles which provide organizing and taking action based on the material practices and cultural discourses existent within different institutional and social sectors, can also be defined as ‘organizational principles that shape the perception and the interpretation forms of the world’(Suddaby&Greenwood 2005).

Even though various researchers mention that only one institutional logic have a tendency to dominate the organizational fields (e.g. Prahalad&Bettis, 1986; Reay&Hinings, 2005), it should also be mentioned that different expectations and demands may require to act in direction of different institutional logics, more particularly may require them to be embedded in different institutional logics (DiMaggio, 1997; Hensman, 2003; Mullins, 2006; Thornton, 2002). Thus, it can be assumed that, in terms of institutional logics, the organizational fields may attain a heterogeneous structure over time and that may contain multiple institutional logics that are against each other at the point of capturing dominance (Boxenbaum&Battilana, 2005; Greenwood et al. 2010; Lounsbury, 2007; Pache, 2010; Reay&Hinings, 2009; Seo&Creed, 2002; Thornton&Ocasio, 1999). In this context, in terms of gaining legitimacy for each time in actor actions in the direction of different logics, it can be suggested that appropriate responses should be given to the rivalry between institutional logics considering the micro-level reflections as well. Despite this determination, it should be expressed that

¹While the ‘capitalist market, nuclear family, bureaucratic government, democracy, religion (Christianity)/science’ are mentioned in the original text, Thornton (2008:3) preferred to provide the similar set under the distinct institutional sectors heading as ‘Market, government, commercial company, professions, religion and family’.

the literature on the management of the rivalry of the different institutional logics are not well developed and only few studies (e.g. Carranza&Longo, 2012; Pache, 2010; Reay&Hinings, 2009) have approached this matter particularly.

In the current study, the management of the rivalry between the 'commercial institutional logics' which developed via the changes that were carried out within the scope of the Turkey Health Transformation Program that is being applied especially since 2003, and via the other legal actions using the 'servant institutional logics' that are traditionally dominant at the incumbent state hospitals by means of presentation of health services which are an Constitutional requirement in Turkey were analyzed for responding to this gap.

For this purpose, the study was structured so that the first section is literature survey, second section is research design and findings, and the last section is results and recommendations.

2. Institutional Logics, Rivalry between Institutional Logics and its Management

By combining many different conceptualizations related to institutional logics, Lounsbury (2007) defines the institutional logics, as an indicator of cultural values and as widespread cultural beliefs that in general direct the decision making activities in any field and structure the perception. In this context, it can be expressed that along with providing rationalization for activities of individuals, and organizations which reproduce institutions by their activities (Glynn&Lounsbury, 2005; Suddaby&Greenwood, 2005) institutional logics also provide time and spatial arrangements for individuals and organizations, and add meaning to their social realities (Thornton, 2004:70)

On the other side, as Dacin et al. (2002) stated, while the actors add meaning and life to institutions in one hand, they also place behaviors in a particular frame by perceiving and interpreting institutional logics at the same time (Battilana, 2006; Suddaby&Greenwood, 2005), and then finally reproduce them in continued actions or in activities as coded (DiMaggio, 1997; Greenwood et al. 2002).

In this context, various researchers (e.g. Lounsbury, 2007; Reay and Hinings, 2005) have suggested that dominance of institutional logic may develop in field level along with the possible development of homogeneity (DiMaggio&Powell, 1983) that is appropriate to the base

assumption of the institutional theory. As for Hoffman (1999), referring to White (1992) also points that 'institutional battles' may occur from time to time between the elements within the fields that create and host variety of power relations. While Reay&Hinings (2005) agree to the existence of such battle with their assessments related to the possible development of 'hostile interaction between the main actors at times', they also put emphasis on at least temporarily solving the conflicts which may occur between the institutional logics especially.

However, until an institutional logic is dominant to reflect the agreement of the powerful actors in a field that is suitable for producing rivalry between the institutional logics (McAdam&Scott, 2002: 15; van Gestel&Hillebrand, 2011), it can be claimed that it is possible to create institutional chaos (Greenwood et al., 2010) along with differences in organizational activities and practices by producing discrete forms of rationality (Lounsbury, 2007), and finally to re-trigger instability each time (Purdy&Gray, 2009; Rao et al. 2003).

Yet, as indicated here, beyond the identifying rivalry between the institutional logics or this kind of battle; it must be expressed that searching for an answer to the question of how this is managed by the actors on field level will be more appealing. But it can be honestly stated that many researchers who prefer to explain the conflicts in this context with the institutional changes (e.g. Lounsbury, 2002, 2007; Greenwood&Hinings, 2006) also prefer to give more concise answers on complex situations which may develop through the institutional logics.

However, during situations such as institutional innovations staying in competition and therefore institutionalization it is not always being possible (Purdy&Gray, 2009), then how the organizational behavior forms out emerges as a major issue. Boxenbaum (2006) tried to find an answer to such a problem and described the structures as hybrid within the scope of assembling various institutions and structuring them in terms of different objectives and tools, so it should be expressed that the hybrid organizations' features that enable combining the competing logics with new ways (Battilana&Dorado, 2010) and holding them together in a sustainable way (D'Aunno et al., 1991; Pache, 2010, Pache&Santos, 2010) along with their ways to create balance in this sense are worthy of attention.

Furthermore, it should also be expressed that it was determined by the researchers, especially in some of the studies conducted in recent years (e.g. Carranza&Longo, 2012; Reay&Hinings, 2009), that the rivalry

between the institutional logics can be managed –*without the hybrid organization*- and that with cooperation (Reay&Hinings, 2009) on the one hand, and on the other hand using strategies such as communication and mutual learning (Carranza&Longo, 2012).

Current study, in favor of participating in small number of studies such as these, aims to determine the actions and activities of the state hospitals via their managers which have to manage the rivalry or conflicts that occur between different institutional logics in the Turkish healthcare example. For this purpose, the study has been structured within the scope of the following research.

3. Research Design and Methods

Even though various researchers (e.g. Oliver, 1991; Reay&Hinings, 2009) suggest that the organizations can give different responses towards different institutional demands, the problem of under which conditions the special responses are given has not been fully overcome as Pache&Santos (2010) have stated. On the other hand, it can also be argued that the studies associated with institutional complexity (Greenwood et al., 2010) which express that different institutional logics can simultaneously enter the game in a field along with the researches that examine how to manage this complexity (rivalry or conflict) have not been well developed.

The current study which is based on these rationales focuses on how actors manage the rivalry between the institutional logics, in other words, examining the responses they gave to the requirements that generated by different institutional. In this context, it particularly made the state hospitals which are one of the public organizations within the Turkish healthcare field its research subject. The main reasons for this are: the rivalry between the institutional logics being more significant in these hospitals compared to the others (e.g. private hospitals) and the actors in question showing a single-sample in managing this rivalry with their public identities.

Thus, as a basis for this study, documents and reports such as regulatory reports along with sector and research reports consisting of the healthcare field, the Constitution, laws and regulations were reviewed first for analyzing the healthcare field and it was determined that the number of state hospitals providing healthcare services –as appropriate for the research samples- are 843 (Ministry of Health, 2010:55). Within the

same reviews, it was identified, in terms of conceptual aspects of the research, that the “commercial institutional logics” and the “servant institutional logics” were both dominant in the field and that both logics were leaning towards keeping the state hospitals under control.

In terms of data collecting tools of the research, the techniques of interview, observation and document review which are preferred for the institutional theory studies (e.g. Thornton&Ocasio, 1999; Reay&Hinings, 2009) were also preferred in this study. Thus, it can be said that two main data sources were used in order to reach the purpose of the study. First of these is the interviews held with the chief physicians (representatives or deputy-chiefs in their absence) of state hospitals within the axis of semi-structured questions. Information regarding these interviews has been provided in the table below:

Table 1. Information Regarding the Interviewees

Interviewee	Number	Duration
Chief physician of the Provincial State Hospital	4	480 minutes
Deputy chief physician	3	270 minutes
Representative of the chief physician	1	90 minutes
Chief physician of the County State Hospital	2	120 minutes

Another data source the research focused on were the conducted document reviews based on the archival researches. Documents analyzed in this context have been provided in the table below:

Table 2. Documents Reviewed in the Research

Document Name	Date
Constitution	1982
Law on the Socialization of Health Services	1961
Law on Civil Servants	1965
The Basic Law of Healthcare Services	1987
Ministry of Health, Directorate of Research, Planning and Coordination Committee – Circular Number 130	2005
Social Security and General Health Insurance Law	2006
Regulations Regarding the Supplementary Payments From the Expenses of the Revolving Funds Made to Staff Employed at the Health Institutions and Establishments Under the Ministry of Health	2006
OECD Health System Reviews: Turkey (OECD&IBRD/World Bank,2008)	2008
Transformation to Health Program of Turkey, Evaluation Report (Akdag, 2011)	2011
Annual Health Statistics - 2010	2011
Ordinance on the Provision of the 663 numbered Law	2011
Health in Turkey While Going Towards the 2011 Elections (TMA, 2011)	2011
Providing Health Services in Turkey Before and After the Transformation to Health Program, Financing and Health Expenses (Sülkü, 2011)	2011

4. Data Collection and Analysis

The data provided for the research to reach its purpose were primarily obtained from the interviews held with the chief physicians and their representatives or deputies in their absence at the state hospitals which were included in the sample set of research. Questions on the interview forms used in these interviews were created by examining the documents collected within the context of the research and reviewing relevant literature. Thus the interviews held on the basis of semi-structured and open-ended questions were carried out within the last quarter of year 2011 and the first quarter of 2012. In this context, total of 10 interviews were carried out and they lasted 16 hours. They were carried out by the first author and decoding of the interview texts was again done by the first author.

The data and information obtained from the documents that were examined as a secondary data source within the scope of the research

have been used primarily in structuring the interview form and strengthening the data and information obtained from these interviews. In addition, reviewing the documents has been deemed important in terms of providing accurate, objective and explicit information about the health field's structure.

From the viewpoint of the analysis, it should be expressed that the data and information obtained from the data resources of the research have been organized within the framework of research question and that the data obtained from the interviews held in this phase have been coded in line with the purpose of the research. The coding focused on two main topics. The first one is directed at identifying the "features of the institutional logics in the healthcare field" and the second at "management strategies of the rivalry between the institutional logics".

Finally, the information obtained primarily from the interviews have been numbered with an interviewer number along with a letter and a number combination (e.g. D1) and the data and the information obtained from the archive texts organized in a simple form –in terms of supporting the desired results of the research- and they all have been presented in excerpts throughout the relevant sections of the study. Thus, it should be expressed that similar methods were used in this study from some of the previously conducted similar studies related to the subject of the research (e.g. Currie and Guah, 2007; Pache, 2010; Reay and Hinings, 2009).

4.1. The Healthcare Field in Turkey

Although it is possible to base the Turkish healthcare system on the Ottoman Empire, it can be suggested that the foundations of the Republican period was laid with the Law number 3 which was enacted in 1920 and thus enabling the establishment of the Ministry of Health for the first time, and that the Ministry focused more on improving legislation in this phase (Akdağ, 2011:19) hence the start of the institutionalization efforts in the field during this period.

Healthcare services were defined as "*medical activities to eliminate several factors that harm human health and society protecting itself from the influence of these factors, to treat patients and to accustom those who lost their physical and mental abilities and aptitudes to work (rehabilitation) is called health services*" under the 2nd Clause of Law on the Socialization of Health Services (SHSHK) dated 1961 and numbered 224 under the title Terms. Along with this definition,

especially the provisions of the 3rd and 4th sub-clauses of the clause 56 of the Constitution dated 1982 under the title of "Health Services and Protecting the Environment" contains such a sentence that "*the government ensures that everyone continues their lives in physical and mental health, and for the purposes of carrying out cooperation by increasing the disposal and efficiency in human and material power, it single handedly plans the healthcare institutions and regulates them to provide service. The government carries out this duty by benefiting from the health and social institutions within the public and private sectors and by monitoring them.*"

All these make up the center of gravity at the point of showing the structural foundations of the healthcare field. As it is understood, the responsibility imposed on the government in order for it to ensure the delivery of healthcare services to the public by using single-handed planning for the healthcare institutions and providing quality healthcare services. It has been proposed that the responsibility of the government in this sense is for it to carry this out by not only using the institutions that belong to the public but also with the ways of benefiting from the "private" healthcare institutions by monitoring them as well as per the continuation of the sub-clause of the provisions. In line with the Constitution's aforementioned provision, the provision under the 1987 dated and 3359 numbered 2nd clause of the Health Services Fundamental Law (SHTK) that contains "*excluding the Ministry of National Defense, this law covers all the public institutions and establishments along with private legal entities and real entities*" is very important in terms of the healthcare field showing its limits. And as for sub-paragraph a, b, and c of the 4th clause titled Basic Principles of this law which can be viewed as an important text in terms of arranging the field, they are worthy of attention on the aspect that they identify the general principles and in this sense make the Ministry of Health the most prominent actor as the extension of the bureaucratic government in terms of structuring the healthcare field:

- a. As per the Ministry of Health, the health institutions and establishments are planned, coordinated, financially supported and get developed by also receiving the opinions of the other relevant ministries in order to provide quality and efficient services equally throughout the country.*
- b. By means of giving priority to the preventive healthcare services and without causing waste of resources and unproductive capacity when establishing and operating all the public and*

private healthcare institutions and establishments and by purchasing services if necessary, the supply of quality service and efficiency are used as basis. The Ministry of Health and Public Welfare obtains the consent of the relevant Ministry and issues the task of preventive health services to all the public and private health institutions and establishments and monitors all the healthcare services of these institutions and establishments.

- c. *It is essential for all the healthcare institutions and establishments along with their healthcare personnel to be distributed and widespread equally throughout the country. The establishment and operation of these healthcare institutions and establishments are regulated by the Ministry of Health and Public Welfare within this basis.*

At this point, as an extension of the government, the Ministry of Health being prominent responsible centralized actor (Investment Support and Promotion Agency of Turkey -TYDTA, 2010: 19) for the health politics and services can be associated with the Buğra's (1994: 264) suggestion that the powers of the administrative elements being extended in general and thus the state apparatus are re-organized so the decision-making mechanisms are centralized by the force of official ideology in Turkey after 1980. The last point that needs to be emphasized on in terms of the structure of the healthcare field, is that since 2003, the works (especially the legal regulations and their implementation) on re-structuring the field under the name of "Health Transformation Program" are being unwaveringly carried out (Akdağ, 2011: 25).

The important steps of the process which were followed at the wake of the structuring of the Turkish healthcare field, from a historical point of view, can be shown as follows:

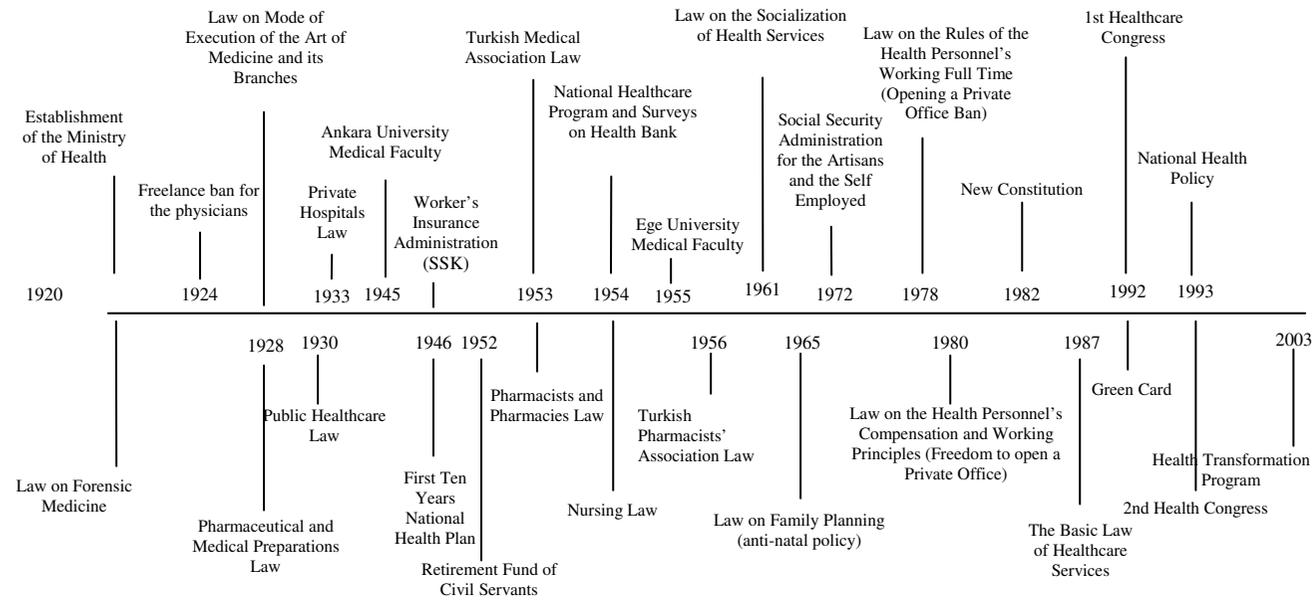


Figure 1. Important Steps in Structuring the Turkish Healthcare Field (Source: Koç&Yavuz, 2012)

The most important one of these regulations of this type that consists of institutional changes is no doubt the Health Transformation Program which has been implemented since 2003. This program created the opportunity to change many occupational, cultural and social patterns within the healthcare field from past to present. However, the institutional changes that are designed and implemented within the scope of this program are met with intense and sharp oppositional actions by the professional associations and the professionals especially.

If looked more specifically, in terms of the actors in the Turkish healthcare field; it can be expressed that the field consists of service providers and suppliers (health professionals, hospitals along with other suppliers and service institutions), consumers (patients of those who demand service), regulatory institutions (organizations under the government and other professional organizations) and other similar institutions (e.g. alternative medicine) who provide health services in line with the classifications Reay and Hinings (2009) reported.

On the other hand, if the hospitals that are the focus of the research are addressed, it was determined that these organizations which offer health services are cascaded by the Ministry of Health in terms of functionality under 3 separate headings in line with the amended 70th clause of the 5510 numbered Law of the Social Security and General Health Insurance (SSGSSK). These consist of:

- 1. bench healthcare institutions; units providing preventive medicine service (such as family practice)*
- 2. bench healthcare institutions; institutions that provide diagnostic-treatment services (such as state hospitals)*
- 3. bench healthcare institutions; institutions that provide education-research services (such as medical schools)*

At this point it should be immediately pointed out that the state hospitals are second-bench organizations in terms of providing healthcare service. The second-bench mentioned here represents the organizations that do not use very advanced diagnostic and treatment techniques with illness researches but do have extensive diagnostic and treatment opportunities (Ministry of Health, 2003). After all this, within the scope of the state hospitals which are institutions that offer second-bench healthcare service and which the research is based on especially, it should be repeated once again that there are two different institutional logics present in the field. Accordingly, the servant logics which manifest themselves with the

definition of “*providing equal, quality and efficient service to everyone* (Health Services Fundamental Law-SHTK, Clause 3/a)” have been based on the government and the providing of “healthcare service” which is one of the major assignments given with the Constitution during the historical process. As for the “commercial logics” in contrast to servant logics have been defined, through the characterization, in line with the “*(...) the supply of quality service and efficiency are used as basis without the waste of resources and unproductive capacity, and also purchase services if necessary, for establishing and operating public and private health institutions and establishments*” provision (Health Services Fundamental Law (SHTK) Clause 4/b) which is within the scope of the relevant laws and regulations. On the other hand, it should be expressed that the “performance-based supplementary payment” is also one of the important institutional arrangements which make up the infrastructure of the commercial logics that were set forth within the context of the Health Transformation Program.

4.2. Servant Institutional Logics within the Turkish Healthcare Field

Under the 224 numbered Law on the Socialization of Health Services enacted in 1961, it was specified that the healthcare services must be provided, to all the citizens, free of charge –or partially free in exceptional circumstances- (clause 14) and in a continuous and an impartial manner in line with the needs of the public (OECD and IBRD/World Bank, 2008:32). However, by being a more essential text, the provision under the 56th clause of the 1982 Constitution “*the government ensures everyone continue their lives in physical and mental health and organizes the healthcare institutions to provide services (...) by doing single-handed planning in order for them to carry out their cooperation*” is significant in terms of servant institutional logics showing the origins of in the sedentariness in the healthcare field in the context of meeting the task which is imposed on the government. Thus, based on the specifications of Friedland and Alford (1991:232), it could be argued that the servant logics are embedded inside the institutional order of the state.

In terms of providing public service which the government is tasked to carry out, the provision under the 128th clause of the Constitution “*the fundamental and permanent duties that are necessary for the public services which the government (...) is responsible to carry out are*

performed by the civil servants and other public officials’’ is worthy of attention in terms of creating general framework.

In this sense, the delivery of healthcare services are being realized at the state hospitals that are organizational actors in the field level and operate under the influence of servant logics, and by diagnosing and remedying patients’ illness care of physicians who are professionally educated (Civil Servants Law-DMK clause 36/III) as inter-organizational individual actors and finally by patients’ responding to these treatments. This process is arranged and controlled by the Ministry. And mostly the effectiveness, equality, quality and accessibility of the services become prominent during this process (Akdag, 2011: 16).

The servant institutional logics analyzed within the context of the state hospitals structure and legitimize especially the actions, activities and identities of the physicians who are members of the healthcare services, and are identified as civil servants (DMK, clause 36/III) with the *‘‘they are tasked with fulfilling the fundamental and permanent public service’’* (DMK, clause 4/a) template. It can be argued that, physicians particularly gain legitimacy during this process, in terms of authority and power, and they become prominent as main actors of the process. Following statement of an interviewed chief physician (D7) at one of the state hospitals is noteworthy in this regard:

‘‘Regardless of who or what the patients are, the diagnosis and treatment processes must be performed. First of all, the service quality standards² which the Ministry seriously monitors in recent years are available. In addition, because we are a government institution, the notion that we are at public’s service confronts us to a certain extent. (...) The complaints of the patients are forwarded to the Ministry immediately and via different channels.

Another interviewee (D3) stated the following:

There is also a perception in society in general that one cannot report the private hospitals but one can report the state hospitals. The patient rights unit especially ensures the active participation of the public at a point where they audit the qualification of the services provided. The Ministry

² After the Ministry of Health took over the Social Security Authority (SSK) hospitals in 2005, it developed and implemented the *‘‘Hospital Service Quality Standards’’* that every public hospitals must comply with which is used as a performance measuring criterion.

for instance very actively uses the 184 SABIM systems in terms of monitoring the services.”

And another (D1) uses the following expressions in much more striking way:

“If paid careful attention, it can be seen that with the regulations carried out recently, the quality of service is more important to the patient than the effectiveness of the service being provided. Because the patient can barely measure the quality, not the effectiveness, of the job performed by the physician within the parallel of their own understanding. Thus, compared to the past, we have come to a point that we unconditionally offer the services that the patient demand. In this respect, the government ruined the paternal relationship between the physician and the patient.”

Thus, it can be expressed that the servant institutional logics mold the field and inter-organization actors with the ways of legally drawn framework, with the identified professional boundaries and standards and with the necessity of rationalized and appropriate activities and actions that meet social expectations.

4.3. Commercial Institutional Logics within the Turkish Healthcare Field

Although it is possible to mention the existence of the commercial institutional logics via the organizations that can be the subject of primarily the private health institutions, private clinics and other private enterprises, the origins of the commercial institutional logics, in the context of state hospitals that are in accordance with the sampling of this study, stem from much more different points. In this context, the concepts of ‘*waste of resources and does not cause of unproductive capacity*’, ‘*supplying quality service by purchasing service*’ and ‘*efficiency*’ which are expressed under the 4th clause of the Health Services Fundamental Law along with the regulation ‘*supplementary payment system based on performance*’ which was designed within the scope of the Health Transformation Program and implemented since 2003 and other regulations that structured this have enabled for the state hospitals to be the discussion of the commercial institutional logics.

Aside from other parameters that require the commercial institutional logics, in order for the Ministry of Health to overcome the developing competition in the field and to retain the official physicians, it can be

expressed that with the ‘*supplementary payment based on performance (döner sermaye) system*’ that the Ministry of Health put into effect in 2003 within the framework of Health Transformation Program, it specifically steered the affiliated physicians and the health organizations at the point where they comply with the commercial logics –which don’t require a private entrepreneur but again provide the opportunity to acquire additional revenue by using occupational knowledge-. It is understood that the Ministry transfers shares by calculating the ‘integrated performance of the hospital as well as the individual performance of personnel’ and as it clearly states under the 2005/130 numbered Circular Note of the Ministry, the system which is based on the physicians ‘*making the supplementary payment as much as they contributed to the revolving funds revenue with the healthcare services that produced by physicians*’ directs the physicians working in the state hospitals to take care of as much patients as possible and perform the process in order to earn high income³. In addition, by saying, after the share of the Ministry and other shares are separated ‘*50% of the remaining amount is allocated to meet the needs of the institutions and organizations (i.e. state hospitals) and to pay for the debts due*’ under the 5th clause of the regulation passed by the Ministry in 2006 which organized the supplementary payments from the revolving funds, it can be argued that the hospital management too who is looking for sources for investment is encouraged towards commercial understanding. Thus, it can be suggested that a new commercial institutional logic has emerged which has been legally regulated in terms of providing healthcare service. In terms of commercial logics, following expressions which have been prepared by the Turkish Medical Association related to the Health Transformation Program are quiet noteworthy (TMA, 2011:5): “(...) For the sake of what? Market, profit, more profit...”

On the other hand, the following statement of an interviewed Deputy Chief Physician (D8) at one hospital on this direction is interesting:

“In terms of increasing their revolving funds income, some of our physicians treat more and more patients and undergo a heavy workload. As a matter of fact, -because the revolving funds payments are made according to the number of work days-, some of them do not even use their sick days or annual leave. (...) Due to the revolving funds’ payment

³ For example: An expert who receives a monthly base salary of 1000 TL can receive a supplementary payment up to 7000 TL (OECD and IBRD/World Bank, 2008: 32).

procedures of the Ministry, I can even say that the physicians who need to process interventional operations whether necessary or not, by treat more patients have developed some psychological trauma. When work is now based on money, we no longer have any authority over the patient. They now interfere more with the written prescriptions, requested tests and etc.’’.

Another Chief Physician’s (D5) statement below is pretty worthy of attention as well:

“(…) As a hospital, I think about providing the materials that can be billed to the patient as a top priority. If purchasing the device with only a service mentality will be cumbersome and not provide an important return, then it may be delayed and in some conditions not be purchased at all.’’

Thus, it can be stated that, in time, the hospitals tend to provide productivity as though they are business organizations with activities that provide revenue (income-oriented) and that at this point, the commercial logic affects the state hospitals as an organizational actor and the physicians inside the hospital as an inter-organization actors.

Finally, resulting from a heterodox perception, the belief that is associated with the healthcare services being the subject of trade, it can be argued that it may be both a reason and a result in terms of functionality of the commercial institutional logics in the field.

In conclusion, in line with the statements of the interviewees and the examined documents, the characteristics of the servant and commercial institutional logics can be shown as follows:

Table 2. Existing Commercial and Servant Institutional Logics within the Turkish Healthcare Field *

Features	Servant Logic	Commercial Logic
Economic System	Service-oriented activities	Income-oriented activities
Sources of identity	Providing healthcare services as a public service	Providing healthcare services as a business that provides high income
Sources of legitimacy	Legislation, Service Standards	Legislation, Service Standards
Sources of authority	Legal regulations Political tendency**	Legal Regulations, Increased interventional operations and revenue
Basis of mission	Satisfied patient	Interventional procedures in excess amounts
Basis of attention	Patient satisfaction, Political recognition	Increasing the recognition, interventional procedures and revenues
Basis of strategy	Legitimizing the political authority, political recognition	Sustainability
Logic of investment	Providing more qualified service, Political assessment	Increasing the capacity and revenues
Governance mechanism	Public Administration	Private Business-like management
Institutional entrepreneurs	Ministry of Health	Ministry of Health

*The features defined and tagged by Thornton and Ocasio (2008: 128-129) have been used as basis.

**Being under the control and influence of the political decision-makers as well as the organization of the hospitals as a public institution

4.4. The Rivalry of Servant and Commercial Institutional Logics and Managing their Rivalry

Considering that the structuring of the institutions is a political project that the strong actors have undertaken (Fligstein, 1996), it can be argued that the government-centered special structure of the Turkish healthcare field gave life, at some point, to both institutional logics which are the subject of the research by political motivation especially and that as Meyer and Hammerschmid (2006) indicated, provided the opportunity for the actors to take advantage of different logics.

However, it was determined there are rivalry and tension at the state hospitals that were analyzed in line with the thought that if there are two different institutional logics functioning in one field, then there are different purposes and related to fulfilling these different action and means (Scott et al, 2000: 171) and there will also be rivalry and related to this tension (e.g. Pache, 2010; Purdy and Gray, 2009).

From the analysis done in order to identify the managerial strategies (i.e. responses) that are followed by the organizations for the management of possible occurrence of rivalry between the institutional logics, it was determined that the tension (rivalry or conflict) primarily between the institutional logics develop towards the necessity of different ends and means for every different institutional logic, and towards the tendency to form actors' actions and activities that are in line with relevant logics' assumptions. In this sense, within their own work Scott et al (2000:171) also emphasize that the institutional logics require special ends along with special means that are necessary to pursue these ends. In fact, with a different wording, it can be stressed that the institutional logics force the actors, through their own agencies, to attempt actions and activities in line with logics' norms, values and beliefs that they primarily represent. If the data obtained in this parallel from this study are addressed; it can be expressed that while the commercial institutional logics force actors (i.e. physicians) for the realization of the interventional procedure that generates more revenue at state hospitals on the one hand, on the other hand it is also a necessity to provide, to those who request qualified and satisfied healthcare services free of charge or partially free which are accessible for everyone. In this sense, Thornton (2004: 12-13) placing emphasis on the managers paying more attention to problem and solution masses that are compatible with dominant institutional logics in fact this determination may also result this time in managers focusing their

attention on the requests and expectations of the multi-institutional logics in the fields that multi-institutional logics are in a dominance race.

On the other hand, as a result of the analysis and coding performed, it can be stated that two types of strategic category emerge on the management of the rivalry between institutional logics.

4.4.1. Tendency to Manipulation

In order to manage the rivalry between the institutional logics, it can be expressed that the micro-actors who decide on behalf of the state hospitals take action towards primarily meeting the requests and expectations received from servant and commercial institutional logics at the same time. However, it can be assumed that they in fact form their actions and activities by manipulating the rivalry between the institutional logics in this process. Because as it is understood from their statements, when the decision-makers tend to meet the requirements of both the institutional logics, after a certain point, they tend to approach any one of them more seriously and the other more loosely. However, it should be emphasized here that approaching an institutional logic loosely will never mean being free of their control.

The deputy chief physician (D2) interviewed in this sense expressed their situation in terms of finally manipulating the dominant rivalry and acting in accordance with the requirements of both the institutional logics as follows:

“While the government identifies the service quality standards and waits for us to satisfy the patients accordingly, it leads all of us, at the same time, to do much more work, whether necessary or not, by introducing the performance-based payment system. This situation increases the workload of physicians and unfortunately, contrary to expectations, it decreases the quality of the service provided. (...) Because I could not receive sufficient investment budget from the Ministry, I am forced to use, for investment, the share of revolving funds moved to the institution. (In other words) I have to invest in order to provide quality service as well as required to supply the necessary (participation share) sources from the patients to invest. The same dilemma applies to my physician friends as well. For instance, in order to increase their revolving funds income they treat more patients than they are able and they strain to perform more medical care. Because none of them wants to have worse living conditions. Of course this condition brings ethical arguments with it.”

Thus, it could be expressed that the decision-maker actors who are in the position to fulfill the requirements of both the institutional logics do in fact use this rivalry as an excuse to respond to one of the institutional logics with closer approaches and the other loosely. Moreover, as Townley (2002) emphasized in of her study, even if institutional logics change on the level of the field, the individuals pretend to accept the new logic but are able to continue to act according to the old logic. It can be stated that this manipulative approach Townley identified manifests emerge in a different context in current study.

On the other hand, even though the expectation of the ministry, on behalf of the government, is to provide quality service at once, it is understood that the physicians are being motivated towards providing healthcare services that are in conformity with increasing revenue with many regulations (e.g. Ordinance on the 663 numbered Law Provision and Regulation of Revolving Funds). Thus, in terms of providing healthcare services, the physicians have started to perform the acts and processes especially which do not risk the health of the patient only to generate more income.

One of the chief physicians (D6) who clearly stated the reasons for manipulative actions in this sense have stated the following regarding managing the rivalry:

“The Ministry directly deducts the revolving funds incomes for itself. And it transfers the revolving funds’ shares to us at a level that we have met the service quality standards (by multiplying it with a specific base point). For this reason we can say we generate revenue for the government first. Then, in order for us to increase our own income, we request the patient to get an examination that we have not thought very necessary for example in the past just to meet the performance levels. (...) We are now opening polyclinics (e.g. rheumatology) that have low costs and high returns that we don’t want to open in the past or purchase devices. Thus, we provide healthcare services to patients as well as striving to increase our income.”

These statements and alike in fact seem quite interesting in terms of results because the decision-makers, on behalf of the state hospitals, shape the organizational actions and activities by manipulating the rivalry between the institutional logics. In this sense, Khan et al (2007) have suggested that the rivalry between the institutional logics may result in supporting any one of the logics *much more* than the others via the hidden activities. As a result, it should be expressed that the actors manipulate

the rivalry for managing the rivalry between the institutional logics specifically in state hospitals and they in fact covertly get much closer to one of the logics and get connected but on the other hand they also do not avoid fulfilling the requests of the other logic.

4.4.2. Reconciliation of the institutional pressures

In line with the research findings, for managing the rivalry between institutional logics, it can be stated that actors may tend to create a new condition of balance by reconciling the actions and activities which are required especially by institutional logics through innovative ways and by getting them closer. It should be immediately stated here that the state hospitals that are under the control of the both institutional logics that are dominant in the field with appropriate means and ends have to reconcile these means and ends with new and creative ways seem to be a vital. It should be expressed that this situation can barely emerge based on the organizational decision-makers' innovation capabilities and experiences, in other words it may not be possible for the different ends and means to reconcile in every situation. In the same direction, the research findings have revealed the need for a strong coordination in terms of reconciling the requests coming from the institutional logics. At this point, developing strong managerial mechanisms should be viewed very important in terms of managing the rivalry between institutional logics and in line with the manager capabilities especially. Another state hospital chief physician (D9) who implied that he is aware of the difficulties of forming and implementing the actions and activities which are under the control of the different institutional logics and reveals efforts of reconciliation he uses in this regard with this statement:

“In terms of patients' rights, the government forces us to be like private hospitals gradually and the private hospitals to be like state hospitals. (...) We have to meet the demands of the Ministry and in this phase what is left for us to do is convincing our friends. We generally hold meetings and discuss all of our expectations with our colleagues. After all, everyone is aware that we cannot generate the revolving funds' income without physicians. Therefore, we try somewhat to meet the requests coming from the physicians. (...) We do not work with professional organizations like Chamber of Medicine but there is union organization in our hospital and the status of that is very weak.”

After a certain point, this finding seems to be similar to the findings of Perkman et al (2011) that actors responds to the institutional pressures in line with their benefits.

In terms of managing the rivalry between institutional logics in the context of state hospitals, while another interviewee (D7) made an covert reference to the capability of a pretty strong coordination, the statement he used below is quite clear:

“We are in fact besieged on all sides. There is Ministry on one side, politicians on another side and the public. As if this is not enough, we are confronted with our conscience and with physicians as well. For example, at one of the recent meetings held with the physicians related to the revolving funds’ income, there were serious attacks against me. (...) Sometimes there are certain different approaches between our physician friends. Because we are representatives, we have to respond to everyone. A physician does not think about this. And when we are faced with a physician, even if we perform an administrative procedure, it generally is not very functional (...) For example: professional institutions such as the Chamber of Medicine or a union step in for the violence against physicians but they do not have the power to sanction us. (...) As a matter of fact, we have to do something and carry out internal-external all the expectations. Ultimately this is management: Must manage everyone and everything.”

This statement coincides with Oliver’s (1991) findings that organizations may face inconsistencies between internal organizational goals related to effectiveness and autonomy and frequently conflicting institutional demands or institutional expectations, and that under these conditions they may prefer the options of balancing, reconciliation and negotiations. On the other hand, as Pache and Santos (2010) and Pache (2010) indicted with a general statement, because organizations will tend to find a common way that enables an acceptable change which can be accepted by all the institutional parties when the organizations encounter a competition against them. Finally, it can be claimed that trying to reconcile the pressures coming from the institutional logics is a reasonable way to manage the rivalry between institutional logics.

5. Results, Constraints and Recommendations

The study addressed the management strategies in two different categories which organizations in the Turkish healthcare field will follow to manage the rivalry between institutional logics they are embedded. Thus, in the context of its own sample set, this study has made a significant contribution to the limited literature that is related to the management of rivalry between institutional logics. Accordingly, it can be stated that, under different conditions, the organizational actors tend to “manipulating the rivalry” and “reconciling the simultaneous pressures stemmed from institutional logics with innovative ways” in terms of managing the rivalry between the institutional logics.

However, it should be stated that despite all these claims, the study was conducted under several limitations related to methods and sampling, and that the results may be criticized in terms of generalization. At this point, it can also be reiterated that the quantitative constraints which are related to primary data sources that the research is especially based on are the most important obstacles in generalization of the research results. And in terms of method, using the Grounded Theory or the further quantitative and qualitative mixed methods may relatively increase the reliability of the results obtained.

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