Institutional field-level change in post-Soviet contexts: logic elaboration in primary care restructuring

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I declare that this thesis is my own work. The work of others is appropriately referenced.
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This thesis examines the evolution of the healthcare field in two countries, Estonia and Lithuania, using an institutional theory perspective and focusing specifically on institutional logics. The study finds that institutional change does not only occur through a shift in dominant logics, as the current literature suggests, but it can also occur through the elaboration of existing logics. Logic elaboration is a process of reconstruction of role-identities, organisational forms, governance structures, and practices and their gradual incorporation into the existing logic. This research shows that logic elaboration may unfold as a process of grafting or appending, depending on specific societal and field-level factors. Societal level factors relate to the flexibility to accept plurality and the ability to synthesise conflicts in a particular societal context. Field level factors relate to the legitimacy of theorisers within a given field and society, the concentration of theorisers in a field and their ability to channel resources and maintain high commitment, and the socialisation of practitioners to the new role-identity.

This research makes several contributions to institutional theory. First, it introduces and develops the concept of logic elaboration. Second, it expands our understanding of logics as toolkits, whose elements can be variably combined in a field. Third, it identifies key contextual factors that shape or impact upon the trajectory of change toward logic elaboration.

Key words: logic elaboration, institutional logics, institutional theory, institutional change, institutional field, health systems, health reforms, primary care, family medicine, transition countries, Estonia, Lithuania.
Acknowledgements

I would like to express my gratitude to all those who supported me during my PhD.

I would like to thank Prof. Nelson Phillips for his constant feedback on my work and help throughout these years. Prof. Rifat Atun for directing me towards research on transition countries and for involving me in other interesting projects.

I would like to thank the Directors of the Doctoral Programme at Imperial College Business School, Prof. Robert MacCulloch and Prof. Erkko Autio, and the administrative staff, Julie Paranics, Frederique Dunnill, and Donna Sutherland-Smith.

I am grateful to colleagues at Imperial College and at various conferences who provided constructive comments on my ideas. Academic and administrative staff at the Strategic Management and Organisation Department at the University of Alberta, for making me feel welcome during my visit and for the productive discussions. Prof. Royston Greenwood and Dr. Namrata Malhotra for their encouraging feedback on the thesis. Dr. Anna Canato, who has been my advisor during the toughest moments of my PhD. Members of the Centre for Health Management, members of the National Centre for Infection and Prevention Management, and my fellow PhD colleagues for their encouragement.

I am also thankful to my informants and particularly to Jarno Habicht, at the WHO in Tallinn, and Gintaras Kacevicus, at the State Patient Fund in Vilnius, for their collaboration on the data collection phase.

I am thankful to my friends for their encouragement, particularly to Moritz and Sanya Gottschalk, Andrea Dell’Amico, Carole Crocetti, Pier Paolo Radaelli, Elena Marchetti.

I am thankful to my family for the love and the essential support. To my mom and dad for their advice and persistent support and for giving me the possibility to be here in this very moment. To my father-in-law for pointing me to the idea of this project, which seemed quite unreachable from a remote place like Sardinia. To my mother-in-low for her trust and advice. To my little sister and my little brother for all their love and for our open dialogue. To our grandparents, who always watch over us. The biggest thank you goes to Gianfilippo, my husband. You have supported me throughout the whole process and encouraged me to pursue my career and my interests. I am really blessed to have you in my life and to share everything with you. I wouldn’t have been able to do this without you. I hope Bollo Ale takes the best of both of us.
TABLE OF CONTENTS

CHAPTER I. Introduction and summary of the research ............................................................. 15
   Motivation for the research .................................................................................................... 15
   Summary of the thesis ........................................................................................................ 16
     Theoretical framework ..................................................................................................... 16
     Case selection .................................................................................................................. 17
     Research focus ................................................................................................................ 19
     Contributions of the study ............................................................................................... 21
   Structure of the thesis ........................................................................................................ 23

CHAPTER II. Grounding the theoretical framework: institutional logics to understand complexity and change in organisational fields ................................................................. 25
   Institutional theory at a turning point: from isomorphism and homogeneity across organisations to diversity and change ............................................................. 26
   Institutional logics to explain field-level change ............................................................... 29
     Controversial definition of institutional logics: concept and dimensions .............. 29
     Institutional change as a shift in dominant logic ....................................................... 33
     Multiple institutional logics within an organisational field ...................................... 34
     Conceptualisation of logics in this thesis ...................................................................... 36
   Justification for the research ............................................................................................. 39
   The gray areas of field-level change in the institutional theory literature .......... 40
   Framing the research questions ....................................................................................... 41
   Envisaged contributions of the study ............................................................................ 42

CHAPTER III. Methodology .................................................................................................... 45
   Research contexts and case selection ............................................................................... 45
     Institutional logics in Estonia and Lithuania ............................................................... 47
   Research Strategy and Design ......................................................................................... 57
   Research Methods ........................................................................................................... 59
     Data Collection .............................................................................................................. 59
     Data Coding and Analysis ......................................................................................... 64
   Issues about the methodological choices ....................................................................... 67

CHAPTER IV. Analysis and findings: logic elaboration and field-level institutional change ................................................................................................................................. 71
   The process of change: chronology of events ............................................................... 72
   Pre-change phase (up to 1989) ..................................................................................... 73
# LIST OF TABLES AND FIGURES

<table>
<thead>
<tr>
<th>Table/Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 2.1: Institutional logics in contemporary Western societies</td>
<td>30</td>
</tr>
<tr>
<td>Figure 2.1: Essential elements of an institutional logic</td>
<td>38</td>
</tr>
<tr>
<td>Figure 3.1: Professional logic of specialisation in the Estonian and Lithuanian Semashko-type healthcare systems.</td>
<td>49</td>
</tr>
<tr>
<td>Figure 3.2: Professional logic of holism introduced in Estonia and Lithuania</td>
<td>53</td>
</tr>
<tr>
<td>Table 3.1: Outcome of logic elaboration in Estonia and Lithuania: complementarity and coexistence</td>
<td>57</td>
</tr>
<tr>
<td>Table 3.2: List of Stakeholders</td>
<td>63</td>
</tr>
<tr>
<td>Figure 3.3: Rationale for the coding and links between the main theoretical categories</td>
<td>67</td>
</tr>
<tr>
<td>Figure 4.1: Phases of the change process and actors’ roles in each stage</td>
<td>73</td>
</tr>
<tr>
<td>Figure 4.2: Logic elaboration process: phases and contextual factors</td>
<td>88</td>
</tr>
</tbody>
</table>
To Gianfilippo
CHAPTER I. Introduction and summary of the research

MOTIVATION FOR THE RESEARCH

Health systems are critical institutions in any society. Changes to health systems have been of widespread concern and interest to both academics and practitioners around the world. This research is motivated by the recent significant developments throughout health systems in different societal contexts. Intrigued by the radical changes that occurred in post-Soviet contexts after the collapse of the U.S.S.R., I began the study of health systems in newly formed republics in Central and Eastern Europe. In order to gain a deep understanding of the health sector changes in these specific contexts, I focused on investigating the broader socio-cultural context which originated such complex health systems.

During the early stages of the PhD, a detailed reading of the management literature brought a stream of literature known as neo-institutional theory to my attention. This literature provided important insights on the influence of the environment on the organisation of a society. Central to this stream of research is the notion of institutions, the taken-for-granted rationalised myths that are produced and reproduced within a particular cultural context and around which social activity is organised (Meyer & Rowan 1977). By uncovering the institutions existing in a given context, it is possible to explain why social activity is organised in a certain way in a given context. This approach seemed to be the most relevant to research on health systems and particularly insightful to explain key drivers underpinning different paths of evolution for different countries.

Within this stream of literature, many theoretical questions are yet unexplored. Particularly, the process through which institutions change is still being investigated by scholars all over the world. The Estonian and Lithuanian healthcare systems, which have thus far been overlooked by theoretical research, offered especially fertile grounds to explore questions related to institutional change and potentially contribute to further expand our knowledge of such institutional process.
Therefore, this thesis embraces an institutional theory perspective to analyse the evolution of the healthcare systems in Estonia and Lithuania and explores field-level processes of change through the concept of logic elaboration.

SUMMARY OF THE THESIS

Theoretical framework

Institutional theorists have observed that, despite preserving some homogeneous traits, organisations differ and change over time. The study of organisations from an institutional theory lens has hence moved away from its traditionally central focus on explaining conformity and homogeneity across organisations and has more recently turned to the analysis of change (Dacin, Goodstein, & Scott, 2002; Greenwood, Suddaby, & Hinings, 2002; Seo & Creed, 2002). Institutional change is studied as a phenomenon that occurs at the level of the field ¹ (DiMaggio, 1983; Greenwood & Suddaby, 2006; Scott, 1994, 2001) and, as such, invests groups of individuals and organisations that share common meaning systems and interact frequently (DiMaggio & Powell, 1983; Scott, 1994).

Field-level change occurs not only through modifications to existing governance structures and actors’ roles, but also through shifts in the underpinning logics (Scott, Ruef, Mendal, & Caronna, 2000). Logics are described as the socially constructed, historical patterns of practices, assumptions, values, beliefs, and rules by which individuals and organisations produce and reproduce their material subsistence, organise time and space, and provide meaning to social reality (Friedland & Alford, 1991; Thornton & Ocasio, 1999). However, there is no complete clarity on the definition

¹ As Wooten and Hoffman explain (2008), the central unit of analysis of institutional theories has been referred to, among others, as the institutional field (Meyer & Rowan, 1977; DiMaggio, 1991). However, scholars generally employ the term organisational field (Scott, 1991) to identify the constellation of actors that comprise this central organising unit. Therefore, for the purpose of this study, I will use the terms organisational field, institutional field and field interchangeably.
of institutional logics. The concept of logics is bound to that of organisational field (Friedland & Alford, 1991) and field-level institutional change, in so far as logics are considered as sets of cultural beliefs and rules that structure cognition, guide decision-making, and shape practices and actors’ interactions within a given institutional field (Lounsbury, 2002, 2007). Building upon this definition and incorporating some of the elements previously indicated as characteristics of logics, the next chapters explain what logics are in the context of this research. This could bring greater clarity to the concept of logics in the current institutional theory debate.

Neo-institutional theory literature has usually interpreted change as a shift in the dominant logic in a given field (Rao, Monin, & Durand, 2003; Scott et al. 2000; Thornton & Ocasio, 1999; Thornton, 2002), thus largely ignoring the complexity and multiplicity of institutions that affect that field as well as the broader society (Greenwood et al. 2010; Kraatz & Block 2008). Nevertheless, change is not necessarily associated with the simple displacement of logics. Recently, institutional scholars have interpreted change as a modification of the balance between competing logics in a field (Purdy & Gray, 2009; Pache & Santos, 2010; Reay & Hinings, 2009). However, logics may actually coexist in a field, without necessarily competing with each other (Dunn & Jones, 2010). Following this insight, this research argues that change may occur when principles of different logics are recombined and integrated into an existing paradigm — through a process labelled logic elaboration.

In summary, this thesis investigates how institutional field-level change originates from changes in one of the logics at play in the field. Particularly, it illustrates the concept of logic elaboration as a process whereby new principles, associated with a different conceptualisation of the professional order, are framed and embedded into the existing professional logic. It shows how, depending on context-specific factors, this process results in a different organisation of the field in the selected empirical contexts, the Estonian and Lithuanian healthcare systems.

Case selection

The criterion for the choice of cases is to maximise the opportunity to investigate the restructuration of the same field, but in different contexts; this will help explore the
specific cultural factors influencing the process of logics elaboration. The healthcare field is studied in two countries — Estonia and Lithuania —, which, despite initial similar institutional characteristics, have presented some variety in the manifestation of such field-level change processes.

The case selection is guided by a preliminary analysis of existing empirical literature (e.g. Atun, Ibragimov, Ross, et al., 2005; Atun, Menabde, Saluvere, Jesse, & Habicht, 2006; Atun, Kyratsis, Jelic, Rados-Malicbegovic, & Gurol-Urganci, 2007) and interview data on the healthcare reforms introducing family medicine-centred primary care in Estonia and Lithuania. Through an initial scrutiny of this material, it appears that, despite departing from nearly identical organisational structures (grounded in the same professional logic), and despite sharing similar reform principles and objectives (reflecting the same conceptualisation of another professional logic), the field has evolved in divergent directions in the two countries.

Until the early 1990s, the Estonian and Lithuanian healthcare systems were rooted in the Semashko model, a hierarchical, centrally controlled and planned administrative system diffused in all the Soviet countries. Services were delivered free-of-charge by an extensive, integrated and exclusively public network of specialised care, along with fragmented and underdeveloped primary healthcare. The work conducted by doctors in primary care settings carried quite a low prestige among the other medical practitioners as well as the general public. This mainly consisted of referring patients to specialists. The healthcare field was organised around a professional logic of specialisation, which supported fragmentation of care.

Following political independence from the U.S.S.R., both countries underwent extensive reforms in all sectors, including fields, such as healthcare, that were traditionally recognised as mature and highly institutionalised (Thornton & Ocasio, 1999). A debate started among academics in the medical faculty and first-contact doctors on the importance of redesigning the provision of healthcare services. The internal mobilisation led to successive reforms which created a solid primary care system. This was based on the ideas of family medicine, reflecting an approach of holism and comprehensiveness of care. This was fundamentally different from that of specialisation.

However, despite a common existing system and similar central reform principles, the outcomes of the reform varied in the two countries. Specifically, the structure and
organisation of the primary care subfield took different forms. In Estonia, the primary healthcare subfield was homogeneous. Family doctors were the only providers of primary care services and were organised in autonomous group- or solo-practices\(^2\). In Lithuania, the primary healthcare subfield was heterogeneous. Family doctors were one of the providers of primary care services; teams of first-level specialists also simultaneously operated in the field. Doctors worked in a variety of organisations, ranging from old, public policlinics, to autonomous solo-practices.

**Research focus**

Against this background, this research is set out to understand the *reasons for this divergent evolution* and, more broadly, to shed light on the *processes of institutional change in different contexts*. In order to do so, the study focused on one of the logics, namely the professional logic, and analyses what happens to it during the reform process that introduced primary care in Estonia and Lithuania. The choice to focus on this particular logic, which was in place at the time the reform started and still plays a fundamental role in the field, derives from the importance that informants and secondary data attribute to the doctors’ thinking and acting in exerting their professional role. Despite the institutional logic guiding the professionals (i.e. doctors) was the same prior to the reform, the logic has evolved differently in the two selected countries following the introduction of family medicine. As a result, this research seeks to explain this field-level change by exploring changes in the internal composition of the professional logic. Specifically, it aims to understand how new beliefs and models related to the medical profession were introduced during the reform process and how they were combined with those already existing in the field.

The study finds that the divergent development of the field in the two countries is the result of different processes of logic elaboration. The focus of the analysis is on the

\(^2\) In this thesis, the word “practice” is used either as “family practice” / “clinical practice” — to indicate the organisational form within which family doctors operate —, or as “working practice” — to refer to the actual routine work of doctors, which reflects their approach to healthcare, identity and role in the healthcare system.
construction of new elements associated with a holistic view of medicine and their incorporation into the existing professional logic of specialisation. The study investigates the formation of the new professional role and identity of family doctors and its conversion into observable (and dissimilar) changes in organisational forms, governance arrangements and working practices. It emphasises the role played by various actors and the influence of specific contextual factors on the process of change.

Existing institutional theory literature has considered how shifts from one logic to another (e.g. Scott et al., 2000; Thornton & Ocasio, 1999) or how conflicts between logics (e.g. Pache & Santos, 2010; Purdy & Gray, 2009; Reay & Hinings, 2009) lead to institutional change. However, previous studies have generally focused on changes between logics deriving from different institutional orders. For instance, Scott and colleagues (2000) explain the evolution of the healthcare field as a shift from the professional logic to the logic of the state and finally to the logic of the market.

In contrast, the originality of this research is its focus on logics deriving from the same institutional order (i.e. the medical profession) to explore how elaboration of the professional logic can also lead to processes of institutional change. Furthermore, in order to emphasise how the institutional environment influences logic elaboration, the study identifies key societal and field-level factors influencing the process in the two contexts, thus explaining their different evolution.

In order to generate a theoretical account of field-level change processes in these two contexts, this work follows an inductive approach (Denzin & Lincoln, 2000) and employs grounded theory techniques for collecting, coding and analysing data (Glaser & Strauss, 1967). The aim is to uncover unexplored social dynamics — context-specific processes of logics elaboration — within a specific stream of research — institutional theory —, and not to generate a stand-alone theory largely detached from previous literature (Suddaby, 2006).
Contributions of the study

In order to expand current institutional theory research on field-level change, this work seeks to explore how institutional change processes unfold in different contexts. It studies the same field in two countries and focus on the elaboration of a central logic in the field to explain how context-specific factors influence the process of logic elaboration and field-level change. Logic elaboration is a process of reconstruction of role-identities, organisational forms, governance structures, and practices, and their gradual incorporation into the existing logic. It may occur as grafting or appending, depending on societal and field level factors. Such factors include flexibility to accept plurality, ability to synthesise conflicts, legitimation of theorisers within the field and the society, concentration of theorisers in the field and their ability to channel resources and maintain high commitment, and socialisation of practitioners to a new identity.

This thesis offers several contributions to the institutional theory literature, which enhance our current understanding of institutional change processes.

It studies logics originating from the same institutional order, the professional order. The literature has so far focused on understanding how logics coming from different institutional orders shifts or are blended in a field (Reay & Hinings, 2009). The findings of this research show that logic elaboration may also lead to field-level change. This extends previous work while indicating that logics deriving from the same order may be interpreted differently in two, or more, geographical contexts (Lounsbury, 2007). This study illustrates that principles of such logics may coexist in the same context and within the same field and explains the specific processes through which these are elaborated.

Despite defining stability, field-level logics may change over time. However, to date, logics have been perceived as rather monolithic and static (e.g. Thornton, 2002). This research endorses the need to embrace a more fluid and evolutionary conceptualisation of logics to understand if and how field-level logics evolve and interact in a specific context. When studied empirically, logics appear to be cultural toolkits (Swidler, 1986), whose elements can be variably combined in a field. This conceptualisation of logics helps uncover the process through which logics change internally (i.e. are elaborated) and introduce an element of flexibility and potential complementarity in the characterisation of logics. This interpretation of logics also
allows to study how logics coexist over time without necessarily being in conflict (Dunn & Jones, 2010; Pache & Santos, 2010).

The study illustrates that logic elaboration is a context-specific process of change. Societal and field-level factors both contribute to the unfolding of this process. Ability to synthesise conflicts and flexibility to accept pluralistic perspectives vary across societies. The legitimation and concentration of theorisers in a field, as well as the socialisation of practitioners to new principles, differ across fields. These factors influence the way principles of different paradigms are combined, consequently reshaping the configuration of the field.

As a consequence of the logic elaboration, fields and collective actors may present different degrees of internal heterogeneity. Fields appear to be layered in subfields, within which actors have specific identities that may be variably linked in an overarching field-level logic. The process of logic elaboration creates identities and practices that are variably embraced by specific groups of individuals, who use them to reshape a particular field or some parts of it — originating the “normative fragmentation of the professional logic” (Kitchener, 2002: 414). This interpretation helps understand how actors conceptualise their roles and enact relationships within the field (Wooten & Hoffman, 2008).

The findings point to the role of intellectual leaders as theorisers of a field-level change in a mature and highly professionalised field. Previous institutional work grounded on healthcare settings has argued that a change in logic is traditionally promoted by the State and imposed on the professionals. As a matter of fact, this study explains that institutional change in highly professionalised fields is more likely promoted by intellectual leaders, who act as theorisers (Greenwood et al., 2002) and institutional entrepreneurs (DiMaggio, 1988; Dorado, 2005). Intellectual leaders rely on their nature as academics and practitioners to theorise institutions and to diffuse these in the field by controlling the socialisation of practitioners to the new identities.

The research shows that socialisation processes are fundamental in substantiating field-level change in professionalised fields, in line with insights from the old-institutionalism. Authors have argued that theorisation, as opposed to reliance on relational networks, is necessary to frame, justify, legitimise and diffuse novel institutions (Strang & Meyer, 1993; Greenwood et al., 2002). This study clarifies that socialisation of practitioners in highly professionalised fields is the process that allowed
the theorised institutions, identities and practices to be transmitted to actors at the micro-level. This links the theorisation to the enactment and further elaboration of institutions through relational networks.

This work extends the investigation of institutional change processes to contexts that have not been previously explored. Institutional studies have been traditionally focused on Western countries, in mature (Reay & Hinings, 2005, 2009; Greenwood & Suddaby, 2006) and emerging fields (Maguire, Hardy, & Lawrence, 2004; Purdy & Gray, 2009). For this reason, we have very limited knowledge of field-level changes in non-Western countries. Central-Eastern European countries are fruitful contexts to study processes of social (re)construction, given the radical transformations that invested these countries after the collapse of the U.S.S.R..

STRUCTURE OF THE THESIS

The thesis is structured as follows. Chapter II presents the theoretical framework for the research and reviews previous work on institutional theory relevant to the thesis, with a focus on logics. It identifies areas of research to potentially expand existing literature. It concludes with the presentation of the research question for this study, namely the process of field-level change in different contexts through changes within a logic.

Chapter III describes the empirical settings of the research and explains the research methods. It portrays the characteristics of the primary healthcare field before and after the reform in Estonia and Lithuania and illustrates the old and the new professional logic. It summarises the evolution of the primary healthcare subfield during the reform in Estonia and Lithuania and shows the outcomes of such process. It outlines the research design and methods and shows the process of data analysis leading to the formulation of the theoretical model. Finally, it explains how some of the issues and challenges deriving from the methodological choices were tackled and clarifies how trustworthiness and credibility were built throughout the research process.

Chapter IV analyses the change as a process of logic evolution. It highlights the phases of the process, the role of actors in each phase, the gradual changes in the logic's elements, and the factors influencing the process. It outlines the main theoretical
concepts emerging from the data and concludes with the presentation of the theoretical model.

Chapter V discusses the findings of the study in relation to the existing body of literature and to the current knowledge about field-level change and institutional logics. It also clarifies the theoretical contributions of the thesis, as well as the implications for future research.

Chapter VI summarises the contributions of the thesis. It discusses some limitations of the study and addresses alternative explanations of the examined process. It concludes by presenting areas of potential future research in view of the findings of this thesis.
CHAPTER II. Grounding the theoretical framework:
institutional logics to understand complexity and
change in organisational fields

This research is grounded in the neo-institutional theory literature. Specifically, it explores how field-level institutional change unfolds in different contexts through processes of logic elaboration.

Institutional theory has moved away from its traditional focus on explaining conformity and homogeneity across organisations (DiMaggio & Powell, 1983), recently turning to the analysis of change (Dacin et al., 2002; Greenwood et al., 2002; Seo & Creed, 2002). Processes of change are observed predominantly at the field level and involve modifications to governance structures, institutional actors, and underpinning logics (Scott et al., 2000).

The concept of logics (Friedland & Alford, 1991; Thornton & Ocasio, 1999) has therefore become central in institutional studies. Logics enable and constrain cognition and action (DiMaggio, 1997). These are the material and symbolic constructions upon which individuals and organisations interpret social reality.

Studies have argued that institutional change happens when there is a shift in dominant logic (Scott et al., 2000; Thornton & Ocasio, 1999; Thornton, 2002). More recently, in response to the complexity of institutional environments (Greenwood et al., 2010; Kraatz & Block, 2008; Seo & Creed, 2002), scholars have started analysing the presence of multiple and conflicting logics in an organisational field (Reay & Hinings, 2009; Pache & Santos, 2010; Purdy & Gray, 2009). These studies argue that stability in the field is reached when conflicts between logics are temporarily resolved (Reay & Hinings, 2009). However, different logics may coexist in the field even for long periods of time without necessarily being in conflict (Glynn & Jones, 2010). In this situation, how can institutional change occur? Is institutional change only related to changes in the balance between logics or can it be also triggered by changes within a logic?
This research explores how institutional field-level change unfolds in different contexts through the elaboration of logics. It focuses on a central logic in a field — the professional logic in healthcare — and observes how this logic evolves over time, as new elements are constructed and nested within it, thereby creating a process of logic elaboration which generates institutional change. The study uncovers the contextual factors underpinning logic elaboration by comparing such processes in the two countries.

This chapter provides the theoretical framework for the research. It concludes with the identification of the research question and areas of potential contribution.

INSTITUTIONAL THEORY AT A TURNING POINT: FROM ISOMORPHISM AND HOMOGENEITY ACROSS ORGANISATIONS TO DIVERSITY AND CHANGE.

Early studies following a neo-institutional approach sought to explain conformity and homogeneity of organisational structures (Meyer & Rowan, 1977; Zucker, 1977; DiMaggio & Powell, 1983). They claimed that organisations adopt similar structures because their environment expects them to take such particular structures. In other words, organisations become isomorphic with the rationalised myths of their environment. Since organisations are expected to behave rationally, they do so, either substantially or ceremonially, in order to fit their institutional context. This allows them to gain legitimacy (Suchman, 1995) in the eyes of their audience and to increase their chances of survival. In this way, organisational structures and practices are shaped by the taken-for-granted beliefs, norms and rules, i.e. the institutions, of the environment in which they are embedded.

This approach has been criticised because it sees individuals and organisations as passive recipients of institutions and does not account for diversity, agency and change (DiMaggio, 1988). Increasingly, research has turned to these issues.

New ideas — either emerging within a field, or being translated from other settings —, may challenge and modify the taken-for-granted ways of thinking and acting, thereby initiating institutional change. Environmental jolts (Meyer, Brooks, & Goes, 1990; Sine
may trigger functional, political or social pressures onto existing institutions. This may induce agents to mobilise collective action to reformulate such myths (Greenwood, Suddaby, & Hinings, 2002; Seo & Creed, 2002), especially when actors become dissatisfied with the status quo because of a misalignment between their interests and needs and the existing social arrangements (Reay & Hinings, 2005; Seo & Creed, 2002). These actors draw from various settings, discourses, cultures and logics to acquire new ideas, translate and edit them to fit specific contexts (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996; Sahlin & Wedlin, 2008; Zilber, 2006), and to theorise new institutions (Greenwood, Suddaby, & Hinings, 2002). Newcomers (Zilber, 2002) or agents in emerging fields (Maguire et al., 2004) may be (or may become) less embedded in the field and more inclined to promote change. However, change may be also brought about by actors within the field, either peripheral (Leblebici, Salancik, Copay, & King, 1991) or central ones (Greenwood & Suddaby, 2006). Since fields have within themselves the motor for change, this may be also prompted by endogenous processes. Privileging this latter view, the idea of institutions as nested systems (Holm, 1995) addresses the paradox of how organisations can activate mechanisms to subvert the very institutions constraining their choices and actions. The conceptualisation of institutions as framework for, and products of, action allows to maintain the premise that institutions guide social behaviour; however, it also suggests that actors manipulate institutions. Recently, actor embeddedness has been interpreted as a basis for action and for the legitimation of a new institution, rather than as a constraint on social activity (Reay, Golden-Biddle, & GermAnn, 2006). This conception stems from the idea that the institutional context shapes, but never completely determines social action (Holm, 1995; Seo & Creed, 2002).

Scholars have started explaining the variability of strategic organisational responses to institutional pressures (Oliver, 1991; Pache & Santos, 2010) and the institutional work of social actors to create, maintain and modify institutions (Lawrence & Suddaby, 2006). They argue that imitation and compliance are just some of the tactics that organisations might adopt. They identify several possible strategies through which organisations may respond to institutional demands, comprising acquiescence, compromise, avoidance, defiance, and manipulation (Oliver, 1991; Pache & Santos, 2010). Given the pluralistic nature of the institutional environment, organisations confront inconsistent institutionalised myths (Meyer & Rowan, 1977; DiMaggio, 1991) and therefore, conform to one of the several existing institutional paradigms. In this way, organisations still become isomorphic, but only with that specific myth, thus being...
perfectly legitimate in the particular context in which that myth is in place (Greenwood et al., 2008). This requires moving away from seeking absolute homogeneity of institutional pressures and organisational responses to acknowledge the existence of multiple and even conflicting pressures to conformity within fields. The coexistence of a variety of organisational structures is therefore consistent with a complex institutional environment (Greenwood et al., 2010; Kraatz & Block, 2008). From this standpoint, institutional logics offer paradigms for action that are often in contrast with each other (DiMaggio, 1997; Friedland and Alford, 1991) and do coexist in the same context.

The phenomenon of institutional change is observed primarily at the level of the field, which is the privileged level of analysis of institutional studies on change (DiMaggio, 1991; Greenwood, Suddaby, & Hinings, 2002; Leblebici et al., 1991). Institutional fields have been defined in different ways (Wooten and Hoffman, 2008). From a rather structural perspective, they are commonly considered groups of individuals and organisations — such as suppliers and consumers/users of resources, products and services, market competitors, regulatory agencies, and state entities — which form an area of organisational life (DiMaggio & Powell, 1983). Fields are also viewed as relational spaces, where actors share common meaning systems and interact more frequently and significantly with one another than with actors outside the field (Scott, 1994). They have been also conceptualised as “battlefields” (DiMaggio, 1983), because social actors within each field share a common purpose but hold competing interests. All players engage in debates and strategic conflicts over the meaning and interpretation of the central issue around which the field revolves (Hoffman, 1999). Actors progressively develop mutual awareness of their involvement in this debate (DiMaggio, 1983).

In line with this approach, this thesis regards fields as characterised by specific structure, logics, and interactions between actors, who are conscious of such connections (DiMaggio & Powell, 1983; DiMaggio, 1983). All these characteristics define the boundaries of the field and its internal dynamics. As such, change at the field level entails adjustments to all these elements together.

In view of the complexity of the institutional environment (Greenwood et al., 2010), fields are affected by institutional pluralism (Kraatz & Block, 2008). Multiple logics coexist in a field and constantly rebalance their relationships. Studies have started accounting for such dynamics while considering field changes as determined by
conflicts between contrasting perspectives (Hoffman, 1999; Reay & Hinings, 2009). The institutional environment is made up of multiple rationalities, meaning structures and practices, which are tightly or loosely coupled, and the relationships between them are constantly reshaped by processes of social construction (Seo & Creed, 2002). These move the external boundaries of the field and revise the internal relationships between actors within the field.

INSTITUTIONAL LOGICS TO EXPLAIN FIELD-LEVEL CHANGE

Institutional change at the field level occurs through modifications to existing governance structures, actors’ roles, and underpinning logics (Scott et al., 2000; see Townley, 2002 and Zilber, 2002 for a more micro-approach). Logics are normally described as the sets of material practices and symbolic constructions that guide social action (Friedland & Alford, 1991; Greenwood et al., 2010; Thornton & Ocasio, 1999, 2008; Thornton, 2002). They identify and ascribe meanings and relevance to words, events, and symbols, which underpin social relations and acts. Therefore, they enable and constrain (DiMaggio, 1997) individuals and organisations in their thinking and acting, in the process of change as well as in their day-to-day activity, in a particular field. When such shared assumptions and rules are called into question or contrast with new beliefs and values, conflicts may rise among the existing and/or emerging logics.

Controversial definition of institutional logics: concept and dimensions

Despite a fruitful line of research on logics, agreement on the definition of the concept is not yet a settled issue among scholars.

The concept of institutional logic was firstly introduced by Friedland and Alford (1991) to describe the potentially contradictory beliefs and practices of modern Western societies. Capitalist societies are conceptualised as interinstitutional systems. Their core institutional orders — capitalist market, bureaucratic state, democracy, nuclear family, Christian religion (to which corporations and professions have been added later (Lounsbury, 2002; Thornton, 2002, 2004; Thornton & Ocasio, 1999) (Table 2.1) —
shape individual and organisational preferences and interests. Each institutional order
is associated to specific logics. Since societies are constituted by all orders and their
logics, there are potential contradictions between institutions in a specific environment.

Table 2.1: Institutional logics in contemporary Western societies

<table>
<thead>
<tr>
<th>Logic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market</td>
<td>Accumulation and commodification of human activity</td>
</tr>
<tr>
<td>Bureaucratic state</td>
<td>Rationalisation and regulation of human activity by legal and bureaucratic hierarchies</td>
</tr>
<tr>
<td>Democracy</td>
<td>Participation and extension of popular control over human activity</td>
</tr>
<tr>
<td>Family</td>
<td>Community and motivation of human activity by unconditional loyalty to its members and their reproductive needs</td>
</tr>
<tr>
<td>Religion (or science)</td>
<td>Truth, whether mundane or transcendental, and the symbolic construction of reality within which all human activity takes place</td>
</tr>
</tbody>
</table>


Logics are the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals and organisations produce and reproduce their material subsistence, organise time and space, and provide meaning to social reality (Friedland & Alford, 1991; Thornton & Ocasio, 1999). They embrace rational and transrational elements, with specific spatial and historical limits. They are “symbolically grounded, organisationally structured, politically defended, and technically and materially constrained” (Friedland & Alford, 1991: 248). Logics are the symbolic systems through which individuals and organisations categorise, give meaning and interpret activity, and the patterns of behaviours on the basis of which actors conduct their material life in a given time and space. They offer a set of assumptions on what constitutes reality and how to interpret it; they derive from those
assumptions and values the formal and informal rules and the patterns of behaviours that shape actions and interactions.

Logics constrain means and ends of social action, which assure continuity; however, they also contain sources of agency and change. The contradictions inherent in these sets of belief systems provide actors with cultural resources for transforming individual and collective identities and reshaping organisations and society (Friedland & Alford, 1991; DiMaggio, 1997). Furthermore, logics work at three different levels of social action, namely “individuals competing and negotiating, organisations in conflict and coordination, and institutions in contradiction and interdependency” (Friedland & Alford, 1991: 240). Industry-level logics draw attention to different sources of power in organisations and operate across these levels of analysis through three mechanisms (Thornton & Ocasio, 1999). At the macro level, logics are perceived as super-organisational symbolic and material patterns of meanings and order. At the industry (field) level, they are embodied in the identity of the players (Lok 2010) — although role relations might be central as well (DiMaggio, 1997; Rao et al., 2003). At the organisational level, logics guide decision-making processes and direct individual and collective attention to particular issues (Ocasio, 1997). Within organisations, logics moderate the effects of economic and structural forces that affect organisations in their decision-making. Logics influence power because they indentify the meaning and legitimacy of the sources of power and determine which strategic issues or problems become important in the internal political struggle between actors (Ocasio, 1997; Thornton & Ocasio, 1999). Finally, they show the appropriate and available answers and solutions for controlling and rewarding political behaviour in the organisation. Therefore, these nested levels are all necessary for the social construction of logics. However, this thesis argues that changes in one level may produce changes in the others to the extent that they are "translated" into these other levels (Holm 1995). This leaves space for partial, temporal or spatial misalignment between the institutions at these three levels and may therefore imply that conflicting paradigms might coexist, to different extents, in each level.

In the attempt to better define the concept of logic, studies have clarified some of the dimensions along which logics can be perceived. These elements include economic system, sources of identity, sources of legitimacy, power and authority, basis of mission, centre of attention, basis of strategy, logic of investment, governance mechanisms, and institutional entrepreneurs (Thornton & Ocasio, 1999, 2008;
Thornton, 2002). This categorisation is by no means exhaustive and other authors have proposed other classifications, which are more empirically grounded in the specific study context. For instance, analysing the abandonment of classic cuisine in favour of novel cuisine by the elite French chefs, Rao and colleagues (2003) have looked at culinary rhetoric, rules of cooking, archetypal ingredients, role of the chef, and organisation of the menus. However, studies do not really explain the reasons why these (and only these) elements are relevant to the identification of a logic. Nor have they examined the process through which elements of logics are constructed and recombined by social actors, just assuming they arise and stand together as a whole over time. Research on logics “often is not precise on the level of which logics become institutionalised, or whether they should be considered institutional logics at all” (Thornton and Ocasio 2008:108). Furthermore, previous research has usually assumed that a change in practice reveals a change in the underpinning belief system. However, even when changes in practices are visible, it cannot be inferred that the logic behind the action has changed as well; actors may have maintained their previous identity (Lok, 2010), or they might have adopted decoupling strategies (Oliver, 1991; Pache & Santos, 2010).

Despite these efforts, the concept of logics is still somewhat unclear and the existing literature interprets logics in different ways. Some scholars look at the overarching logics that are present at the societal level and directly apply to specific fields, such as the higher education publishing industry (Thornton & Ocasio, 1999; Thornton, 2002, 2004), healthcare (Scott et al., 2000), symphony orchestra (Glynn & Lounsbury, 2005), or manufacturing (Greenwood et al., 2010). Others investigate the paradigms as they appear in the interactions among organisations within the field (Haveman & Rao, 1997; Lounsbury, 2002, 2007; Purdy & Gray, 2009; Rao et al., 2003; Reay & Hinings, 2005, 2009). Finally, some observe the micro-processes within organisations. They uncover how individual and group repetitive actions and practices reshape the logics inside organisations and, eventually, redefine logics at the field level (Reay et al., 2006; Smets, Morris, & Greenwood, forthcoming; Townley, 2002). Generally, the higher the level of analysis, the more static is the idea of logic upon which the study is based. Because of this prevalent rigid representation of logics, field-level change has traditionally been considered as originated by shifts from one dominant logic to another (e.g. Scott et al., 2000). Only recently the motor of field change has been identified in the dynamic interplay between multiple forms of rationality, co-existing and co-evolving in the field (Reay & Hinings, 2009; Purdy & Gray, 2009; Dunn & Jones, 2010).
Institutional change as a shift in dominant logic

Various scholars have suggested that institutional change in a particular field results from the shift from a dominant logic to another one (Thornton & Ocasio, 1999; Scott et al., 2000; Lounsbury, 2002). Studies focusing on the healthcare field offer an example of such theoretical accounts. Analysing the changes along three dimensions, i.e., logics, actors, and governance structure, and grounding their empirical research on the healthcare system in the San Francisco Bay area, Scott and colleagues (2000) identify three eras of institutional change in the field. They name these eras professional dominance, federal involvement, and managerial control and market mechanisms. Consistent with this approach, many studies have explored the organisational responses to changes in logics as a result of the shift from professional and state logics towards more managerial and market logics in healthcare (Kitchener, 2002; Reay & Hinings, 2005; Ruef & Scott, 1998). This transformation has its antecedents in a change in discourse proposing health as an economic good, as opposed to a public good, and supporting business-like structures and managerial practices. This is made possible by the mobilisation of powerful actors, namely the popular business press, governing boards of healthcare organisations and management consulting firms (Kitchener, 2002). Blomgren and Sahlin (2007), who studied the evolution of the healthcare sector in Scandinavian countries, argue that a fourth and more recent era should be added to the three abovementioned ones. They refer to it as the quest for transparency. Contemporary society is dominated by an increasing demand for additional and more elaborated accounts of healthcare performance, a growing awareness of patient rights, and a raising attention to knowledge transfer, quality and management development among key actors.

During periods of institutional change, the rising logic gradually dismisses and replaces the former one (Haveman & Rao, 1997) — a process also known as reinstitutionalisation (Rao et al., 2003; Scott, 2001), if the logic had previously been a dominant one. However, old myths rarely disappear completely; in fact, secondary logics may play an important role in the field for long periods of time (Scott et al., 2000; Reay & Hinings, 2005). A closer attention to the rival logics may help explain organisational variations and (non)adoption of specific organisational forms and practices (Rao & Hirsch, 2003) and, hence, shed light on the process of resistance to change (Marquis & Lounsbury, 2007). Institutions associated with new logics may be
loosely coupled with enduring structures of the old logic that are still left in place (Cooper, Hinings, Greenwood, & Brown, 1996; Kitchener, 2002; Lok, 2010). Yet, the dynamics through which dominant and latent logics relate to, support or challenge each other, and the extent to which they are embodied in particular organisational models or routines and not in others, have only recently attracted the attention of institutional scholars.

In general, studies have been more concerned with defining the unfolding of change along the identified dimensions (e.g. logics, actors and governance structures) than with explaining the contradictions emerging in each era and the origins of change. Furthermore, this body of literature does not investigate how the change in logics affects the organisations’ internal processes or how and why organisations conform to or reject the dominant or secondary logics (see Pache & Santos, 2010 for an exception).

Indeed actors may respond to institutional change in different ways, depending on the power they hold and the extent to which their interests and value commitments are served by a particular institutional logic (Kitchener, 2002; Reay & Hinings, 2005), on their structural positions (Davis & Greve, 1997), on internal power struggles and specific organisational characteristics or archetypes (Greenwood & Hinings, 1993, 1996), or on organisational identity (Fox-Wolfgramm, Boal, & Hunt, 1998). The specificity of the historical context in which the organisations are placed is also key in understanding why some organisations respond to particular logics in a certain way (Greenwood et al., 2010). Such arguments are left open to additional empirical and theoretical investigation.

**Multiple institutional logics within an organisational field**

Authors have only recently started to address the importance of considering multiple and competing rationalities to explain field-level change (Hoffman, 1999; Reay & Hinings, 2009; Townley, 2002). Existing studies show that contradictory logics may be rooted in different geographic locations (Marquis & Lounsbury, 2007; Lounsbury, 2007) and that regional and community embeddedness are indeed expression of cultural, context-specific elements of institutions (Greenwood et al., 2010). However, multiple
and potentially conflicting paradigms may simultaneously exist (Dunn & Jones, 2010), even within the same geographical setting and within the same field.

Assuming that practices are shaped by logics and that logics as well as their manifestations are historically contingent, competing institutional demands have heterogeneous effects on the decisions adopted by organisations at a given point in time (Greenwood et al., 2010; Kraatz & Block, 2008). Organisational responses may therefore vary, ranging from acquiescence, to compromise, to avoidance, to defiance, to manipulation (Oliver, 1991). The specific reaction of an organisation depends upon the nature of the demand and pressures to change at the field level — the conflict may involve means or goals —, and upon the internal representation of such demands — the conflict may or may not be translated within the organisation and the internal interest groups may support one or more of the sides of the argument (Pache & Santos, 2010).

Focusing more on strategic choices at the field level, actors may manage the rivalry of institutional logics by developing collaborative relationships (Reay & Hinings, 2009). Pragmatic collaborations allow actors to maintain separate identities and, at the same time, work together towards a common goal and meet their responsibilities. This approach is deemed to be at times more productive than attempting to create a common identity for the collaboration in the first place (see also Fiol, Pratt, & O’Connor, 2009). When a field is emerging, actors could aim to transform the field from the outside, by replacing existing practices; they may graft the field from within, by integrating old and new practices; they may bridge between two fields, by decoupling formal and informal organisational practices; or they may exit from a field and realign to a different one (Purdy & Gray, 2009). Finally, originally conflicting logics may be blended in the same discourse (Glynn & Lounsbury, 2005). This is a rather incremental process that seems to involve initially only the edges of the repertoire, while the main practices and actors remain faithful to old canons.

Organisations rely on different logics to match diverse institutional conditions in their environments and multiple sets of practices supported by conflicting logics may coexist within the field (Dunn & Jones, 2010; Purdy & Gray, 2009). However, despite such recent efforts, the dynamics whereby the existing logics are altered are still relatively unknown. We lack an understanding of the mechanisms through which rising logics are reproduced and enforced and the ways in which such rising logics affect the existing
combination of logics in the field (Greenwood et al., 2010). Therefore, the study of multiple logics needs to be substantiated with a deeper understanding of the gradual construction and/or rejection of logics in a specific field, and of the existing relationships between such logics. This would allow us to perceive whether and to what extent logics support, tolerate or contradict each other. It may help understand the internal structure of logics and their flexibility to accommodate change or their tolerance towards contrasting assumptions. It may also shed light on the mechanisms through which the field evolves and other previously discarded actors (e.g. patients in institutional studies on healthcare) may participate in processes of institutional change.

**Conceptualisation of logics in this thesis**

Since the theoretical interest underpinning this research lies in uncovering processes of field-level change, this thesis adopts a definition of logics elaborated in previous studies, which investigated changes in believe systems in a given field (Lounsbury, 2002, 2007). Logics are treated as sets of cultural beliefs and rules that structure cognition, guide decision-making, and shape practices and actors' interactions within an institutional field. In summary, logics are sets of ideas and practices that guide and organise social action in a given field.

This section presents some of the elements and concepts that can be characterised as central features of logics, which have been identified through a closer examination of the existing literature, supplemented by theoretical insights gained from this study; these elements are also related to the empirical data presented later in the thesis (see Figure 3.1 and 3.2 for an illustration of logics in the empirical context under study, and Appendix D for the corresponding codes derived from the data). Specifically, the thesis proposes that logics are instantiated in: (i) **roles and identities**, (ii) **governance structures**, (iii) **organisational forms**, and (iv) **practices** (Figure 2.1). In empirical investigations, logics emerge as identity-centred claims that are enacted through specific practices and protected by particular organisational forms and governance arrangements.

Since the focus of this research is on field-level logics, identities and relationships between actors assume a key position in the analysis; the reconstruction of roles and
identities seems to be central in the process of logic elaboration. Indeed, this reflects findings of previous studies, which have addressed identity as one of the key elements that characterise a logic. In her presentation of ideal types, Thornton has always included sources of identity (Thornton, 2002; Thornton & Ocasio, 1999; 2008) as a distinctive element of logics. Following this early empirical work, institutional scholars have generally agreed upon the importance of identities for describing logics in a number of contexts and fields (e.g. Greenwood et al., 2002; Rao et al., 2003). More recently, Lok (2010) showed that logics are actually identity projects. However, this thesis argues that a more comprehensive notion of role-identity (e.g. Chreim et al., 2007), derived from the identity literature, would be more appropriate to analyse logics. This concept embraces both the individual’s self-definition as a member of a group (identity) and the interaction structure in a given setting (role), thus helping defining self-categorisation as well as describing the structure of relationships around a specific actor.

Another element that is usually considered to be a characteristic of logics is authority structure (e.g. Thornton and Ocasio 2008). Power and authority derive from the actor’s formal position within an organisation or a field, the organisation’s status and reputation, the existing social relationships and the ability of an actor to manage those relationships, as well as the available resources (Lounsbury 2002; Thornton & Ocasio 1999). Some authors argue that actors that occupy central positions in the field would be more powerful and potentially more able to promulgate change (Greenwood et al., 2002; Greenwood & Suddaby, 2006). Others show that, instead, institutional entrepreneurs occupy peripheral positions, which allow them to maintain legitimacy, but also to bridge stakeholders and control key resources (Leblebici et al. 1991; Maguire et al., 2004). In both cases, actors that embody a dominant logic would enjoy special status within a field and would further create specific authority structures to maintain their power and position and protect the logic. However, given the fact that authority structures are not simply imposed by powerful actors over other actors in the field, but are, to some extent, agreed upon (at least temporarily), this research argues that, more broadly, governance arrangements within the field would need to be considered an element of logic.

Logics are more than just abstract ideas and beliefs; they are embodied in material manifestations, including particular organisational forms (Haverman & Rao, 1997; Rao et al., 2003). Theories and assumptions existing at the societal level and at the
field level originate specific organisational types and structures, which, in turn, reflect the principles of such logics and further consolidate them. Changes in institutions are accompanied by changes in organisational form; at the same time, changes in organisational form inevitably yield changes in the underpinning institutions (Haverman & Rao, 1997). The process by which new organisational forms are created is still unclear to institutional theorists (Tracey, Phillips & Jarvis, 2011); however, it is clear that the duality between institutional logics and organisational forms is fundamental when exploring change over time. The creation or abandonment of particular organisational forms indicates a modification of the systems of beliefs that are present in the institutional environment. Vice versa, the emergence or decline of logics is reflected in the presence or absence of specific organisational forms.

Logics are often described as sets of symbolic meanings and associated material practices (e.g. Friedland & Alford, 1991; Greenwood et al. 2010). Attention to such micro-foundations of logics and attempts to explain how changes in practice could trigger broader changes in meaning systems have only recently started to emerge in the literature (Reay et al., 2006; Smets, Morris, & Greenwood, forthcoming; Townley, 2002). Practices are variably defined as patterns of activities that assume specific meanings because of common understanding of how activities should be carried out (Jarzabkowski 2005). The meaning of local practices is related to broader, shared understandings and frameworks: it is through practices that actors enact logics (Sahlin & Wedlin, 2008).

Figure 2.1: Essential elements of an institutional logic
Other elements of logics that have been identified in the literature could in fact be linked to one of these four fundamental dimensions and, therefore, *per se* would not be considered as essential to define a logic. For example, what Thornton and Ocasio (1999, 2008) call the basis of mission and the basis of attention could derive from the fundamental identity of the actors that embrace the logic. Because publishing is seen as a profession or as a business, a publishing company would privilege more the author-editor relationships and networks rather than the competition for resources. Elements such as economic system or institutional entrepreneurs do not really define what the logic is; however, they indeed provide further contextual elements to understand how a logic becomes relevant in a field.

The thesis illustrates how these fundamental elements of logics are applied to the professional order in the selected case studies (Chapter III). Particularly, it shows that Estonia and Lithuania departed from the same starting point — the same specialised professional logic was in place in both countries before the reform —, and introduced similar principles — derived from the holistic professional logic — during the reform process. However, this process followed divergent trajectories in the two contexts, because the professional logics were elaborated in different ways.

**JUSTIFICATION FOR THE RESEARCH**

Despite these advances in our understanding of institutional change, we have limited knowledge of the dynamics through which fields are restructured by processes unfolding *within* logics rather than processes triggered by conflicts *between* logics. This study shows that institutional field-level change does not occur just through a shift from a dominant logic to another, or as an alteration in the balance between existing logics; change may occur also through the elaboration of a logic. In addition, the research illustrates how the process of logic elaboration in different contexts may result in dissimilar outcomes because of specific contextual factors. It identifies such important contextual factors influencing processes of internal elaboration of logics in order to further explain how the institutional environment shapes field-level change.
The next section outlines some areas of further research that will potentially expand our theoretical understanding of profound field-level change processes. It also explains how this study intends to address these concerns.

**The gray areas of field-level change in the institutional theory literature**

Existing literature has documented the effects and the outcomes deriving from institutional pressures. However, evidence is lacking on the processes originating those effects (Barley & Tolbert, 1997; Suddaby & Greenwood, 2009).

Until now, logics have been mostly treated as static and monolithic sets of assumptions and practices that permeate the whole society and reach across fields, or directly apply to specific fields (Lok, 2010; Thornton & Ocasio. 1999; Thornton, 2002). This conceptualisation led researchers to focus more on the effects of shifts from one dominant logic to another to explain field-level change rather than on the social processes that originate such shifts (Thornton & Ocasio. 2008).

Recognising these limitations, more recently institutional scholars have interpreted change as a modification of the balance between competing logics in a field (Purdy & Gray, 2009; Pache & Santos, 2010; Reay & Hinings, 2009). However, some authors believe that logics may actually coexist in a field, without necessarily competing (Dunn & Jones, 2010). Therefore, there may be other dynamics, perhaps linked to changes within a logic, that trigger field-level change and that have not been explored yet.

It is in fact rather unrealistic to assume that field logics would remain stable over time; it is more likely that logics are extended after their diffusion (Shipilov, Greve, & Rowley, 2010). Even early conceptions of logics view them as historically contingent and geographically situated (Friedland & Alford, 1991). However, to my knowledge, research has so far mostly ignored the evolving nature of field logics, thus possibly underestimating their ability to change and to be changed.

We lack insights on how logics are constructed, how they evolve and how they are contested and eventually de-institutionalised in a field. A focus on how logics change does not neglect the nature of logics as paradigms that assure continuity of
interpretation and action. However, it draws attention to the processes of social construction that create new institutions and embed them within logics.

Furthermore, we lack an understanding of these context-specific social phenomena outside North American settings (Greenwood et al., 2010). Most of the research to date has focused on Western countries, mainly the United States and Canada. Research on other empirical settings may provide new insights on institutionalisation processes. For instance, the construction of new beliefs and meanings and the conflict between paradigms may be more apparent during the transition from communist to market and democratic systems. Expanding the analysis of logics to include these settings might help identify the historical (Friedland & Alford, 1991) and spatial limits of logics. It would also allow us to compare the different institutional conditions within or between these societies that led to specific processes of change in particular fields (Scott et al., 2000).

Framing the research questions

The aim of this research is to understand how field-level institutional change unfolds in different contexts. The study examines two countries, Estonia and Lithuania, in which the same field of healthcare, and particularly one of the logics within it, i.e. the professional logic, underwent a similar transformation, but eventually evolved in different ways. The research detects the context-specific factors that influenced these change processes and that ultimately led to different outcomes in the two countries.

Empirical research on the healthcare sector in transition countries (e.g. Atun et al., 2006) demonstrates that the Estonian and Lithuanian healthcare systems were almost identical before the 1990s, since both countries were part of the former Soviet Union. After gaining political independence from the U.S.S.R., the countries activated a reform process which, among other goals, aimed at strengthening primary healthcare and at developing a holistic approach to the patients by promoting family medicine. However, despite departing from the same logic and field organisation and despite sharing fundamentally the same logic and ideas for reforming healthcare, the systems developed in divergent ways in two countries. This triggered an interest in understanding:
Why does a field with the same original characteristics and similar arguments for change evolve in divergent ways in different contexts?

What are the context-specific dynamics through which beliefs, ideas, structures and practices are manipulated to restructure the same field in different settings?

Further elaborating on these empirical questions in consideration of a broader theoretical interest, this study explores how an existing logic changes as new elements are introduced and embedded in it. Specifically, it investigates:

How do logics change over time in different contexts, originating processes of field-level institutional change?

What context-specific factors influence the process of logic change?

The findings of this research show that field-level change may occur through processes of logic elaboration. This is achieved by particular theorising agents, who collectively frame new institutions, mainly translated from other contexts, and variably place them within their institutional environment. Actors elaborate on existing paradigms on the basis of context-specific factors — which allow logic elaboration to occur through the alternative processes of grafting and appending. Elaborating a logic, actors reconstruct roles and identities, governance structures, organisational forms, and practices, as well as modifying the common goal of the field. As a result of social action, logics and fields emerge as evolving systems that progressively stratify upon their previous structures as new institutions are constructed and introduced.

Envisaged contributions of the study

This work expands current knowledge of field-level processes of change by addressing the internal elaboration of institutional logics. This process is studied through a comparative analysis of the same field in two countries, in order to uncover the context-specific factors that influence logic elaboration in different environments. The novelty of this work lies in the first attempt to explore dynamics of change which occur within logics rather than between logics. This thesis offers a number of insights which may contribute to expand our current knowledge of institutional field-level change.
Given the diversity of all fields, we have to assume that some broader, societal-level logics come into play in some fields and not in others (at least not to the same extent). However, if we adopt a rigid conceptualisation of logics (Lok, 2010; Thornton & Ocasio, 1999; Thornton, 2002), we cannot account for such diversity. This research highlights the importance of embracing a more fluid and evolutionary conceptualisation of logics to understand if and how logics evolve and interact in a specific context.

This study looks at a variety of actors within the institutional field and illustrates their role throughout the process of change. However, it considers their action in light of a broader focus on process, particularly concentrating attention to the juxtaposition of paradigms and to the mechanisms through which actors come to share and support the same principles (Hardy & Maguire, 2008). It examines how social actors participate in the process of logic elaboration, emphasising agency in contexts of extremely radical institutional change that is spatially and temporally situated (Langley, 1999, 2009).

The research explains how internal changes within a logic restructure the field and modify the relationships between the groups inside a social actor. Typically, a social actor embraces one specific logic. However, during processes of logic elaboration, groups within the same actor may conform just partially to the changing system of beliefs. Therefore, not only actors may respond differently to institutional pressures (e.g. Pache & Santos, 2010); but groups within the same actor may also do so, sharing only some of the elements of the same logic.

Finally, this thesis extends the investigation of institutional processes to contexts that have not been previously included in theoretical formulations. To date the majority of the institutional theory literature has concentrated on Western countries, mainly the United States and Canada, and has looked at changes in mature fields (e.g. Reay & Hinings, 2005, 2009; Greenwood & Suddaby, 2006). Very few studies have focused on other settings, such as, for instance, developing countries (Lawrence, Hardy & Phillips 2002) and emerging fields or fields in crisis (Maguire et al., 2004; Purdy & Gray, 2009). For this reason, we have limited knowledge of field-level changes in non-Western countries and hardly any information on contexts where all institutional orders are challenged at the same time. In this regard, Central-Eastern European countries are interesting settings to study processes of radical change. Within these settings, following the collapse of the Soviet Union, even the fields that have traditionally been recognised as mature and highly institutionalised, such as healthcare (Thornton &
Ocasio 1999), have been profoundly transformed. As a consequence, this study is situated in a *unique setting*, the post-Soviet states, which are still relatively under-researched, but which, nevertheless, offer fertile grounds for exploring radical change processes.
CHAPTER III. Methodology

This inductive case-study research is conducted to expand existing theory on institutional change at the field level by investigating logic elaboration. The formal theoretical model that emerges from the findings of the study (Glaser and Strauss, 1967) builds upon the comparative analysis of the evolution of the primary healthcare field in two countries, Estonia and Lithuania. These empirical settings are identified as case studies given the potential for exploring field-level change dynamics through internal modifications of institutional logics in two different contexts.

The assessment of existing empirical literature and the analysis of preliminary data determine that Estonia and Lithuania presented similar initial institutional traits and field configuration prior to the reform. In addition, both countries promoted similar guiding principles for reforming primary healthcare, by introducing principles of the same, new institutional logic. However, they developed dissimilar institutional characteristics after this radical change. As a consequence, the healthcare field evolved in different ways.

This chapter offers a detailed explanation of the methodological choices and their implications. The first section outlines the research contexts, justifies the case selection and briefly illustrates the story of change and the outcomes of logic elaboration in the two countries. The second section explains the research strategy and design. The third section describes the process of coding and analysis, concluding with some considerations on the consequences of the methodological choices.

RESEARCH CONTEXTS AND CASE SELECTION

The criterion for the cases’ selection is to maximise the opportunity to investigate the divergent evolution of the same field in different contexts as a result of logic elaboration. After a preliminary assessment of empirical literature concerning post-Soviet countries, Estonia and Lithuania are identified as two cases that share the same field logic before the reform, but then appear to have diverged in the process of
change. As a result, these two countries seem to present some variety in the manifestation of field-level change processes.

A case-study research design is chosen in light of an interest in studying the cases per se and as different expressions of phenomena that are embedded in their context. The significance of the cases is *instrumental to understanding* the process of change through logic elaboration and their comparative analysis is valuable for shedding light on the context-specific factors influencing such field-level dynamics. The current dissimilar roles and social status of relevant actors, organisational forms, governance structures, and practises signal a divergent evolution of the logics underpinning the modes of organising primary care in the two countries (see Table 3.1). As such, not the representativeness, but the potential and the opportunity to learn about field-level dynamics of institutional change in different spatial contexts guide the selection of the cases. The cases represent sources of traits, mechanisms and concepts that may be generalised to theory to explain the phenomenon of interest (Stake, 2000).

Furthermore, this study is situated in this unique setting, two post-Soviet states, because they are still relatively under-researched, but, nevertheless, offer fertile grounds for exploring radical change processes that invest the whole society. To date, given the concentration of the institutional theory literature on Western countries (Reay & Hinings, 2005; Galvin, 2002; Thornton, 2002; Lounsbury, 2002, 2007; Scott et al., 2000), we have very limited knowledge of field-level changes in non-Western countries and hardly any information on contexts where all institutional orders are challenged at the same time. This happened in Central-Eastern European countries during and after the collapse of the Soviet Union. Within these settings, even the fields that have traditionally been recognised as mature and highly institutionalised, such as healthcare (Thornton & Ocasio, 1999), underwent a profound transformation. In these contexts, “it was not only a matter of remembering the new but also forgetting the old” (Czarniawska, 2002: 165). Such change was driven by actors within as well as outside the field and was placed in the general restructuring of the countries.

Besides these theoretical considerations, the contacts established in the area through previous research conducted by the Centre for Health Management at Imperial College Business School secure access to the field for data collection and assure the feasibility of the study. They also secure the availability of basic information on the reform processes in the countries, as well as access to (English speaking) key informants. In
addition, the relatively small size of the countries makes it feasible for only one researcher to collect and analyse data.

**Institutional logics in Estonia and Lithuania**

A tentative initial observation shows that Estonia and Lithuania shared similar antecedents and a common trajectory in their political and economic transition. They seem to have moved from the same professional logic towards another professional logic during the process that reformed the primary healthcare (PHC) sector. However, the evolution of the healthcare field diverged, especially in relation to political and economical orientations towards the development of primary healthcare as well as the introduction of market-related principles and practices (Atun et al., 2005). This led to the current observable dissimilarities in the elements of the professional logic elaborated in the two countries (Table 3.1).

These countries were part of the Soviet Union but, following decoupling in 1991, experienced a rapid transition from command- to market-economies. They underwent a profound transformation to homogenise their political, economic and legal systems to those of the Western European countries, with the aim of joining the European Union in May 2004. Their health systems were rooted in the Soviet Semashko model, a hierarchical, centrally planned and funded public system. During the transition period, these healthcare systems were transformed by the introduction of market mechanisms, a greater involvement of the private sector, and a renewed attention to primary care (Atun, 2007).

*Characteristics of the Semashko system: professional logic of specialisation*

Until the early 1990s, the Estonian and Lithuanian healthcare systems were rooted in the so-called “Semashko model” (Figure 3.1). This was introduced in the Soviet Union by Nikolai Aleksandrovich Semashko, who served as People’s Commissar of Public Health from 1918 until 1930. The Semashko model firmly reflected the *hierarchical, centrally controlled* and planned administrative system typical of the Soviet republics.
Primary and secondary data (see Appendix D) show that the principles underpinning the organisation of such health system reflect a **professional logic** fundamentally orientated towards **specialisation** and **fragmentation** of the provision, planning and monitoring of healthcare services (Table 4.1).

Professionals in the field considered healthcare to have a marked **curative** rather than preventive focus and their **role** was essentially to provide treatment, possibly consisting of highly specialised care (Balabanova 2007). Doctors working in PHC settings included district internists or district paediatricians in rural areas; therapeutists, paediatricians, gynaecologists, psychiatrists or other subspecialists, such as ophthalmologists and ear, nose and throat surgeons, in urban polyclinics (Atun, 2007). Given the fragmentation of the system, they could **not** establish a **personal relationship** with their patients. As a consequence, their **practices** consisted mainly in providing **episodic treatment** and in referring patients to specialists (Lember, 2002).

A variety of healthcare **organisations** delivered services free-of-charge. They constituted an extensive, integrated, and exclusively **public network of specialised care and fragmented primary healthcare** (Lember, 2002; Oona, Kalda, Lember, & Maaroos, 2004). The provision of care was unbalanced between the primary and secondary level, with an underdeveloped primary care structure and an exaggerated focus and development of hospitals and bed capacity (Starkiene, Smigelskas, Padaiga, & Reamy, 2005; Seifert, Švab, Tiik, Kersnik, Windak, Steflova, & Byma, 2008). The main focus of the service delivery structure consisted of **inpatient hospital services** to increase the activity of secondary care doctors, which were considered “the real doctors”. The PHC delivery structure comprised a variety of health centres, which included, amongst others, **polyclinics** and paediatric polyclinics (state healthcare facilities, providing ambulatory outpatient care to adults and children respectively) and women's consultation centres (department of the polyclinic or maternity hospital, which provided

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3 Early specialisation in training was also endorsed. From the beginning of the medical training, students could choose between different tracks of study, targeting specifically paediatrics or internal medicine or sport medicine. This reinforced a separate identity of the professional groups and fuelled the resistance to introduce a family medicine-centred primary care. Therefore, the first step of the reforms would be to create a homogeneous medical training for all students.
ambulatory out-patient obstetric and gynaecological care) (Shabarova, 2001). In such organisations the boundaries between primary and secondary care were blurred.

The governance of such system was based on centralisation of decisions and direct control of the activity of clinicians. Primary care doctors were not autonomous in their decision-making. They had to respect the formal authority of the head of the policlinic, who usually promoted referral practices from first-contact to specialist doctors to increase the profitable activity of secondary care doctors.

Figure 3.1: Professional logic of specialisation in the Estonian and Lithuanian Semashko-type healthcare systems.

The reasons for change

A number of concurring factors contributed to prompting the change in the healthcare field. Even though the Estonian and Lithuanian health systems, as most health systems in Soviet Union countries, initially achieved positive results — for example in terms of
health outcomes (Balabanova, 2007), universal access to care and tackling common infectious diseases (Figueras, Menabde, & Busse, 2005) —, in the 1970s problems started to emerge. The system was inefficient, financially unsustainable, underfunded and featuring poor infrastructure. There was no prioritisation in the allocation of resources and delivery of services, both of which were usually following political motivations rather than actual needs. Access to good quality of care was undermined (Balabanova, 2007) and access to technological innovations and pharmaceuticals developed in the Western world was not allowed. As a result, the citizens’ health deteriorated (Atun & Mendabe, 2008).

The main motivations that brought about change in Estonia and Lithuania may generally be identified in the need to assure financial resources to the system, the desire to move away from the past and the willingness to acquire legitimacy as independent countries in the international arena. For the healthcare field, this essentially meant the separation of the healthcare budget from the state budget, through the creation of an insurance system; the abandonment of the Semashko model, in favour of a more decentralised system; and the engagement in the international healthcare debate, which was centred on primary care and family medicine. All these functional factors created a momentum for reforming the health system. In order to ensure additional resources for this purpose, the countries sought international assistance. International organisations, such as The World Bank, which intervened to support the process, planned a strategy focused on health sector restructuring, infrastructure rehabilitation, and health facilities’ development (The World Bank, 2003).

From a national perspective, once they became independent, all post-Soviet countries had to face similar political, social and economical challenges. Whilst dealing with the transition process, most of them shared the desire to follow models and practices used in Western European countries, which were generally perceived as superior (Figueras, Menabde & Busse 2005). In the independent countries — including the Republics of Estonia and Lithuania —, although to different extents, at all levels, a strong motivation to differentiate from the previous model emerged. This cleared the way for incorporating new values and structures drawn from Western democracies and market economies into all sectors (Atun, 2007). Governments reduced the state involvement and endorsed decentralisation of responsibilities and privatisation policies in every area.
of economic activity, following the New Public Management approach (Hood, 1991; Osborne & Gaebler, 1992).

The period of uncertainty that followed the dissolution of the U.S.S.R. opened an opportunity window for Estonia and Lithuania to restructure their administration and to reform various sectors, including healthcare. The vision of the role of the state that grounded the socio-economic and political system of the Soviet republics and further legitimated the Semashko system was altered, if not completely eroded. Therefore, the countries had to face the urgent challenge of adjusting to the withdrawal of the ideological premise of free and universal health care that was dominant under the Soviet system (Permanand & Mossialos, 2000). Healthcare, in many ways, ceased to be perceived as a ground of pervasive state activity and space was created for the introduction of innovative ideas and models, largely derived from Western European systems.

Attention was originally devoted to creating a health insurance system (Estonian Health Insurance Act, 1991) that, through a purchaser-provide split, would secure sustainable financing for healthcare and, in particular, for primary care (Koppel, Hahur, Habicht, Saar, Habicht, & van Ginneken, 2008; Lovkyte, Reamy, & Padaiga, 2003). Another main concern at the beginning of the reform process was the need to decentralise the provider network (Cockcroft, Andersson, Paredes-Solís, Caldwell, Mitchell, Milne, Merhi, Roche, Konceviciute, & Ledogar, 2008; Jakušovaitė, Darulis, & Žekas, 2005; Estonian Health Service Organisation Act, 1994) and to increase the system’s efficiency (Cerniauskas, Murauskiene, & Tragakes, 2000). The hospital sector reform was mainly focused on improving efficiency and reducing waste of resources by downsizing hospital capacity. The primary care reform was primarily concerned with maintaining equity in access to care and promoting a greater freedom of choice for the patients, while enhancing efficiency. Increasing attention was also devoted to strengthening patients’ rights and enhancing quality of services (Bankausaite & Saarelma, 2003).

In Lithuania, the logic underpinning the approach to healthcare reforms was outlined in the National Health Concept, a document prepared by medical professionals and approved by the Seimas in 1991. This document was soon praised internationally as innovative and comprehensive and represented the “intellectual basis for decision-making in the field” (Cerniauskas et al., 2000: 8) throughout the reform process.
However, since the Concept was not supported by medium-term plans, the country struggled with its implementation. This created a gap between strategic directions and actual changes that characterised most of the Lithuanian reform process.

**Primary healthcare reforms: professional logic of holism**

In Estonia and Lithuania, in the late 1980s — even before the declaration of independence — a debate started among doctors and medical educators on the need to redesign the service delivery in healthcare. Doctors providing first-level services saw the regaining of political independence as an opportunity to restructure the organisation of the health system and to gain higher professional and social status (Koppel, Meiesaar, Valtonen, Metsa, & Lember, 2003; Lember, 2002). This internal mobilisation led to successive reforms that introduced a social insurance system, promoted decentralisation of decisions and responsibilities, and created an integrated primary healthcare (PHC) system centred on family medicine, following the example of most Western European countries (Atun, 2007; Bankauskaite & O’Connor, 2008; Polluste et al., 2000; Rechel & McKee, 2009; Rese, Balabanova, Danishevski, McKee, & Sheaff, 2002).

When Estonia and Lithuania accessed the international discourse on health systems, this was dominated by the emphasis on the centrality of a strong primary care. In the late 1970s, a “Primary Health Care movement” of professionals, institutions, governments, researchers and civil society organisations mobilised the health system debate to tackle the “politically, socially and economically unacceptable” health inequalities in all countries (The World Health Organisation, 2008: xii). In 1978, countries all over the world joined the International Conference on Primary Health Care and signed the Alma Ata Declaration, advocating PHC as the main strategy to achieve health for all and reduce health inequalities (The World Health Organisation, 1978; Wibulpolprasert, Tangcharoensathien, & Kanchanachitra, 2008).

According to the Declaration, primary healthcare is defined as “essential health care [...] the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (The World Health Organisation, 1978; emphasis added).
The reform of the healthcare sector involved the reorganisation of first-level services in line with principles of the Alma Ata declaration (Appendix C). Estonia and Lithuania espoused a vision that promoted a person-centred approach and dealt with health problems in all their dimensions — physical, psychological, social, cultural and existential (WONCA Europe, 2005). The idea of embracing a comprehensive view in the care of a person is central to a **professional logic of holism** (Figure 3.2). In denial of the Semashko model, countries under the influence of the U.S.S.R. captured this main discourse. Professionals were the main promoters of this bottom-up transformation, which eventually created a proper PHC subfield.

**Figure 3.2: Professional logic of holism introduced in Estonia and Lithuania.**

- **Role-identity:**
  - Doctor as guarantor of well-being;
  - Preventive function, expanded responsibilities;
  - Centrality of doctor-patient relationship;

- **Governance arrangements:**
  - Decentralisation;
  - Accountability for patient lists (and for practice management);
  - Individual responsibility towards patients;

- **Organisational forms:**
  - Strengthened primary care;
  - Separation between primary and secondary care;
  - Contracting mechanisms, independent organisations;
  - Focus on outpatient care;

- **Core principle**
  - Comprehensive care for the person

- **Practices:**
  - Continuity of care and coordination;
  - Manage patient lists.

With this approach, the role of the doctors becomes that of a *guarantor of well-being*. Primary care doctors predominantly focus on *prevention, health advisory and coordination of care* for the patients, with whom they can maintain a strong, personal
relationship as family doctors. **Governance structures** are decentralised to the community level. Individual doctors have to *manage their own list of patients*: they become directly *responsible for* and *accountable to* identifiable patients. **Practices** of doctors are adaptable to the need of each patient, to ensure that they are followed *continuously* throughout their life and throughout their journeys within the health system.

Boundaries between **organisations** that delivery primary care services and those that deliver secondary care services are clearly *defined*. The balance between *outpatient* care and inpatient care is in favour of the former because the health system is centred on the idea of a *strong primary healthcare*, which could solve up to 80% of the health problems of normal people. Service delivery organisations stipulate *independent contracts* with the national insurance funds for the reimbursement of their activity, and are, therefore, *accountable* for the amount and quality of the services provided.

**Current differences in the professional logic in Estonia and Lithuania**

The existing logic of *pervasive specialisation*, which was typical of the Semashko model of care, was elaborated by the introduction of new ideas, identities, practices and organisational forms related to family medicine. These belonged to a professional logic of *holism*, which was common in the organisation of primary care in most Western European countries at the end of the 1980s. The fundamental elements and steps of the primary care reform process were basically the same for both countries. Organising training and re-training courses was the first action taken and was used as a mechanism to socialise practitioners to the new principles. Opening Family Medicine units/departments within the Medical Faculty signalled the recognition of family medicine as an academic discipline. Declaring family medicine as a medical specialty conferred political legitimation and support to the new profession. The creation of professional associations for family doctors increased the legitimation of the new professional role among the other medical professionals. Modifying the legal status of the providers and creating new organisational forms reflected changes in the relative power of professional groups and facilitated the adoption of practices related to the new family medicine principles. Decentralising decisions and conferring clinical and managerial autonomy to family doctors allowed them to enact their role properly and to practices as “real doctors”.

54
Despite these similarities between the reforms in Estonia and Lithuania, the outcomes of the process of change are contradictory in the two contexts (Table 3.1). In both countries, but to different extents, during the past two decades family doctors replaced district internists and district paediatricians in the delivery of primary care services. The percentage of family doctors over the total number of physicians grew from 9.9% in 1993 to 16.0% in 1998 in Lithuania, and from 14.3% to 18.3% in Estonia, against an average of respectively 29.8% and 27.4% of all European Union countries (Lovkyte et al., 2003). However, in Estonia primary care is provided only by family doctors, while in Lithuania district internists, gynaecologists and paediatricians are still working as a “team” in primary care (Boerma, 2003) — from now on referred to as “transitional period teams”, following the suggestion of one interviewee. Generally, in Lithuania the adaptation and recognition of the new specialty has been more problematic than in Estonia (Seifert et al., 2008).

In Estonia all doctors working in primary care were progressively retrained in family medicine, thus eradicating the Semashko specialisation from training programmes. In Lithuania some doctors were not retrained and, therefore, not socialised to the new principles and identity associated with family medicine. In Estonia retraining programmes were more systematic and targeted to paediatricians and internists, while in Lithuania duration and curricula depended upon prerequisites of doctors from many other specialties (Seifert et al., 2008). In Estonia undergraduate education in family medicine has been provided by an established and dedicated department at Tartu University, whereas in Lithuania courses of family medicine have been hosted by other departments, such as that of Public Health.

Estonia adopted a uniform organisational model across the country, consisting of autonomous family doctors as independent contractors. Conversely, Lithuania tolerated a mixed system where family doctors and teams of specialists both provided primary care services, and where big public providers coexisted with smaller autonomous ones. In Estonia the whole population was enrolled with a family doctor already in 2003 and, since then, primary care has been provided only by family doctors (Hakansson et al., 2008). In 2006, the number of family doctors reached 853, while in 2008 it grew to more than 900, accounting for about 20% of the total number of doctors in Estonia (Koppel et al., 2008). In 2006, in Lithuania only 25% of the population was registered with a private family doctor, while the majority of the population was enrolled with family doctors working in public polyclinics. In 2008, 40% of the population was still served by
“transition period teams” in polyclinics (Seifert et al., 2008). At that time, primary care was provided by 1,837 family doctors (about 66% of all doctors in Lithuania), 475 district internists (17%) and 490 (17%) district paediatricians (Boerma, 2003). Despite the unbalanced distribution of doctors between cities and countryside, Lithuania has not put incentives in place to encourage physicians to work in rural settings (Lovkyte et al., 2003). Estonian policies have instead endorsed monetary incentives, such as a car allowance to drive to remote locations, for that purpose (Seifert et al., 2008).

In Estonia the new ideas and practices associated with family medicine have been embraced more coherently throughout the field, because the status of independent private entrepreneurs protected the autonomous work of family doctors and helped them develop a strong professional identity. In Lithuania, where the new and the old delivery structures coexisted, the beliefs and the practical work of doctors considerably differed. Doctors’ role and practices varied significantly between family doctors in private practices, specialists in “transition period teams”, and family doctors in public polyclinics.

These divergent trajectories potentially indicate the existence of differences in the process of logic elaboration between the two contexts (Table 3.1). Specifically, in Estonia principles of the holistic logic were elaborated in primary care in such a way that they perfectly and clearly complemented those of the specialisation logic, which still survived in secondary care. In Lithuania, principles of the holistic logic were introduced in primary care and eventually coexisted with those of the specialisation logic in this context.
Table 3.1: Outcome of logic elaboration in Estonia and Lithuania: complementarity and coexistence

<table>
<thead>
<tr>
<th>Logic elements</th>
<th>Estonia</th>
<th>Lithuania</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main idea</strong></td>
<td>Specialisation in secondary care; Comprehensive approach in primary care;</td>
<td>Specialisation in secondary care, tolerated also in primary care; Comprehensive approach in primary care;</td>
</tr>
<tr>
<td><strong>Role-identity</strong></td>
<td>Doctor as gatekeeper and coordinator; Preventive and curative function, expanded responsibilities; Personal doctor-patient relationship;</td>
<td>Doctor as gateway-to-treatment and coordinator; Preventive and curative function, limited responsibilities; Personal doctor-patient relationship;</td>
</tr>
<tr>
<td><strong>Governance arrangements</strong></td>
<td>Accountability and individual responsibility;</td>
<td>Hierarchy; Accountability;</td>
</tr>
<tr>
<td><strong>Organisational forms</strong></td>
<td>Firm separation between primary and secondary care; Autonomous providers;</td>
<td>Blurred actual separation between primary and secondary care; Autonomous providers;</td>
</tr>
<tr>
<td><strong>Practices</strong></td>
<td>Managing patients; Medical and managerial responsibilities</td>
<td>Limited managerial responsibilities; Increase activity of secondary care (referrals)</td>
</tr>
</tbody>
</table>

**RESEARCH STRATEGY AND DESIGN**

In consideration of the apparent different trajectories of the change process in the two countries, this research is set to confirm and fully establish a divergent evolution of the two cases and to explain the reasons underpinning such differences. It theoretically explores the reasons for this divergence by shedding light on the social processes
underpinning the reforms that the two Baltic States\(^4\) undertook on their respective primary healthcare subfield. The main concern is to explore the influence that historical context and socio-cultural factors exert in shaping the way in which actors’ identities, roles and relations change and originate particular field structures.

In order to do so, the research relies on an inductive approach and embraces naturalistic methods of inquiry (Denzin & Lincoln, 2000; Pope & Mays, 2000). It employs grounded theory techniques to analyse the data and generate theoretical propositions about the phenomenon of interest (Glaser & Strauss, 1967) — which is the field-level institutional change through logic elaboration in a specific temporal and geographical context. Therefore, it does not test a theory that is logically derived from a priori assumptions, but rather discovers a theory that emerges from, and works for, the selected research contexts.

The adopted design is a multiple case-study design (Yin, 2003). Developments in the healthcare sector are examined by looking at different countries as cases. This aims to capture the internal changes in institutional logics that led to the creation and evolution of different innovative organisational forms, governance arrangements and practices in the primary healthcare subfield and in the broader healthcare field.

The study concentrates primarily on one level of analysis, the primary healthcare system, which is considered a sub-field of the broader healthcare field. The healthcare system is conceptualised as an organisational field (DiMaggio & Powell, 1983; Scott, 1994), consisting of a multitude of actors, including suppliers, patients, regulatory agencies, and funders. These actors interact in order to reach a common goal, which is to assure that the population in a specific area is healthy. Within the healthcare field, primary healthcare consists of those actors who cooperate to plan, finance, deliver, monitor, or use those healthcare services that play a central role in the community. Primary healthcare providers act as the patients’ first point of contact with the health system to ensure they receive accessible, comprehensive, coordinated and continuous care.

\(^4\) The expression “Baltic States” usually refers to the Republics of Estonia, Latvia and Lithuania. Due to time and resource constraints, I could not include Latvia in this study. However, I may be able to conduct a study of the healthcare reform process in Latvia at a later stage to further investigate issues that I raise in this thesis.
While the main level of analysis is the primary care subfield, some insights are derived from a more micro-level of analysis, the primary care practices. These are the organisations dedicated to the delivery of primary healthcare services. This choice is in line with the focus of the research question and with the strategy of previous institutional studies of field-level change. The field is the operating ground where the dynamics of logics formation can be perceived (Thornton & Ocasio, 1999) and where the interconnections between professionals, organisations and industries can be captured (Lounsbury, 2007). The level of the organisation allows to understand how social actors reconstruct and embody logics in their routine activities and how they constantly reshape their identities, roles and relationships through ordinary practices.

**RESEARCH METHODS**

**Data Collection**

The research methods comprise exclusively qualitative elements. These were appropriate to investigate a process of change through the analysis of constructed systems of shared beliefs and meanings that reflect cultural and context-specific social dynamics. Multiple sources of evidence were used to capture data, including face-to-face in depth interviews, field notes, extant academic literature, published and unpublished reports and studies, and documents. Triangulation of data emerging from the abovementioned sources was employed primarily to put information into context and better understand the development of new ideas. This added rigor, richness and depth to the understanding of the phenomenon (Denzin & Lincoln, 2000) and helped build trustworthiness (Lincoln & Guba, 1985).

Interviews were used as primary data source to uncover the process of field-level change in the two cases. Interviews concerned both recollection of past events and discussion of contemporary problems (retrospective and contemporary interviews). They touched upon a range of issues from the ideas underpinning the old Semashko system until the beginning of the 1990s and the main drivers of the reform, the introduction of primary healthcare and the interpretation of such new ideas in each
context, as well as the latest developments in the organisation of the field towards the end of the 2000s. The sampling strategy was predominantly theoretical in order to further investigate the emerging concepts and their relationships, until the point of redundancy. The aim was also to document maximum variations of the studied phenomenon — institutional field-level change through logic elaboration — within and across cases (Lincoln & Guba, 1985). A snowball technique was used to expand the sample and obtain representation of conflicting viewpoints on the reform principles, outcomes and main actors (relational and variational sampling, and discriminate sampling), until redundancy was reached.

The early stage of data collection was used to explore themes that were further developed and analysed during a second, explanatory phase. The purpose of the early data collection was to understand how the healthcare field was organised in the two countries before the reform, what were the main ideas introduced through the reform, and what were the outcomes of the reform, that is how the healthcare field was re-organised after the reform. This phase aimed to uncover similarities and differences in the main reform ideas and outcomes, to detect the potential for a comparative investigation of the process of change through the concept of institutional logics.

For this purpose, an initial literature review was conducted to gather relevant studies investigating the evolution of the healthcare systems in the selected countries since the beginning of the 1990s. These included World Health Organisation (WHO), World Bank and European Union reports; materials available on official websites of specific ministerial departments; universities and professional associations’ online resources; and academic literature and articles published in English peer-reviewed journals. The retrieved information was used to understand the general aspects and trends of the reforms, and to detect important information about the contexts in which the reforms were implemented. Ultimately, this helped identify potential themes to be theoretically developed later in this study. These themes were preliminary discussed with some colleagues at Imperial College Business School and the initial contacts both in Estonia and Lithuania to better prepare for the interview stage. The empirical account of ideas related to the Semashko system and the new health system centred on primary care presented in the previous section is largely based on archival and documentary information, integrated by insights gained through interview data (see Appendix D for a summary of the codes (Table D.1) and associated quotes (Table D.2)).
Furthermore, in the initial exploratory phase of the research, interviews were conducted with a purposeful sample of key informants, based on theoretical relevance (Glaser & Strauss, 1967; Strauss & Corbin, 1990) and convenience (Lincoln & Guba, 1985) as criteria for selection. This aimed to identify a multi-level sample of key stakeholders involved in policy development and implementation and to capture divergent viewpoints to enrich the study with pluralistic perspectives on the process of change in each country (Pettigrew, 1990; Pettigrew, McKee, & Ferlie, 1988). The ultimate purpose was to discover perceptions and understanding of the goals and objectives of the reforms, consequent changes in structures and processes, issues pertinent to legitimacy vis-à-vis the new organisational forms, enabling factors and obstacles, major achievements and key shortcomings, critical success factors and lessons learned (open sampling). At this stage, both interview data and archival data confirmed that both countries shared the same organisation of the health system and the same fundamental principles of the Semashko system. Both referred to the ideas of the Alma Ata declaration as those that were introduced in the countries during the reform process. However, archival documents and interviewees highlighted the presence of differences between the two countries in the approach to the reform, the support of specific actors, the legitimacy related to the new professional role of family doctor, and the particular types of organisations which were allowed to provide services in the healthcare field. Further rounds of data collection and analysis demonstrated that divergent trajectories of change were related to general, national differences between the two countries as well as field-specific factors (for further details on the coding process, see Appendix D; for further background information on Estonia and Lithuania, see Appendix B).

A second, more explanatory phase followed in which additional information was collected and the analysis expanded. This aimed to explain the process of logic elaboration in each country and to disentangle those country-specific factors that shaped the change. After preliminary discussions with the initial contacts in both countries, the first set of interviews was conducted in September 2008 in Estonia, specifically in the two biggest cities, Tallinn and Tartu, with 13 representatives of different stakeholders. The second set of interviews was conducted in June 2009 in Lithuania, specifically in the two biggest cities, Vilnius and Kaunas, with 19 representatives of different stakeholders. Stakeholders ranged from national and local governments, relevant departments at the Faculty of Medicine, and central and territorial health insurance funds, to international organisations, professional associations, managers of primary healthcare centres, and family practitioners. Data
collection continued up to June 2010 via phone-interviews and written follow-ups with 10 additional informants from university departments, insurance funds, professional associations, and practicing family doctors. A comprehensive list of stakeholders is provided in Table 3.2. The names of the informants are not disclosed in order to respect the request of some to remain anonymous.

When asked for the consent to be interviewed, all informants were notified in advance that the interviews would produce data to be used for this research project. Furthermore, they received beforehand a brief summary of the research proposal, broadly explaining purpose and methods of the study. Depending on the competences of the interviewee and on the amount of data already collected, interviews were either predominantly unstructured (Lincoln & Guba, 1985) or semi-structured (Pope & Mays, 2000). An interview schedule was used and constantly revised to touch upon previously identified and potentially relevant issues and/or to further explore constructs emerging from the analysis (Appendix A). All interviews were conducted in English; however, in one instance, despite being able to understand and speak English, the interviewee preferred to be assisted by an interpreter. The interviews lasted approximately one hour and twenty minutes each, although the variation in their length ranged from one hour to two hours and a half. They were all fully tape-recorded and transcribed, paying attention to ensure confidentiality to the information provided by the interviewees.
<table>
<thead>
<tr>
<th><strong>ESTONIA</strong></th>
<th><strong>LITHUANIA</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Family Medicine, Tartu University</td>
<td>Centre for Family Medicine, Vilnius University</td>
</tr>
<tr>
<td>Department of Internal Medicine, Tartu University</td>
<td>College of General Practitioners</td>
</tr>
<tr>
<td>E-Health</td>
<td>Department of Family Medicine, Kaunas University</td>
</tr>
<tr>
<td>Estonian Family Doctors Association</td>
<td>Faculty of Strategic Management and Policy, Mykolas Romeris University</td>
</tr>
<tr>
<td>Estonian Health Insurance Fund</td>
<td>General Practitioners Association</td>
</tr>
<tr>
<td>Health Protection Inspectorate</td>
<td>Health centres, Vilnius (Vilnius universitete Antakainio ligonine; Vilnius Centre Polyclinic)</td>
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<td>Healthcare Department, Tallinn City Government</td>
<td>Health Economic Centre, Research Centre Vilnius</td>
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<td>Healthcare Department, Tartu City Government</td>
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<td>PRAXIS Research Centre for Policy Studies</td>
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<td>The World Bank, country experts</td>
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<td>The World Health Organization, Regional Office</td>
<td>Vilnius City Government, Social Welfare Division</td>
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Data Coding and Analysis

Data collected through interview transcripts and field notes were ordered in numbered folders, to ensure anonymity of the information source, and transcripts were uploaded into a data coding software (ATLAS.ti version 6.0). Generative-subjective processing strategies (Lincoln & Guba, 1985) were employed for the data coding, so as to discover categories and constructs directly from the data and formulate theoretical propositions about their relationships to explain the process of institutional change in the two cases. Particularly, a grounded theory approach was followed in the data analysis (Glaser & Strauss, 1967). This is a “qualitative research method that uses a systematic set of procedures to develop and inductively derived grounded theory about a phenomenon” (Strauss & Corbin, 1990: 24), which, in this case, is the change within logics. Other organisational and institutional scholars have based their research on similar methodological approaches (e.g. Ravasi & Shultz, 2006; Dacin et al., 2010) to address questions related to actions, interactions and processes (Strauss & Corbin, 1990).

Building on the existing body of institutional theories of change (see Chapter II), this research expanded it by clarifying the field-level processes leading to the introduction of new ideas and their embeddedness in the existing logic. Therefore, a grounded theory approach was used to uncover yet unknown mechanisms within a specific stream of research, more than to generate a stand-alone theory, detached from previous literature (Suddaby, 2006). Grounded theory is relevant to the exploration of the social processes that impact on behaviour. It aims to generate new theory that accounts for the relationship between individual or collective experience and society, history, groups or organisations. It offers a structured approach to exploring the social, the symbolic, and the context specific behaviour (Goulding, 2009). It has the main concern of showing a clear logic and apply and make explicit the principles and processes involved in the generation of the findings. Finally, the methodology fits the observation of social behaviour in naturalistic settings.

*Constant comparison* techniques and *theoretical sampling* were employed as main strategies for data coding and analysis. These processes were conducted fairly simultaneously, since they constantly informed each other (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Goulding, 2009). Starting with the preliminary analysis of the empirical literature and the available archival data, the researcher went back and forth...
from the relevant emerging concepts, to the literature, to the data, progressively refining the list of codes and categories (Miles & Huberman, 1984). At first, the aim was to grasp the starting and the end point of the reform, the core ideas underpinning the introduction of family medicine in both countries and the main differences between the two cases (part A of Table D.1). This helped detect the potential to explore internal changes in one particular logic, the professional logic, and guided me during the following stages of data collection and analysis. This phase explored new issues and progressively explained emerging concepts and themes, until theoretical saturation of the categories (Glaser & Strauss, 1967). Particularly, it aimed to confirm whether or not the process of logic elaboration resulted in different outcomes for the two countries, as it appeared from the earlier stages of the research. Subsequently, it identified specific phases of the reform process during which it was possible to detect modifications of specific elements of the logic (part B of Table D.1). Finally, it uncovered contextual factors that influenced the process of logic elaboration and contributed to shaping different trajectories of change in the two countries (part C of Table D.1).

The coding consisted of three steps, which were generally conducted in parallel (Strauss & Corbin, 1990). During the first round, the aim was to discover and develop an extensive list of open codes to categorise facts and information contained in each interview. These descriptive codes helped attribute temporal order to the events, understand which actors played a role in the change process, and identify ideas that were abandoned or introduced during the reform process. Where possible, these were checked against the archival data and available records to assure reliability and consistency. With the assessment of every incident, the range of applicability of the codes was progressively refined. First-level categories and possible relations among them were identified by provisionally separating the categories from their subcategories, properties and dimensions. The total number of codes resulting from this first phase of coding was 203. From these, 03 refined codes, or first-order categories, were derived. These codes isolated specific and practical concepts that

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5 “A code is an abbreviation or symbol applied to a segment of words […] in order to classify the words” and text produced as a result of the data collection; codes “are categories […] retrieval and organising devices” (Miles & Huberman, 1984:56)

6 I further analysed these first-order categories and build the theoretical model upon them, while I use the remaining of the original 203 codes to write the empirical description of the reform
were modified during the reform process and that appeared to signal a potential change in logic or to relate to a national, structural or cultural difference between the countries.

The second round moved across interviews and used the textual data to further ground temporal, spatial and causal effects between categories. First-order categories were systematically compared and contrasted, those which presented similar properties and/or referred to overlapping concepts were merged, and those which comprised conflicting dimensions or properties of the same concept were unpacked. This iterative process led to the identification of provisional spatial, temporal, and cause-and-effect links between the refined codes and to the discovery that specific theoretical concepts — linked to the elements of the logic — emerged at different stages of the reform process and that specific factors came into play at different moments. This phase ultimately generated 43 second-order categories.

The third round of coding reached higher levels of abstraction as links between the codes were sought and validated. The emerging categories were integrated into 18 theoretical categories. These categories described the elements of the logic detected from the data, which changed at different times during the process, and the societal and field-level factors that influenced the change. These were used to explain the phenomenon of interest — field-level institutional change through logic elaboration — and the drivers for its different manifestations in the two countries.

At all stages, operational codes and theoretical memos and logic diagrams supported the analysis and informed the theory building. The data structure that derived from the coding and analysis is outlined in Table D.1 (Appendix D).

In order to ground the theoretical model, examples of illustrative quotes and correspondent first-order categories are provided in Table D.2 (Appendix D), as well as in the text when explaining the analysis and findings of the study (see Chapter IV). The links between the categories and the rationale for the coding is shown in Figure 3.3.

process and to corroborate the identification of links between the categories in the following stages of the analysis.
ISSUES ABOUT THE METHODOLOGICAL CHOICES

The criteria for judging the quality of naturalistic inquiries differ from those used to evaluate logico-deductive, positivistic research (Lincoln & Guba, 1985; Denzin & Lincoln, 2000). Issues around internal and external validity, reliability and generalisability of the findings may emerge with regard to a traditional scientific report; concerns on trustworthiness, credibility, confirmability and transferability are more appropriate for an inductive case-study. The research process aimed to address these points at all stages. The declaration of the methodological choices and procedures serve the purpose of showing a strive for methodological rigor (Langley, 2009).

The judgement on credibility rests upon the assessment of how conclusions are reached (Glaser & Strauss, 1967). In order to increase the chances of generating a more integrated and clear theory, memos were created to keep track of ideas as they developed during the coding and to document the choices of interpretation. These supported the classification of homogeneous concepts and the creation of categories.
Those categories deemed more representative of the phenomenon of interest were selected as main categories. While analysing the data and building the theoretical model and propositions, feedback from colleagues and members of the research sites was sought to validate interpretations (Langley, 2009; Miles & Huberman, 1984). Discussions with colleagues on the initial and more advanced formulation of the model were particularly illuminating for abstracting categories to a more theoretical level. An extensive conceptual account of the theoretical framework was provided and statements emerged from the data were presented in various sections of the manuscript (Glaser & Strauss, 1967), so that the reader could be constantly reminded about the abstract concepts and the research questions.

Large amounts of original textual data was included in the final manuscript, in order “to offer corroborative detail for the proposed conceptualisation” (Langley, 2009) and to present “data as evidence for conclusion, thus indicating” how theory was derived from the data (Glaser & Strauss, 1967: 228). Data coding procedures as well as quotations supporting the theoretical arguments were documented in different parts of the text (Chapters III, IV and V) and additional tables (Appendix D). Seeking for verifiability and replicability, the sources of information were reported as extensively as possible, in a way that did not clash with confidentiality agreements previously discussed with informants.

Portions of texts and sources of data were triangulated with the aim of reducing the likelihood of misinterpretation — to address accuracy, clarity and validity — and assessing and assuring the basic quality of the data (Miles & Huberman, 1984). Multiple perceptions of the same phenomenon were taken into account, so as to clarify the meaning of such a phenomenon by identifying different ways it could have been perceived and to verify as much as possible the repeatability of an observation/interpretation (Stake, 2000). Interview data constituted the main source of evidence; however, these were checked against secondary data. Additional data sources included official reports and documents, journal articles, preliminary discussions, field notes, and interviewees’ personal notes. This increased the richness and variability of the codes while allowing to account for an accurate temporal evolution of the reform process. This helped address the retrospective bias and the limitations of memory and rationalisation that interviewees might have had in reconstructing and making sense of past events. The purpose of triangulating evidence was to reach as much agreement as possible on the representations of the phenomenon emerging from
the different sources of data (Denzin & Lincoln, 2000). This helped keep the valuable individual insights and, at the same time, recognise at least some shared meanings (Suddaby & Greenwood, 2009). In order to reach the needed level of abstraction, the emerging codes and categories were constantly triangulated with the existing literature, so as to generate a theory that would fit the empirical contexts as well as the body of theoretical research. The research process developed a theory that would be understandable and generalisable beyond the instances that grounded it (Glaser & Strauss, 1967).

All methodological choices concerning adequacy of the research process through which theory was generated were explicitly declared (Strauss & Corbin, 1990). The criteria for selecting the cases and the sample of informants within each case were clearly stated. The major categories and theoretical formulations were described, providing evidence of the events, incidents and actions that originated them. The analysis identified links between codes which originated from explicit relations among the concepts made by the interviewees, as well as from personal insights and intuition of the researcher — on the basis of empirical as well as theoretical considerations (Glaser & Strauss, 1967). These emerging relationships were “tested” by re-assessing the data already collected and, where necessary, collecting additional data. The emerging findings were constantly checked through comparisons among the categories and the temporal evolution of the observed phenomena. The meaning of outliers was sought to confer breadth and depth to the theoretical propositions (Miles & Huberman, 1984; Strauss & Corbin, 1990). While working towards discovering and verifying the relations between the categories and ultimately building up the theoretical model, findings from the two case studies were treated separately. The analysis checked for possible rival explanations of emerging concepts and links and for replication of the findings in the two contexts. This helped ground the findings empirically, increase the conceptual density of the categories and build variation into the theoretical model. The contextual factors affecting the phenomenon of interest and the temporal evolution of the process in the theoretical formulations were both taken into account, conferring a processual significance to the theorising, i.e. deriving temporally ordered explanations (Langley, 2009). Additionally, graphical representations of the theoretical model showed a streamlined and more direct abstract framework. This helped the reader gain confidence with the findings and build credibility and trustworthiness towards the overall research process.
The researcher had limited influence on the research site (Miles & Huberman, 1984) — and vice versa —, since she did not spend an extensive period within the field. This had the advantage of not interfering too much with the informants’ routine and not deviating the ongoing unfolding of events, thus probably originating less bias on the data quality. However, it had the drawback of not allowing a more intense immersion into the everyday life of informants within the research site. This was overcome by rapidly gaining access to the field and constantly keeping contacts with key informants, so as to build mutual trust. For the same purpose, all interviewees were contacted prior to and after the interviews, to express appreciation for their collaboration. The contacts were enquired for feedbacks on the emerging themes and the concerns they raised regarding the research process were addressed, for instance with regard to information confidentiality.
CHAPTER IV. Analysis and findings: logic elaboration and field-level institutional change

“The starting point for both countries was exactly the same [the Soviet model]. The difference was that Estonia did a very clean-cut, comprehensive reform, and I think in Lithuania they just did a piecemeal…they didn’t really reform, but the new forms of provision emerged and they coexisted with the others, and you have a more plural system.” (The World Bank)

This Chapter outlines the process of change in Estonia and Lithuania and explains how logic elaboration occurred through the gradual modification of specific elements of the logic. It shows that logic elaboration unfolded differently in the two countries. Finally, it uncovers the context-specific dynamics underpinning this change.

During the reform process in Estonia and Lithuania, the existing professional logic of specialisation (Figure 3.1) is restructured by the introduction of new ideas, identities, governance arrangements, organisational forms and practices related to family medicine. These belong to a different logic, that of holism (Figure 3.2). The revised overarching professional logic is elaborated thanks to specific identity-based claims, governance arrangements, organisational forms and innovative practices. The healthcare field is variably restructured to incorporate those claims through the creation of a primary healthcare subfield.

In Estonia, through a grafting process, principles of the holistic logic are grafted within the specialised logic. Family medicine permeates the newly created primary care subfield, and the work of family doctors in primary care complements that of the specialist doctors in secondary care. The resulting overarching professional logic is elaborated by expansion of the specialised logic to encompass new principles of a more holistic and patient-centred view of medicine. This leads to a revised logic of complementary specialisations.
In Lithuania, through an appending process, principles of the holistic logic are appended to the specialised logic. Family medicine and other first-level specialties are all legitimate in primary care, and family doctors simply coexist with old service providers in primary care. The resulting overarching professional logic is elaborated by a collection of the specialised logic and the new principles of a more holistic and patient-centred view of medicine. This leads to a revised logic of coexisting specialisations.

These two modes of logic elaboration generate specific configurations of the healthcare field. Specifically, in Estonia the healthcare field is well-integrated and the primary care subfield more homogeneous. In Lithuania the healthcare field is, instead, disconnected and the primary care subfield remains quite heterogeneous.

Context-specific societal and field-level factors fundamentally shape the process of logic elaboration, originating such conflicting outcomes. These comprise the ability to synthesis conflicts; the flexibility to accept pluralistic perspectives; the legitimacy and status of theorisers; the concentration of theorisers in the field and their ability to convey resources and commitment; and the socialisation process to transmit new role-identities to practitioners, who are supposed to enact them.

This chapter is structured as follows. The first section outlines the process of change in Estonia and Lithuania and provides a chronology of events. The second section analyses how the process of logic elaboration unfolded in the two countries, by showing that specific elements of the logic were revised at specific stages of the change process. The third section identifies the reasons for the divergent evolution of the two cases and presents the contextual factors that shaped logic elaboration.

THE PROCESS OF CHANGE: CHRONOLOGY OF EVENTS

This section outlines the chronology of events and provides a timeline for the reform process in both countries (Figure 4.1). The process of change in Estonia and Lithuania started at the end of the 1980s and lasted until the mid-2000s. Based on primary and secondary data and adopting a “temporal bracketing” strategy (Langley, 1999), the study identifies four phases of the reform process in both cases. In the enforcing, pre-
change phase, the healthcare field in the two countries displayed similar characteristics and actors appeared to enact the same logic. Some differences started emerging in the destabilisation phase and became progressively more evident in the adjustment and consolidation phases.

Figure 4.1: Phases of the change process and actors’ roles in each stage

Pre-change phase (up to 1989)

Until the early 1990s, the Estonian and Lithuanian healthcare systems were rooted in the so-called “Semashko model” — which reflected a logic of specialisation (Figure 3.1; Appendix D). This was introduced in the Soviet Union by Nikolai Aleksandrovich Semashko, who served as People's Commissar of Public Health from 1918 until 1930. The Semashko model firmly reflected the hierarchical, centrally controlled and planned administrative system typical of the Soviet republics (Polluste, Kalda, & Lember, 2000). It offered universal entitlement to a comprehensive package of services, full
geographical coverage, and free access to care at the point of delivery for the whole population. Equity was a key priority and redistribution of resources was strongly pursued by the central government (Balabanova, 2007). Healthcare was financed through general taxation and healthcare funds were allocated residually from the State resources, i.e. after other sectors’ needs had been met. In the 1990s, healthcare budget in Estonia and Lithuania amounted to an average of 4% of GDP, against an average of 6% of GDP in the OECD. Resource allocation reflected historical patterns and was largely based on inputs (such as the number of staff and beds per population) rather than on outputs/outcomes (such as indicators of clinical activity or health impact of the provided services). Private contributions were very limited and consisted mainly of pharmaceuticals purchases.

The State was not surprisingly a key player at this stage. The central government planned, financed, managed and controlled the provision of services through its administrative structure of counties and municipalities. The achievements of the Semashko systems were advertised as accomplishments of the Soviet ideology and the overall organisation and culture of the health system reflected this view.

The bureaucracies dominated over the whole system, while the physicians had complete control over the patients, who were not organised to defend their rights. The centralised and hierarchical network of public providers had a markedly hospital-focus and was characterised by over-specialisation and fragmentation of care.

The PHC network was organised by catchment areas; citizens were assigned to a particular doctor on the basis of their living or working place. Parallel systems assured coverage of particular categories of employees, such as the military and railways workers. PHC had a tripartite system and, hence, provided separate services for adults, children and women. More specifically, the PHC delivery structure comprised a variety of health centres, which included, amongst others, polyclinics, paediatric polyclinics and women's consultation centres (Shabarova, 2001), in which the boundaries between primary and secondary care were blurred.

First-contact doctors had very limited clinical responsibilities and held no managerial responsibilities. Especially when working in polyclinics in bigger cities or towns, despite providing basic treatment, they mostly referred patients to the secondary care specialists. The work they conducted carried quite a low prestige among the other
medical practitioners as well as the general public, as reflected by the lower salaries of first-contact doctors compared to those of the specialists. The low socio-economic status of such doctors reflected their lack of thorough and specific training and contributed to their scarce motivation on the workplace (Jesse, Schaefer, White, & McKee, 2000; Jesse, Habicht, Aaviksoo, Koppel, Irs, & Thomson, 2004; Starkiene et al., 2005).

**Destabilisation phase (1990-1994):**

This vision faded away when Lithuania and Estonia obtained political independence respectively in 1990 and 1991 and embraced more democratic principles, yet translating them differently in the two contexts. Central governments modified their priorities and promoted privatisation in commercial sectors and decentralisation of responsibilities to local governments or other public bodies. Despite recognising the need for some healthcare restructuring, the Estonian and the Lithuanian governments did not consider healthcare as a priority.

“But it was a difficult time. I had many, many problems during my job at the Ministry with unemployment and social security, and these health problems were not disturbing me during those years, really.” (Estonia, Health Protection Inspectorate)

The most urgent concern was to make the body of legislations consistent with the European directives, so as to join the European Union as soon as possible. This led to the privatisation of big state enterprises and the laws on unemployment and social security. If compared with the previous stage, the absence of the State as a theoriser and initiator of the reform debate left the healthcare field open for other actors to reshape the organisation of the system.

Taking advantage of this destabilisation and absence of State actions, an active group of professionals and academics took initiative in promoting the change and introducing family medicine. Liasing with international organisations and partnering with professionals and academics abroad, intellectual leaders joined the current international discourse and learned practices associated with a different approach to
medicine — a holistic professional logic (Figure 3.2). They placed emphasis on the conceptualisation of comprehensive care and on the development of a solid primary care (Jakušovaitė et al., 2005). The core idea of the reform was to build a system that would create a stronger and more personal relationship between the first-contact doctor and the patient. This could ensure continuity of care and motivate doctors to become more responsible for the health and well-being of their patients. Thanks to those external contacts, they were able to access international funds that supplied resources which were lacking within the national context. Intellectual leaders employed these resources to frame family medicine in a way that would fit the specific healthcare context.

“So the philosophy at that time was that primary care is the basis of our health systems and we have to develop it, and this is our priority.”

(Lithuania, State Patient Fund)

Key events in this first stage of reform included the creation of professional associations in Estonia (1991 Estonian Society of Family Doctors); the opening of university departments and centres of Family Medicine (1992); the set up of training (1992) and retraining programmes in family medicine (1992 in Estonia and 1994 in Lithuania); and the declaration of family medicine as a separate medical specialty (1992 in Lithuania, 1993 in Estonia).

Already in 1991, a group of doctors gravitating around the University of Tartu founded the Estonian Society of Family Doctors, the sole professional association of general practitioners in the whole country. The Society still exists and nowadays gathers the majority of the 900 family doctors, about 20% of the total number of doctors in Estonia (Koppel et al., 2008). In 1992, re-specialisation courses started to be offered at the University of Tartu and the Department of Family Medicine opened as an independent department within the Faculty of Medicine (University of Tartu official website). In 1993 the medical training at the University of Tartu was reorganised and a new 3-year postgraduate programme, the family medicine residency, was opened. In the same year, Family Medicine was finally established as a medical specialty.

The idea of having a separate primary care within the health system officially appeared for the first time in Lithuania in the National Health Care Concept (Cerniauskas et al., 2000). This is a key conceptual document prepared by academics and professionals.
and ultimately approved by the Seimas in 1991. It was praised as one of the most comprehensive and pioneering plans of this kind in Europe. Despite its innovative views, the contents of such document encountered difficulties in their implementation. Generally speaking, the Lithuanian primary care reform proceeded less smoothly than the Estonian one and found variable political support, due to frequent shifts of power in the government from left to right parties.

In Lithuania Family Medicine was declared a separate medical specialty in 1992 (Hakansson, Ovhed, Jurgutis, Kalda, & Ticmane, 2008). Training programmes in family medicine started in 1992 together with the creation of dedicated university departments, namely the Centre of General Practitioners (later the Centre of Family Medicine) in Vilnius, and the Department (or Clinic) of Family Medicine in Kaunas. The Centre of Family Medicine was part of the Internal Medicine, Family Medicine and Oncology Clinic at the Faculty of Medicine in Vilnius University. The Department of Family Medicine was part of the Faculty of Public Health at the Lithuanian University of Health Sciences in Kaunas. Despite its early start, the training of physicians was problematic, due to the lack of teachers who could train the residents, and to the unwillingness of medical students to enter family medicine courses. The unattractiveness of the specialty was undoubtedly a consequence of the traditionally low prestige of first-contact doctors in the Soviet context (Starkiene et al., 2005).

Interrupted residency programmes were introduced in 1994 to allow practicing district internists and paediatricians to retrain without leaving their workplace for too long.


Despite these changes, doctors who trained or retrained in family medicine had still to work in an old-fashioned health system and did not feel completely autonomous in exercising the skills they had learnt during the residency courses. In the second half of

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7 Lithuania has one of the highest physicians to 100,000 population ratios in the EU, while having one of the lowest family physicians to 100,000 population ratios. Moreover, while about 20% of doctors are over-60 years old, the rate drops to 2.5% for family physicians (Starkiene et al., 2005).
the 1990s, a series of legal acts established a *decentralisation* of responsibilities for primary care to the municipalities and set the formal requirements for organisations that provided primary care services. Specifically, *primary and secondary care services were separated* and the same organisation could not provide both. Furthermore, primary care organisations became *independent contractors* with the national insurance funds, although their legal status differed in the two countries. The fact that the same entity cannot provide both primary and specialised care firmly differentiates Estonia and Lithuania. In Lithuania, despite the financial management of primary and secondary care has truly been kept separate, polyclinics are still allowed to provide both these services.

In Estonia, in 1997-8, a Ministerial Decree established the new legal status of family doctors (Koppel et al., 2008). They ceased to be public employees and became independent providers that would need to stipulate contracts\(^8\) with the Estonian Health Insurance Fund in order to be reimbursed for the services provided to patients in their lists. Their payment method were based on a mix of capitation, fee-for-service and allowances (now respectively 73%, 15% — to be increased —, 10%), to which a “bonus payment” was added recently (2%). In 2002, family doctors became private owners of their practice and could practice as private entrepreneurs or fund companies that provide exclusively primary care services\(^9\). The most common service delivery structure was originally the solo-practice, but the number of small group practices has increased over the years. A couple of bigger organisations with internal contracts between the doctors and assorted managerial arrangements — which might slightly resemble the polyclinic structures — have also been created.

With the Health Service Organisation Act of 2002, the gatekeeping function of the family doctors as first point of contact with the health system was strengthened (Koppel et al., 2008). Nowadays, family doctors control most access to specialised care: patients need a family doctor’s referral in order to see most specialists and to be

\(^8\) The basic terms of the contract are negotiated yearly by the Estonian Society of Family Doctors and the Estonian Health Insurance Fund (Koppel et al., 2008).

\(^9\) In this respect, the reform was never planned with the ideological goal of carrying out privatisation in the healthcare field. Giving family doctors the status of independent contractors was motivated mainly by the intention to allow them to better perform the tasks for which they had been trained.
admitted into non-emergency inpatient services. However, the gatekeeping is only partial, since there are some specialised services that can be accessed without referral, especially by particular groups of patients, such as the chronically ill.

In Lithuania, until the end of the 1990s, family doctors kept practicing only in state-owned primary care facilities, contracting with the State Patients Fund (SPF). Primary health care in Lithuania has been financed by weighted capitation (a fixed amount given to the family doctor for each patient registered in the list, weighted by the age of patients and the number of patients living in rural areas) (Dobravolskas & Buivydas, 2003), a fee-for-service component and some “bonus payments” — now respectively 82%, 12% and 6% of the reimbursement10.

In order to select the most appropriate organisational arrangements for primary care, four pilot projects were launched in 1996 in different Lithuanian municipalities (Cerniauskas et al., 2000). These corresponded to the geographical areas around the four biggest cities: Kaunas, in the central-Eastern area; Klaipeda, in the Western coast; Siauliai, in the North; and Vilnius, in the South. The Kaunas project was modelled on Scandinavian health systems, where primary care is related to social and long term care. Its evaluation revealed that this scheme would be too expensive to be implemented in the whole country. In Klaipeda the innovation was to make family doctors available to children and adolescents at specific elementary schools and high schools, and to connect family medicine with occupational health. In Siauliai a mixed model that could work for both smaller towns and rural areas was introduced. In Vilnius, the city model was mainly dominated by big public polyclinics in the centre and small autonomous family practices in the outskirts. This approach evidently contrasted the willingness of the Estonians to converge to a single model in primary care. Actually:

10 Fee-for-service pays for most preventive services, ambulatory nursing, and services. These services which are formally listed among the family doctor’s standard competences; however, so far have been actually provided mostly by the specialists (Dobravolskas & Buivydas, 2003). "Bonus" payments are related to the actual work of the family doctor and are measured by increase in immunisation and decline in hospitalisation rates compared to the national average of the previous year. The intention is to gradually increase this part of the formula, which is more directly related to outcomes, as a means to enhance service quality. However, general opposition from the professional associations hampers this increase.
“The evaluation was done just on this Kaunas project. For the others it was more or less the political will that helped to choose which was better and which was not. And actually Lithuania has chosen [to give] a lot of independence to the municipalities in organising primary care the way they like.” (Lithuania, Mykolas Romeris University)

In 1998-1999 some plans were made to promote publicly funded autonomous family practices, but the challenge for the government was to create a solid framework to develop a system of family doctors as independent contractors (Cerniauskas et al., 2000). In 1998 the Ministry of Health approved guidelines for “privatisation” of family medicine. In 1999 the European PHARE project supported this development by opening a tender for family doctors who wished to establish private practices (Jakušovaitė et al., 2005). With the aim of improving accessibility of primary health care services for the population, the project offered technical and financial support for the creation of family practices to private, independent contractors. Autonomous practices were granted basic equipment under the condition that an approved business plan was presented and family doctors owned or rented premises. Another requirement was that premises and services for the population should be located in the area where family practices were needed, as negotiated with the municipalities. More than 100 applications were presented and 56 practices were supported by the project in 2000. By 2007, the number of private practices had already increased to 218, accounting for around 53% of the total of primary care centres (412) (Boerma, 2003).

Contrary to what happened in Estonia, in Lithuania dedicated professional associations appeared quite late in the process. The Lithuanian College of General Practitioners was created in 1997 and it was affiliated to the Department of Family Medicine in Kaunas. The Lithuanian Society of General Practitioners was created in 2002 and it was affiliated to the Centre of Family Medicine in Vilnius. According to a high-profile representative of the professional associations:

“(There is) no difference (between the two). Maybe one, the Vilnius association, was established in 2002, later, and like in opposition to the College of Family Physicians...the so-called Vilnius association and Kaunas association, so like in opposition. But the functions are the same. Now we collaborate, there are no problems at all.” (Lithuania, Lithuanian College of General Practitioners)
Consolidation phase (2002-2008)

At the political level, the early 2000s were fundamental years for Estonia and Lithuania. The countries reached the objective of joining the European Union (EU), officially becoming EU members in May 2004. As the State strengthened its democratic basis and assimilated the *acquis communautaire* in view of the accession to the EU, the national ways of handling decision-making processes and implementing political strategies became more apparent. In Estonia, field actors increasingly expressed the need to clarify accountability lines and to make responsibilities more transparent at all levels. In Lithuania, attention was paid to allow individuals and organisations to be free to choose among many options, without imposing one way of doing things. These different approaches influenced the consolidation of the newly-created primary care field and showed a different degree of tolerance to conflicting models in the two countries.

Primary healthcare had been established for almost a decade and the universities had already trained a number of family doctors that was sufficient to cover the population of each country. Therefore, *retraining programmes were stopped* in 2003 and 2004 respectively in Estonia and Lithuania.

Thanks to a revision to the Health Service Organisation Act (2007-8), the local governments in Estonia (that is Tallinn and Tartu municipalities and all county governments) could act as owners of primary care practices; they could contract a number of family doctors to provide services to the population that is registered in such municipal practice. No municipal practices have been established so far. The general trend in the organisation of primary care delivery is to consolidate single-handed practices and establish group practices, in line with what happens in other developed countries.

By the year 2002, almost 1/3 of the specialists working in primary care had already been retrained. The retraining process accelerated when the EHIF introduced an extra “quality payment” for doctors who had gained their diploma in family medicine. Between 1991 and 2004, 979 doctors either specialised or retrained in family medicine (Maaroos & Meiesaar, 2004). In 2003, the number of family doctors was already sufficient to cover the whole population and retraining programmes were stopped.
Postgraduate training in family medicine (residency) continued to be offered. Notwithstanding the type of training, the general aim of such programmes was to develop the identity of the general practitioners (Lember, 1996), empower them and give them confidence.

“…for family doctors I think it was...I remember that I felt like 'I am a very important person now!' Yes. This was the feeling as a family doctor, that I am very important and that I have my own patients and money to manage and, you know this kind of thoughts.” (Estonia, City Government)

In Lithuania, the interruptive retraining was stopped in 2004 as the number of trained family doctors was deemed enough to cover the whole population. In 2005, the average length of patient list was around 2,050 per doctor, slightly over the 2,000 recommended, and in 2006 the number of family doctors amounted to 1,792 (Health in the Baltic Countries 2006). To date, about 2/3 of the family doctors are retrained internists and paediatricians (Starkiene et al., 2005; Lithuanian Family Medicine News Network).

Currently, patients seem to have accepted family doctors. There has been an increase in the health service utilisation in terms of PHC consultations per insured individual from 3.1 visits to family doctors in 2003 to 3.8 in 2006 (Koppel et al., 2008). People are generally well informed about primary health care and nearly 70% of patients appear satisfied with the services provided by their family doctors (Polluste et al., 2000).

"Within half year or one year, we saw that these real family doctors were working much more effectively, they were giving more diagnostic services and patients were satisfied with their own family doctors much more than with the district doctors.” (Estonia, World Health Organisation)

Public acceptance of family medicine in Lithuania seems comparable to that of Estonia. Recent surveys reveal that about 70% of Lithuanians are satisfied with their primary care doctor (Jakušovaitė et al., 2005). Nearly 70% of Lithuanians declare to trust the physician with whom they have direct contact; however, their trust on the general functioning of the healthcare system appears to be low, around 41% (Grabauskas, Peicius, & Kaminskas, 2004). In 60% of the cases, patients are not satisfied with primary care administration. The main reasons for dissatisfaction are especially due to inappropriateness of the appointment system, rudeness of the employees at reception
Despite an exemplar application of the western model of family medicine-centred, comprehensive primary care, the implementation of the reform encountered some resistance, especially at the local level. For example, in both countries resistance to the introduction of independent practices was stronger in bigger cities rather than in rural areas. This is counterintuitive, since one would expect the cities to be more progressive and open to innovations. However, it might be related to the stronger presence and personal influence of powerful groups of bureaucrats and specialists within polyclinics

### Resistance to change

Despite being successful in introducing new ideas related to primary care, the reform was contrasted by groups of specialists and polyclinic managers, as well as some bureaucrats and individuals in key position within local governments (Jesse et al., 2004).

On the one hand, heads of polyclinics feared to lose control over resources. Since more services would be provided at the primary care level, the internal demand for specialist services and the related payments would be reduced. On the other hand, specialists whose work was closer to that of family doctors (e.g. paediatricians or gynaecologists), feared to lose their job. Patients would need to be registered (exclusively, in Estonia, or preferably, in Lithuania) with a general practitioner and not with any other professionals.

“One objective was to separate primary and secondary, hospital care, and of course the managers of hospitals and big health centres were one of the key players and they were extremely against this reform. […] They are and they were very skilled and clever and they knew that they would lose the power…how to say…over the primary care budget and over the primary

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11 From a theoretical standpoint, this would be consistent with the assumption that in different local context the balance of power between actors may vary and may also reflect the blend of logics in that area.
care physicians, when we gave family doctors this gate-keeping function.”
(Estonia, Ministry of Social Affairs)

Such resistance to change was grounded in fear of losing power, in terms of both resources and professional competences. However, the counter-theorisers also appealed to professional values and norms to contrast the introduction of new ideas into the existing professional logic of specialisation. They argued that the quality of the service would decrease, to the detriment of the patients, because of inadequate preparation of family doctors.

“They always, from the very beginning, saw us like competitors...and...well, hard discussions went on from the very beginning about the competences of family doctors. “Why family doctors? Is she better than a cardiologist in handling cardiac problems?” It’s not, I think, what should be discussed...it’s different. These tasks are different in primary care. But until maybe 2000, we had very hard discussions and confrontations, and they tried to push us out of every medical field.” (Lithuania, Lithuanian College of General Practitioners)

Their resistance lasted firmly until the third phase (i.e. adjustment phase), but progressively weakened thereafter. Most specialist doctors gradually started to accept the new role of their colleagues and to cooperate with family doctors. However, some still attempt to discredit the work of family doctors using their personal and professional influence during the socialisation process, and their visibility on the academic as well as political scene. This is especially evident in Lithuania:

“I think today in Lithuania academics do not want to recognise family doctors as specialists...as equal to the other specialists. [...] I tried to begin to talk about family medicine during the first year of Medical School, in the first year of training. But all professors said “no, no!” This is a very interesting problem.” (Lithuania, Family Practice Manager)

Specialists increasingly reduced their resistance to principles of a holistic logic because they realised that the introduction of family medicine would actually allow them to become even more focused and specialised on their particular competences. Thanks to the expanded medical responsibilities of family doctors, specialists could conduct purely specialist work. Resistance to change decreased not because the counter-
theorisers embraced principles of the new logic. It decreased because the enactment of new principles by the supporters of the new logic allowed opponents to further consolidate their existing professional identity and their role within the field.

"Usually family physicians can deal with most of the cases, they can handle the problems. And, if not, then it is already, let's say, a selected decision and they are already selecting the patients for the specialists. The specialists also complain that family doctors send them too many patients without [conducting] any deeper investigations. They are also angry and say it is better for them if family doctors work better." (Estonia, Estonian Society of Family Doctors)

Local governments also played a role in the reform implementation. Municipalities variably supported family doctors who needed to buy or rent facilities and equipments and maintained contradictory positions with regard to public ownership of practices and infrastructure. These different attitudes of the city governments reflected contrasting perspectives and values and inevitably created disparities and potentially unequal working conditions among the family doctors. In addition, some municipalities sought to alter the current structures in an attempt to push back towards a polyclinic-type model.

The establishment of independent family practices in Lithuania was declared a priority by the central government, whose target was to reach a 50% population coverage by private family doctors by the year 2005. However, unequal functioning conditions, more favourable to municipal institutions and less to autonomous practices, have been in place for more than 10 years (and still partially exist). Such conditions caused some of the first private practices to suffer from financial problems. Therefore, the autonomous providers, despite representing half of the total number of primary care centres in the country, currently deliver care to nearly 25% of the population. This reveals another gap between the political target and the actual implementation of the policy.

“The objective that was approved with the National Programme for Primary Healthcare Reform was that in 2008 we expected that 60% of our institutions would be private. We almost succeeded, we have more than 50%, but the problem is that those institutions are very small, they are like solo-practices, and they cover only 25% of the whole population. So in terms of the number of institutions, it looks like we achieved the goal, but in
terms of coverage of the population we didn’t. So this is also good and bad.” (Lithuania, Mykolas Romeris University)

In general, political support for family medicine and, particularly, for private initiatives in primary care has been inconsistent in Lithuania. Some municipalities, influenced by the heads of public polyclinics, introduced restrictions for opening family practices (Jakušovaitė et al., 2005). In planning the supply of primary care services, they variably limited the geographical areas where it was allowed to establish autonomous centres to ensure these would be distant from the existing public institutions. As a consequence, public polyclinics remained operating in the city centres, the most profitable areas, whilst private practices opened in the city outskirts or in smaller towns and rural areas.

LOGIC ELABORATION: PHASES OF THE PROCESS

As outlined above, the process of change analysed in this thesis spans across about twenty years, from the early debate at the end of the 1980s, until the most recent developments in the late-2000s. This change consists of four identifiable (although not exactly sequential) phases. In this timeframe, several actors promoted new ideas and variably linked them to emerging concepts in other fields, creating support for the change or generating resistance to it. A number of actors participated in the reform process; however, the most active theorists of the reform were the professionals and, within them, academics. These intellectual leaders had a key role at all stages of the process of change.

The elaboration of field-level logics is a more specific process of institutional change. It invested the formulation of a new identity and the reconstruction of a (professional) role, their consolidation through organisational forms, and their association with specific practices (Figure 4.2). Introducing a new professional role, the theorising agents needed to frame the new family doctors’ identity, socialise practitioners to it and embed it within an existing system (i.e. the existing professional logic in healthcare), thereby elaborating this logic in a new fashion. This altered the relationships between all those enacting the professional logic. As illustrated by a family doctor, “educators must not only train new family physicians but also graft family medicine into the polyclinic model” (Canadian Family Physician).
The elaboration of a specific element of the professional logic was introduced at each stage of the process. The *enforcing phase* focused on maintaining the existing structures and implementing the specialisation logic typical of the Semashko system. The *destabilisation phase* promoted a change in the role-identity of professionals by introducing the new family doctors. The *adjustment phase* created particular governance structures and organisational forms that allowed family doctors to operate as they should. The *consolidation phase* confirmed the practices associated with family medicine and established appropriate models of care.
Figure 4.2: Logic elaboration process: phases and contextual factors
Enforcing the existing logic

As mentioned above, the governance structure of the health system in Estonia and Lithuania at the end of the 1980s consisted of a centralised and hierarchical network of public entities. It had a markedly hospital-focus and was characterised by overspecialisation and fragmentation of care.

The State was not surprisingly a key player at this stage. The central government planned, financed, managed and controlled the provision of services through its administrative structure of counties and municipalities. The achievements of the Semashko systems were advertised as accomplishments of the Soviet ideology and the overall organisation and culture of the health system reflected this view.

The bureaucracies dominated over the whole system, while the physicians had control over the patients, who were not organised to defend their rights.

Before the independence, during the Soviet period, we had a very centralised system and within it, for the health system, the main actor was the municipality, particularly the major and the municipality doctor, and in rural municipalities the head doctor of the local hospital. And all the money — all public money — was in their hands. (Lithuania, Territorial Patient Fund)

The professionals organised their activity around a specialisation logic (Figure 3.1), which suited the bureaucratic logic of the State in place at that time. Professionals participated in the decision-making process and their vision supported fragmentation and specialisation of service delivery. Polyclinic and hospital managers had direct control over the allocation of resources and over the work of doctors. Funds were distributed on the basis of political decisions rather than on activity or actual needs of the population. Doctors acting as first point of contact for the patients with the healthcare system did not usually provide actual care; they used to refer patients to specialists, who were considered “the real doctors”. This practice stimulated internal demand for specialist services in polyclinic structures, where first contact doctors and specialists worked close together; hence, the referral system influenced the amount of
resources that the polyclinic would receive from the State budget as reimbursement for the provided services.

“Before this [family medicine] we had big, huge polyclinics and the head doctors really controlled the situation and the [primary care] doctors had little to say on how they thought the system could be better, how the patient could be treated better, [how] the service could be more user-friendly”. (Estonia, Ministry of Social Affairs)

First-contact doctors had very limited medical responsibilities and held no managerial responsibilities; as a consequence, they were not respected as much as the specialists. Given the poor socio-economic status and reputation of the doctors working in primary care settings, very few valuable medical graduates were attracted to a career in this profession.

“Primary care doctors were not really popular doctors, because first you wanted to become a neurosurgeon; then, when you couldn’t, you wanted to become a cardiologist; and, when you couldn’t, then the very last choice was primary care.” (Estonia, Ministry of Social Affairs)

Such a logic of specialisation was gradually modified by the introduction of a proper primary care subfield, centred on family medicine, an idea associated with a holistic logic (Figure 3.2). However, the specialised logic was not abandoned. It definitely survived, although with some revisions, in other parts of the field — secondary and tertiary care in both counties, as well as primary care in Lithuania.

**Reconstruction of the professional role-identity through the framing of family medicine**

The process of logic elaboration started with a reconstruction of the professional role-identity of practitioners in the primary care field. At first, intellectual leaders used their status and privileged position as academics and their awareness of the strengths and weaknesses of the Soviet system as practitioners to theorise this role-identity for the new family doctors. They were able to link the opportunity to introduce a new
system to the prevailing sentiment and desire to construct something new — in line with the general political sentiment.\(^{12}\)

“And it was in 1991 that our first group of doctors entered retraining [in family medicine]. These were mostly experienced doctor already, half of them working in rural areas. So with their help actually we designed the first curriculum, because they were working as first-contact doctors, we must say, they were alone in rural areas, and they knew what they were lacking from the previous university education.” (Estonia, Tartu University)

They suggested that the introduction of family medicine would consolidate the professional legitimacy of the first-contact doctors within the international healthcare community. It would also show that the countries were making efforts to homogenise their systems to those of Western European countries, thus enhancing the political legitimacy of the national governments. This ultimately led to the creation of a proper primary healthcare (PHC) subfield, which did not exist before, through the conceptual separation of primary and secondary care.

“Already during the Soviet period, the people at the University and some physicians started to think that we needed such kind of GP [=general practice] specialty for primary care. [...] And it shows that it wasn’t the Ministry’s decision, but the University and some physicians, who were open for changes, were the driving force of this reform. And the Ministry level joined this initiative in 1993, when — and also the role was very small — it recognised [family medicine as] the new specialty...and that’s all.” (Estonia, Ministry of Social Affairs)

Intellectual leaders aimed to modify the existing professional identity of those working as first-contact doctors by constructing a specific family doctor identity. The introduction of a family medicine model with comprehensive, first level services provided by the family doctor created a new professional role that changed the way primary care physicians conceived their professional identity. The family doctors’ identity was no longer related to “being second-order professionals” who provided single treatment interventions or simply referred patients to specialists. Family doctors became the

\(^{12}\) See also Lember 2002
coordinators of ongoing prevention, health and well-being and the promoters of a more personal relationship with the patient.

“When the reform started, for us the motivation was that having a “family doctor” meant that she was going to take care of all the family. [...] we thought…that we all know that there are some genetically transmitted diseases, like the chronic illnesses transmitted from generation to generation…and in this case the family doctor would know a bit more about all family members' health, conditions, relationships, social skills, health education and all these things. This was a very big motivation. [...] I think she would be like a member of my family, if we are talking about the family doctors.” (Estonia, City Government)

The boundaries of the new professional role were defined through the approval of official documents describing family doctors' competences, including their work and responsibilities (e.g. the Family Medicine Concept in Lithuania). From the start, intellectual leaders aimed to socialise practitioners to this new identity by organising and progressively refining national training programmes in family medicine for their colleagues. Although at different times in the two countries, intellectual leaders sought legitimisation of the representatives of the new profession in the eyes of the general public and the specialist colleagues through the foundation of specific university departments, the creation of professional associations, and the legal recognition of family medicine as a separate specialty. Indeed, their intention was to elevate the status of family doctors in the society and to empower the doctors, giving them more clinical responsibilities.

"First among the specialists in Lithuania, we wrote the medical norm with the competences of the family doctors. It is a law. We tried to do that to keep [part of the] medical field under our competence. We didn't wait for cardiologists, gynaecologists...they would have just divided the field among themselves and we would have been left with nothing! [...] it is how to say more like a project, it looks at responsibilities, such as prevention and continuity, rehabilitation, management and so on..." (Lithuania, Kaunas University)
Construction of new organisational forms and restructuring of
governance arrangements

The process of logic elaboration continued with the creation of specific organisational forms and governance arrangements harmonised with the newly-introduced professional role-identity.

In this phase, intellectual leaders variably sought other actors’ commitment to the newly framed ideas. At the macro- and local-level they tried to gain political support, by working with the professional associations to lobby the government for pushing the reform in a particular direction. The State contributed more actively to the debate on constructing family medicine-centred primary healthcare. Despite the State had been present in Lithuania more than in Estonia even in the previous phase, its role in this phase was very different in the two countries.

In Estonia, the State enabled the changes that had already occurred in primary care by legally formalising the new ideas. In a renewed system, intellectual leaders and professional associations were able to identify impediments to a smooth development and firm growth of primary care. Therefore, in Estonia more than in Lithuania, they were able to mobilise attention on these issues and gain the support of the politicians, who could then proactively collaborate in directing the reform and overcoming such difficulties.

“But at the beginning [...] the doctors continued as salaried doctors. Although the private practice was allowed, only a few could establish their own contracts with the Health Insurance Fund, I think in ’94-’95. But then in 1997, when the Ministry took the lead, really the reform in healthcare organisation happened, because at that time there was already a considerable group of doctors in retraining, [...] and 1997-98 were the years of big changes in practical healthcare.” (Estonia, Tartu University)

The process led to actual structural changes in healthcare, through the restructuring of governance arrangements and the creation of specific organisational forms for primary care delivery. These were strictly related to the formal separation between primary and secondary care.
“Therefore, it was very important to have a separate system of financing for primary healthcare and separate it from the secondary care and hospitals, and it was achieved in that way that family doctors have their own contracts with the Health Insurance Fund. And in my opinion it was also very important for the specialty because it was like posing it as a condition that the specialty itself took decisions and doctors themselves felt stronger.” (Estonia, Tartu University)

This phase essentially promoted decentralisation of responsibilities from the central government to the municipalities and from the head of polyclinics to the individual doctors. Doctors became responsible for the patients in their lists and accountable for their activity and, to some extent, their practice management, depending on the type of organisation in which they worked.

The formal separation between primary and secondary care was deemed necessary to reinforce the identity of family doctors and allow them to work as they are supposed to:

"But in that situation, in polyclinics, family physicians don't work as family physicians, because of the specialists; they just refer." (Lithuania, Vilnius University)

The split between primary and secondary care was firmer in Estonia than in Lithuania. In both countries family doctors were independent contractors, whose activity was financed through public funds. However, in Estonia family doctors were also required to be private entrepreneurs and owners of solo- or group-practices. This change was not promoted as a way of introducing soft privatisation in healthcare; it was deemed necessary to practically empower the doctors, strengthen their autonomy and, ultimately, ensure that family doctors would be able to practice what they had learnt during their training programmes. These structural changes would allow family doctors to actually start gaining legitimacy in the eyes of the general public as well as the specialist colleagues.

In Lithuania, family doctors had the possibility to work in an independent practice; however, this was not mandatory. Therefore, the association between new professional role and new organisational forms was not automatic. This did not help build legitimacy of a new professional role and awareness of a new identity and generated extreme variations in the actual work of doctors across the possible organisational forms.
“ [...] in the ‘90s the family doctors were very proud: they wanted to have their own practice, they wanted to have their own patient list. If you compare this to the system where many of them [=the doctors] of the older generation practiced, now they could manage and be the doctors. The youngest saw also the possibility for business and other things, but they saw that...you know...I can manage my practice and my patients. [...] This would help the respect for the family doctors and the family doctors’ system. (Estonia, World Health Organisation)

While there was resistance to change in Estonia, especially in Tallinn, this ended because of coercive as well as normative forces. An increasingly closer interaction between family doctors and specialists, thanks to residency programmes and thanks to the mediating role of the University, facilitated the cooperation and the dialogue between the different disciplines, decreasing the perceived rivalry. Where resistance was stronger, the political will to maintain a uniform model across the country contributed to increase acceptance of family doctors and their new organisational forms.

In Lithuania, the frequent changes in government coalitions created sudden changes in the reform’s political direction and did not allow to promote a uniform, desired organisational model in primary care throughout the debate. The primary healthcare reform received variable support and, therefore, did not proceed as smoothly as in Estonia, due to this unstable position of the State. This harmed the firm separation between primary and secondary care delivery structures and the introduction of private family practices. In addition, the general sentiment of trust over innovative, privately-owned organisational models was lower in Lithuania than in Estonia, due to fear of corruption.

“Also the privatisation process that went on in the country was no successful at all...and I am talking now not only about healthcare, but in the whole country...so the people lost trust. So I can understand why those politicians wouldn't allow family doctors to do that [=to own private practices], because there was a lack of trust.” (Lithuania, Mykolas Romeris University)

This resulted in the decision to launch four pilot projects in the areas around the most important cities, each implementing a specific organisational model of primary care
delivery. None of the projects were later extended to the whole country; instead, all municipalities were free to decide which model they would support. This meant that, in most cases, the bigger cities kept the specialised model of care that was in place even before the reform, tolerating the development of a parallel system of private general practitioners. Other areas, mostly smaller towns or rural areas, had to rely on private group-practices of family physicians. Actors were willing to let the system develop by itself. They provided some fundamental directions and then allowed the field to naturally evolve.

“It’s difficult to say something very certain on that, but my feeling is that our direction is to have more small providers and more private providers. But I am not sure about what will happen in big Vilnius polyclinics, in which we have primary and secondary care under one roof. I am not sure about them, maybe they will stay some 5 years or so, or even 10 years. So…but in fact, regarding the [transition period] teams... it is quite easy and clear because we have some documents which say that it was prohibited to contract with these teams if we hadn’t contracted with them in the past, [...] like a natural death of these teams.” (Lithuania, State Patient Fund)

Universities and professional associations helped convey political attention to the development of primary care and represented family doctors in the political decision-making process. However, while in Estonia they strongly linked the new professional role to new organisational forms and governance arrangements, in Lithuania they did not promote family doctors as the only professionals in primary care; nor did they support a single organisational form for the primary care subfield.

**Enactment of practices**

While the previous phases concerned mostly meso-level dynamics, the final stage of logic elaboration more closely involved micro-level processes and focused on the enactment of practices coherent with the new professional role-identity, governance arrangements and organisational forms. The consolidation of the new role-identity of family doctors occurred through two mechanisms: the ongoing theorisation by intellectual leaders and professional associations, and the relational networks of the
socialised family practitioners. Intellectual leaders and professional associations participated in political and professional negotiations to build legitimacy for the new profession. The routine practices of the family doctors reshaped this identity and helped redefine their new role thanks to the day-to-day work of family doctors. The link between the new role-identity and the associated practices grew stronger through the enactment of those practices, which were centred on the coordination of care and the management of the doctors’ patient list. They also restructured the relationships and boundaries between the different professions.

“[…] if you do some reform the most important thing is to have people who support and who are able to perform those tasks. And therefore, as I said that we started with those active doctors, it was a great advantage for Estonia, because 60 active doctors after their training, after three years, started to be teachers for others who started the training as family doctors. In my opinion it is the most important thing, because if you have an empty field, there is nobody there and you cannot train others and also you cannot show what the work in family medicine is.” (Estonia, Tartu University)

In this respect, the university maintained a central role. During residency programmes, the trainee was supposed to work for a given period of time with a supervisor, who was either a family doctor or a specialist doctor. The day-to-day contacts between the trainee and the supervisors helped share the sentiment of belonging to a specific profession, which was based on a holistic approach to the patients and a close relationship with them. Such contacts also contributed to improve the relationships between different specialties through shared routines. These micro-processes of reciprocal learning and increasing daily collaboration between family doctors and specialists allowed to build mutual trust between the specialties, so that family doctors could be considered as equal and peer by other doctors. This legitimated family medicine from the bottom of the field, thus complementing the theorising and political process concerted by the university and the professional associations. A family doctor stated:

“And I think residency has a very good impact on the attitude of the other doctors, because we can make direct contacts with these other doctors during residency. Residency is one factor, not the only one. Of course, there has been quite a lot of cooperation and negotiation with the other doctors to improve the health system and so on. During residency I spent
about one month almost in every department where specialists worked, so I got many contacts and I leaned from them and they learned from me, so they saw that probably family doctors are not the most stupid! It’s again an idea [that comes] from Soviet times.” (Estonia, family doctor)

The enactment of practices reflected a specialised or holistic approach to care and was associated to specific organisational forms and governance structures. Professionals who worked in polyclinics were less likely to enact principles of a holistic logic than professionals who worked in independent, private organisations. They were less likely to take independent decisions and their work was more influenced by the formal authority of the head of the polyclinic. All family doctors in Estonia and those working in newly-created family practices in Lithuania took over more responsibilities and provided a broader array of services than those doctors working in polyclinic-type organisations.

“So, mainly in these polyclinics, these teams [consisting of] a district paediatrician, a district therapist, and assisted by a surgeon and a gynaecologist, are still practicing. So, but we think...how to say...it’s an old approach to primary care, one thing; and, another thing, the service is not sufficient. [It is] not the same as [that of] family physicians, if we just look at the medical competences, the simple medical competences. So they only look at the ear, at the eye, maybe do not make neurological tests; and [they are] not pursuing a holistic approach and continuity [of care]. No continuity, no holistic approach.” (Lithuania, Lithuanian College of General Practitioners)

Generally, the gradual acceptance of the new professional role of family doctors at the micro-level, through daily contacts between professionals, allowed for a growing legitimisation of family medicine also at the macro-level.

LOGIC ELABORATION AS GRAFTING AND APPENDING AND FIELD-LEVEL INSTITUTIONAL CHANGE

Ideas and working practices of first-level doctors have changed in the last 20 years. Referring to “ideal types” of professional logics in healthcare, this research claims that the old Semashko system was based on a pervasive specialisation logic (Figure 3.1).
The principles related to family medicine and introduced in Estonia and Lithuania during the reform process belonged, instead, to a holistic logic (Figure 3.2). This logic was new to the countries under study, but dominated the international discourse at the end of the 1980s.

The creation of a proper primary care subfield, with its distinctive norms drawn upon the holistic logic, variably influenced the traditional ways of organising and thinking about healthcare. Ultimately, the introduction of family doctors altered the relationship between the service providers and the users, modifying people’s understanding of the general functioning of the health system. As outlined by the informants:

“I think the creation of the system of GPs — because we have more than 70% inhabitants who are under GPs and we didn’t have it at all [before the reform] — has changed also the culture of people. They don’t go to specialists directly; and if they have good GPs, of course they receive many services; they don’t need to go to polyclinics.” (Lithuania, Ministry of Health)

Family medicine contributed to modify the very concept of healthiness, the goal of the healthcare field. Health was intended as well-being in a broader sense, embracing not only a physical and clinical state, but also a mental and social dimension.

"I think it has changed already some years ago, about 20 years ago, in line with what the WHO says...that health is not only, how to say, it doesn’t mean that you don’t have any diseases, but it means full well-being and full health. The concept of health means that you feel happy, you feel healthy and you can leave your life fully. We all work towards this goal." (Estonia, family doctor)

Existing institutional theory literature would explain this change by arguing that the dominant logic in the field was substituted by a new one, or that the blending of logics in place was progressively altered. Although this thesis does not exclude that these forces do play a role, it draws attention to a different phenomenon, which is the change derived from the internal evolution of one of the logics. The two ideal types of professional logic, the specialisation and the holism, were variably combined within each context. As a result, the overarching professional logic in the healthcare field was revised differently in the two countries (Table 3.1).
The specific process of logic *elaboration* linked principles of these two paradigms in a distinctive way, depending upon the context-specific characteristics of each setting (Figure 4.2). In Estonia, new ideas are *grafted* within the existing framework so that the exclusive work of the family doctors in primary care *complements* that of the specialist doctors in secondary care. In Lithuania, new ideas are *appended* to the existing logic so that the family doctors simply *coexist* with specialists and old public providers in primary care. These different modes of logic elaboration originate more or less homogeneous fields. A World Bank expert summarises the differences in the change process as follows:

"The starting point for both countries was exactly the same [the Soviet model]. The difference was that Estonia did a very clean-cut, comprehensive reform, and I think in Lithuania they just did a piecemeal…they didn't really reform, but the new forms of provision emerged and they coexisted with the others, and you have a more plural system."

In Estonia, family medicine complements secondary care. In order to emphasise the nature of this clear relationship between different parts of the field, this study refers to the resulting overarching logic as one of *complementary specialisations*. Family doctors and specialist doctors have noticeably defined roles, which do not overlap, but rather complete each other.

"This is also the new role that we wished for, that the family doctor was also the advisor...because — far from that! — we don't say that family doctors can answer all the healthcare-related questions. No. Specialised medicine has its own role. But not the whole population should go to specialists, only in some selected cases." (Estonia, Tartu University)

The overarching specialised professional logic has been expanded to include new principles of a holistic logic. Principles of the specialised logic and the holistic logic are *integrated* harmoniously in the field and explicit and unambiguous claims are provided to explain the links between the two.

"And actually we did reform in parallel also all the other levels of service: after primary care, we started with emergency services and we did also the Hospital Master Plan. So the whole system was kind of described and
measured and clear for us...how the patient should get in and what happens afterwards.[...] ” (Estonia, Ministry of Social Affairs)

The primary healthcare subfield in Estonia has developed rather homogeneously, centred on a uniform organisational model across the whole country, which is one of private family doctors as independent contractors.

In Lithuania, family medicine coexists with other forms of care provision in primary care and its function vis-a-vis secondary care is clear in theory, but not in practice. In order to emphasise the nature of this unsettled relationship between different parts of the field, this study refers to the resulting overarching logic as one of coexisting specialisations. Family doctors have the role of providing primary care services; however, their role is not exclusive, since teams of first-level specialists may also provide primary care services. In addition, the services provided by family doctors are not consistent across the country. Given the diversity of acceptable organisational forms and governance structures in primary care and the proximity of family doctors to specialists in polyclinics structures, the range of services provided by family physicians in polyclinics is narrower than that of physicians in solo-practices.

“There were several waves in our reform process. [...] Ideally, the idea was from the beginning — but we didn’t do this — [to have] groups of GPs, not teams of specialists instead of family doctors, but groups of GPs, who should work in general practice. There are maybe some, but it is not mandatory.” (Lithuania, Ministry of Health)

Principles of the specialised logic and the holistic logic are disconnected in the field and no explicit and unambiguous claims are provided to make sense of the way the two coexist.

“Really we are on the point that we promoted family medicine and it’s really our future, but on the other hand the relationship between the GPs and the specialists is very difficult and there is not an easy solution.” (Lithuania, State Patient Fund)

The primary healthcare subfield in Lithuania has developed quite heterogeneously, since actors tolerate a mixed system where family doctors and specialists operate and where public organisational forms coexist with autonomous ones.
The process of logic elaboration differs in Estonia and Lithuania, because it is fundamentally grounded into the context-specific characteristics of each setting. As one of the informants points out:

“If you compare [the countries in] this part of Europe, you can probably find lots of very interesting things and see that Estonia is the most developed in primary care, definitely. […] I don’t know why the others have not succeeded so well, but…let’s say it is possible that there are other reasons not inside healthcare, but inside the society to motivate this.” (Estonia, Estonian Society of Family Doctors)

The data show that these reform “styles” derive from national, socio-cultural and field-level factors that were latent when the countries were part of the U.S.S.R. and when their health systems were organised around the Semashko model. These conditions reflected the set of context-specific institutions, the taken-for-granted values and norms, which developed and layered throughout the history of each country. The different modes of logic elaboration were rooted in this unique background of traditions that Estonia and Lithuania preserved even during the Soviet period. When the pivotal actors, the intellectual leaders, understood that an “opportunity window” might have opened for the introduction of innovative ideas, they unconsciously enacted those institutions in their attempt to import the core concepts of the international healthcare debate within their countries.

Specifically, logic elaboration depended upon five factors:

1. The ability to synthesise conflicts: the nature of decision-making process at the national and local levels and the gradualness in the introduction of new principles in the reconstruction of the field influenced the tendency that actors have to reconcile contrasting views and perspectives;

2. The flexibility to accept multiple views, such as identities or practices: the extent of tolerance to diverging principles and the degree of coupling of concepts and practices affected the inclination of actors to allow for the existence of a plurality of perspectives and to accommodate those within existing frameworks;

3. The legitimacy of theorising agents: the social status of intellectual leaders — both within the field and within the broader society — gave them exposure and access to external inputs as well as authority and credibility to have a say;
4. The concentration of theorising agents within the field: the possibility to identify a centre of the field and the degree of concentration of intellectual leaders within it favoured the generation of a coherent discussion and channelled resources in one particular direction;

5. The socialisation of the practitioners to principles taken from the new logic: the organisation of training programmes was fundamental in translating ideas into practices, so that new principles, identities and roles could be enacted in the field through micro-processes of day-to-day interactions.

Each of these factors acquired more relevance in a particular phase of the change, although they indeed played a role throughout the whole process (Figure 4.2). In Estonia, the practical and cooperative process, the radical approach, the focus on internal consistency, and the strong emphasis on translating ideas into practices created a concept of family medicine that was comfortably applied throughout the primary care subfield and found its space and legitimacy vis-a-vis the other specialties. In Estonia, powerful, high-status intellectual leaders framed a new identity and embedded it within an existing overarching logic.

In Lithuania, the ideological and loose process, the incremental approach, the focus on flexibility, and the “implementation gap” led to the conceptualisation of family medicine as one of the possible legitimate alternatives in primary care and to the availability of several possible organisational structures. In Lithuania, the dispersion of intellectual leaders originated a new identity for family doctors, which however, was simply added to the existing one which was based on a specialisation logic.

The structure of the field in Estonia made it possible to clearly identify a champion for the theorisation. This contributed to the promotion of a coherent organisational model, consisting of a primary care field, covered with private family doctors. In Lithuania the impossibility to identify a centre of the field led to conflicting theorisations. The dispersed intellectual leaders were unable to catalyse the new ideas into a common framework, thus leaving room for pluralistic interpretations of the translated principles.

In managing the transition process, in Estonia the prominence of academics, associated with the long life of the universities, and the involvement of the departments’ directors in the decision-making process gave intellectual leaders a platform to launch and discuss their ideas. In Lithuania, where the universities did not create autonomous
departments for Family Medicine and where often the heads of such units were not family doctors, academics could not bind together strongly and gain the political support they needed.

Training of family doctors was used as a way of socialising professionals to a new identity. It aimed to both deinstitutionalise the previous model and legitimise the new approach, but there was a fundamental difference in the two cases. In Estonia the eradication of the old identity was felt as more urgent; emphasis was placed on retraining programs to create a homogeneous community of doctors who could train their colleagues and start practicing as family doctors. The emerging model was associated with a formal separation of organisational forms, governance arrangements and practices from the old system. It was presented as the most appropriate solution for the particular context, on the basis of internationally recognised practices. In Lithuania the acceptance of the old model survived in the socialisation process and in the working practices of doctors within PHC organisations, supported by old-fashioned governance arrangements within polyclinics. Hence, other specialties kept partial control over the training and the work of general practitioners. Training and retraining programs run in parallel, without any additional incentive for the doctors already in the system to retrain in family medicine.

CONTEXTUAL FACTORS INFLUENCING THE PROCESS OF LOGIC ELABORATION

While the phases of the process were generally common in the two cases, the outcome of change differed in Estonia and Lithuania due to a number of factors, which led to either grafting or appending to take place. The study identifies two sets of factors that fundamentally influenced these processes, which are related to the societal (macro) level and to the field (meso) level. Societal level factors are the ability to synthesise conflicts and the flexibility to accept pluralism (e.g. identity plurality). Central to the reconstruction of logics are identity claims; however, instead of being necessarily uniform, those identity claims may stress different aspects of the same identity or may in fact refer to multiple identities. Actors in one context may be more willing to accept and accommodate multiple identities within an overarching logic. Actors in another setting may instead reject all identity claims which do not precisely conform to the
existing ones. Furthermore, actors may be more or less flexible in accommodating such plurality of identities and may strive to relate them to different extents. Other important factors shaping the process of logic elaboration pertain to the level of the field. These concern the legitimacy of theorisers within the field and, more broadly, their status within the society; the possibility to identify a centre of the field, where theorisers are located, from which they are able to convey resources and commitment to their cause; and the socialisation process of practitioners to the new role-identity via training programmes and daily practices. The following paragraphs explain each of these factors in detail.

**Ability to synthesise conflicts**

Throughout the reform process and, specifically, at the beginning of it, actors variably linked potentially contrasting ideas. In Estonia, actors revealed a constant willingness to reach a common solution to a targeted problem, even if required major changes to the existing system. In Lithuania, actors supported a tendency to participate to a debate and pursue their views, even if this sacrificed the achievement of a final agreement.

The analysis identified two factors that help detail these approaches further: the nature of decision-making processes and the gradualness of change.

**Nature of the decision-making process**

In Estonia the process of change had a marked cooperative and concerted connotation. Actors aimed at framing and implementing a reform that could work within the Estonian context. They maintained the strongly practical and pragmatic attitude that had generally characterised Estonian policy processes during the transition period. In shaping the reform Estonian theorising agents maintained an internal focus, but tried to embed external inputs. They always remained open to a dialogue with institutional partners on the feasibility of the planned reform and on alternative approaches, wishing to become more visible and appear more “Westernised” to the international community.
The initiative to reform primary care came from the doctors in both countries. In this sense, the personal influence and visibility of some individuals was indeed vital for the reform to gain legitimacy. However, in Estonia, the focal actor, the intellectual leaders, were able to catalyse attention of other groups, activating a collaborative process in which every collective actor took part. Cooperation was key not only in healthcare reforms, but in all decision-making processes during the transition period.

"We were satisfied with many things we did even in other areas. There was a pension reform that was done at the time I was in the Ministry, together with the opposition. We were a minority in the Parliament…and, in this way, some things are still working today, because they were done with the opposition." (Estonia, Health Protection Inspectorate)

This intense cooperation did not only characterise the discussions about the reform’s main ideas, but it was also targeted to achieve specific results and produce actual changes, so that additional measures could be taken if needed. This reflected a very practical and result-oriented mentality.

"In many countries these things [=breaking up the polyclinics] have happened too, because of some like really political, ideological vision or agenda. In Estonia, these reforms in healthcare did not have any ideological agenda, it was rather searching for what would work... our objectives are these, what would work. [...] We are very pragmatic in Estonia in that sense." (Estonia, National Institute for Health Development)

Such a pragmatic orientation characterised Estonians as entrepreneurial and ready to innovate. This particular aspect might have supported the doctors who had to become private owners of their practice and work as independent contractors.

"Definitely this is the case in Estonia, because if you look at what Estonia has achieved, [there are] a lot of new innovations and the people are ready to accept new things more easily than other countries." (Estonia, Estonian Society of Family Doctors)

The development of political and decision-making processes, as in the primary care reform, was internally driven, although Estonia was always open to discussion and to external inputs. Estonians used concepts derived from abroad, such as contents of international projects or training programmes, and embedded them in the specific
national context, in such a way that these new concepts could actually work smoothly and homogeneously.

"I think international organisations had their role, but the good thing was that Estonians were very keen to have this dialogue, they had their own ideas, and they wanted to debate about them…because what the WHO and others did in the ‘90s was that they played the mirror-role, basically, it was possible to have a dialogue, because if you are trying to develop your reforms only within your own country you might forget something." (Estonia, World Health Organisation)

These characteristics were also perceived outside Estonia. By contrast, Lithuanian political processes were perceived to be more ideologically and politically oriented.

The difference between the countries’ organisation of society was reflected in their approaches to any problem. For instance, while Estonians pragmatically found even partial solutions to their problems, adjusting them later to fit the purpose, Lithuanians privileged the freedom of being able to try different solutions.

"Estonian society is much more ordered in all senses and in Soviet times it was much more ordered and much more practical, and not so much political. In Lithuania, every person is political [...] in their strategic understanding, in that sense, and every person is so resistant." (Lithuania, Lithuanian Institute of History)

The origin of such diverse orientations in the Estonian and Lithuanian culture and society were associated with different external influences that other countries had historically exerted upon each of the Baltic States before they became part of the Soviet Union (Appendix B). Specifically, Estonia was governed by German rulers and, later, by the Swedish monarchy, before gaining independence for a short period of time. This may have contributed to the diffusion of the Lutheran faith and to a generally high rate of atheism, actually the highest in Europe. Lithuania, on the other hand, formed a huge empire with Poland and derived many traditions from this historical period, such as the influence of the Christian Catholic Church on Lithuanian peasants’ everyday life. In the eyes of the informants, German and Swedish cultures were categorised as generally ordered, organised and practical, while Polish and Slavic cultures were more associated with political and ideological connotations. In addition,
Estonians felt a strong connection to Finland and the Finnish culture, because of geographical proximity, but also because of the similarity of their languages. Lithuanians, instead, felt more connected to cultures and languages of Central European countries rather than those of Scandinavia, because Lithuanian is an Indo-European language.

“If we compare us with the Estonians, I think that they have a better understanding of how to deal with pressures than we do in this country. Maybe it depends on historical traditions. Lithuania was a country which was part of a very big empire for a long time, some 500-700 years ago. And it was Catholic, of course, and in that we still feel more conservative. And after that, we formed a very big state with Poland. After that our country was occupied by Russia. […] In our traditions we had this very big, strong [state] that could push others around." (Lithuania, Lithuanian Society of General Practitioners)

The period spent under the U.S.S.R. probably consolidated a more negative and passive attitude towards changes and a generally conservative approach. This related to a more marked closeness of the Lithuanian society as compared to the Estonian one.

“Our first, very important document was the National Health Concept, which was signed by the Lithuanian Parliament in 1991. The draft was adopted by the Lithuanian Medical Association, officially. And this is the first paper where primary healthcare and family doctors was mentioned, the institutions. And according to this concept, other legal acts were prepared. So it was all internal. At the beginning I mentioned international organisations, institutions and projects which we implemented together, but they were implemented later, in the year 2000." (Lithuania, Ministry of Health)

The nature decision making process that led to the reform in primary care differed in the two countries. In Estonia, it aimed at framing a feasible reform and getting it implemented soon. In Lithuania, it focused on gathering different opinions around the direction of the reform and establishing a dialogue between internal actors. In Estonia, actors cooperated to effectively theorise the new role-identity of family doctors with the purpose of reaching an agreement over the change. In Lithuania, actors variably
participated in the process for discussing their ideas regarding what the identity of the new professionals and the organisation of the PHC subfield should be. However, they were less concerned with finding a common solution to the identified problem.

**Gradualness and degree of change**

In the destabilisation phase, when new organisational forms and governance arrangements were promoted by theorisers in association with the new professional role, the approach to change became more evident. When dealing with broad reforms, not just in primary care, theorising agents in Estonia pushed for a more radical and comprehensive change.

"In Estonia there was a very clear hospital reform, because they changed the hospital legal status. They merged hospitals, which are now all autonomous. They have a very clear mandate, they provide only specialised care, and the hospital system is now an acute-care system. So you don’t have hospitals that are kind of in between primary care and secondary care, so hospitals just provide acute care. The financing model is very clear, for both primary care and hospitals. So...that’s true not only about primary care, but it is a clean-cut reform approach that they apply to other parts of the health system as well." (The World Bank)

This led to the request to transform not only the identity, but also the organisational environment in which anybody who wanted to operate at the primary care level would work, as well as the distribution of power within such primary care organisations:

"In Estonia, they were more radical, they just forced all GPs to become private." (Lithuania, State Patient Fund)

Therefore, in Estonia there was a strong identification of family doctors with independent practitioners. In Lithuania this connection was not immediate, nor was it mandatory. Additional professional roles and models of care delivery were introduced in the existing institutional environment. Doctors were offered an additional opportunity to become qualified as family doctors and they were left free to decide where to practice. This softer approach to reform reflected the intention to allow the system to develop on its own, so that adjustments will be made incrementally over time.
"We made this in a very moderate way, in a very smooth moderate way, with a lot of options, with a lot of pilots." (Lithuania, Mykolas Romeris University)

In Estonia, radical changes were implemented very rapidly. Even though there was resistance to change, actors aimed to find a solution to conflicting viewpoints by discussing and modifying the field structures with the aim of reinforcing the change rather than impairing it. In Lithuania, the reform happened slower and was stopped in various moments because of resistance to change. Actors preferred not to solve conflicts, but to adopt a more incremental approach and let the field develop naturally. This would ultimately lead to the adoption of a solution that mostly fit the local environment.

**Flexibility to accept plurality**

Throughout the reform process and, specifically, in the last phases, different degrees of flexibility in accepting multiple and potentially contrasting ideas emerged in the two countries. The elaboration of logics involved the introduction of potentially controversial beliefs within a field-level logic. Some logics might be more flexible than others in embracing and tolerating such internal contradictory meanings and practices. In Estonia, actors privileged internal consistency in the supported principles and strong links between identities, organisational forms, governance arrangements, and practices. In Lithuania, actors allowed for multiple perspectives to coexist and supported loose links between identities, organisational forms, governance arrangements, and practices.

The analysis identifies two factors that would help detail these approaches further: the tolerance to conflicting principles and the degree of coupling between ideas and practices.

**Tolerance to conflicting principles**

In Estonia, where the family doctors in primary care complemented the work of the specialists in secondary care, the internal consistency of the overarching professional
logic and the congruence of its principles and practices were preserved through a clean-cut reform. In Lithuania, where the family doctors coexisted with first-level specialists, the plurality of visions and the field misalignment, with a number of professional roles and organisational forms, were privileged through a piecemeal reform. These factors manifested more strongly in the creation of specific organisational models and governance arrangements, and in the enactment of new practices by the family doctors.

In Estonia, the primary care reform was part of an overall plan to change the healthcare system that was pursued over the years and that produced quite a compact and coherent health system. Theorising agents structured the primary care reform in a very comprehensive way, so that, over time, the “whole package” was changed in a consistent fashion. They framed the new role-identity, but also modified various aspects, such as legal status of the entities, financial mechanisms, decision-making schemes, and service delivery structures, and specifically linked them to this new role-identity. The coherent introduction of new principles and their embeddedness in the evolving structures allowed actors to create a new PHC system and reinforce its stability. It also allowed them to clearly explain the links between the new primary care system and the changes in the other segments of the healthcare sector, therefore increasing legitimacy of the new arrangements.

"When we were planning [the reform] in our Society of Family Doctors we had many discussions on what should be the role of family doctors... whether this was what we called the “lead doctor” and there could be other doctors in primary healthcare as well, who are not family doctors; or we should try to cover the whole field with family doctors. This was the opinion that was shared by the majority who felt that all our colleagues should be in the same system even if they were not all very happy with this leadership role...but for that purpose the reform was designed to have the possibility of a group practice, where someone within the group could take some more administrative tasks, permitting all the other colleagues to do maybe more clinical work. This was decided in this way." (Estonia, Tartu University)

Furthermore, theorising agents aligned their views and integrated other actors’ contributions, so to create convergence of the primary care subfield towards a single model, thus rejecting mixed or ad-hoc solutions for specific areas. Implementing the
reform over the whole country was indeed one of the success factors of the transformation in the Estonian primary healthcare.

“Because what we didn’t do… what the other countries used to do is piloting too much…because you cannot really pilot something that is really small because you don’t get the real outcome. [...] I think most of the countries have done the reform and piloted one model, then piloted the other, then piloted a third one…Ok, in Tallinn we piloted these salaried and not salaried doctors models, but then we decided that if we reform we need to go over it all of us, otherwise it doesn’t work if we leave [some parts out].” (Estonia, Ministry of Social Affairs)

In Lithuania, although the trend has been to promote family medicine, theorising agents left actors in the field the option of choosing which specific organisational forms they would adopt. The reform privileged malleability of principles and decisions. Alternative professional roles could be embraced by doctors working in primary care and alternative models could be created; these alternatives were considered perfectly legitimate. Actors endorsed more flexible and mixed arrangements that allowed to choose among an array of available options across the subfield. Whilst introducing family doctors across the subfield, they also allowed previous structures to remain in place, either unchanged or slightly modified to accommodate the new professional roles.

“It depends on the local politicians and the local management, because it was not forbidden, it’s better to say, to create one or another model...There was no clear definition of what a ‘model’ means for primary care and it was allowed to create different models” (Lithuania, Ministry of Health)

Freedom of choice was felt as a fundamental principle around which the field had to be organised, partially as a reflection of the impossibility to exert the right of choice in the previous system. This showed that, despite the different interpretations of how the primary care field should be organised, for Lithuanians, the system was just one; however, it has been locally adapted and governed by principles that can overall coexist.

The tolerance to the existence of multiple views within the same field could be related to the flexibility of logics to the influence of principles derived from other logics. A given
institutional environment may allow for the coexistence of a number of identities, organisation forms, governance arrangements, and practices, even though they might be derived from different approaches. Others may privilege internal consistency and, hence, reject some ideas that are not completely aligned with the existing assumptions.

**Coupling of principles and practices: translatability**

Especially in the last stages of the reform process, the new ideas became consolidated through their connection with the corresponding day-to-day practices and their repetitive use. In Estonia, concepts related to family medicine were associated to specific organisational forms, governance arrangements and practices. In this way, the newly trained family doctors knew that they could work only in private solo- or group-practices and that they would be responsible for providing as much services as they could to a composite list of patients. This clarity in connecting ideas and concepts to practice helped speed up the process of reform implementation.

“*And if we think about why the family medicine reform has been successful since 1998 it is because the whole package was created and changed. Not only ownership, or legislation, or some regulations, but also the financing was shaped in the way to create incentives, and it was agreed at the policy-making level, and of course it was advised by foreign consultants as well.*”

(Estonia, World Health Organisation)

In Lithuania, concepts related to family medicine were introduced in the field, but did not find an explicit and univocal link with organisational forms, governance arrangements, and practices. The newly trained family doctors tended to adopt different practices and take over different responsibilities depending largely on the type of organisation in which they worked — which they would not know in advance before leaving the university. Family doctors in a public polyclinic or in a big public organisation were tempted to refer patients to specialists more than family doctors in private solo- or group-practices. In private practices, family doctors worked more independently and carried out more autonomous investigations and treatments. This increased the presence of old concepts, behaviours and practices in contradiction with those promoted by the reform, thus hampering the smooth and exclusive introduction of family medicine-related concepts. This generated an implementation gap, a
perceived discrepancy between the desired changes and their actual application. A Lithuanian external consultant commented:

“On paper we have a lot of very nice documents and maybe you know that our Health Program in the 1980s was one of the best in Europe. But the problem is that we are not implementing them [...] To decide and to do are two very different things. In Lithuania we are producing a lot of papers, but we have problems with the implementation.”

However, to close this gap between theorisation and changes in practice, theorisers needed to provide the tools for the new professionals to enact their role. As one of the Estonian World Health Organisation experts pointed out:

“There should be people in the system who understand the linkages, and there should be people who translate the ‘value for money’, the ‘quality’, the ‘access’, all these questions that we have as health policy specialists into the practical tools that the family doctors have. [...] And this is extremely difficult and this is the key [...] So somebody has to translate these concepts into the practical things for the family doctors, because we could dream but family doctors would never think in the same terminology of the policy makers, and they have to do different things.” (Estonia, World Health Organisation)

The connection between ideas and related practices might not be straightforward in all logic elaboration processes. In Estonia practices were tightly coupled with beliefs and identities associated with a new approach, while in Lithuania practices were loosely coupled with these new concepts and identities. In some cases, the process may require an immediate and unilateral association of ideas and practices, visible to all actors. In others, the elaboration of the logic may accept that, for a period of time, new ideas might not be perfectly connected to one and only one corresponding practice, organisational form or governance structure. This leads to either the existence of multiple practices associated with one belief, or the lack of enactment of particular rules and cultural norms.
Legitimacy of the theorising agents: status of intellectual leaders

In Estonia and Lithuania, intellectual leaders, the main theorists of the reform, operated in universities with a different organisational structure, which reflected the status associated with family medicine as opposed to other specialties. Despite the early creation of specific units inside the medical faculty, family medicine could not enjoy the same recognition within the academic and political community in both countries. In Estonia, Tartu University immediately created an autonomous Department of Family Medicine in 1992 within the Faculty of Medicine. In Lithuania, Vilnius University formed a Centre for Family Medicine within the University Hospital in 1992, while Kaunas University opened a Department of Family Medicine within the Faculty of Public Health a couple of years later. Therefore, while in Estonia the new discipline had an independent department, in Lithuania it was linked to already existing departments belonging to other medical specialties.

In addition, the higher the visibility intellectual leaders enjoyed within society in general, the more they were able to spread awareness about new concepts and influence political decisions. In this sense, the different history of the universities in the two countries may help understand the specific role of intellectual leaders in the primary care reform processes. In Estonia, the Medical Faculty was established at Tartu University in the early XVII century, on the basis of the classical university structure with four faculties — Philosophy, Theology, Law and Medicine. It has always been highly regarded, also because it has been the only centre in the country which provided medical education (Maaroos 2004). In Lithuania, the Medical Faculty was created in the late XVIII century in Vilnius following the Jesuit college structure — with only the faculties of Philosophy and Theology — and in the early XX century in Kaunas. Nowadays Kaunas is the biggest institution providing medical training in Lithuania.

“When the Department was opened, it signalled the acceptance of family medicine, because our Department was at the same level of all other Departments, no difference: if you have a professorship, you belong to the city council and you can diffuse our great ideas about family medicine also in those places. In some countries, up to now they don't have academics in family medicine and therefore the whole [idea of] family medicine in these
countries encounters many difficulties, because other specialties have much power.” (Estonia, Family Medicine Department)

The distribution of power between academic disciplines remained unbalanced in Lithuania. This was reflected in the appointment of specialists to leadership positions in family medicine departments and units.

“I think in Lithuania academics do not want to recognise family doctors as specialists, as equal to the other specialists [...] The former Director of the Family Medicine Department had several professorships, in surgery, cardiology, [...] but he was not even a family doctor!” (Lithuania, Primary Care Centre Manager)

In Lithuania, despite the creation of family medicine ad-hoc departments or centres, academics in family medicine did not seem to have the same level of control over these centres as their Estonian counterparts.

In summary, the universities immediately assumed a pivotal role as theorists of the change and maintained it throughout the whole process. Particularly during the destabilisation phase, intellectual leaders leveraged their personal academic position and professional recognition as well as the legitimacy of the universities within the society to introduce principles deriving from the holistic logic. They used their links to the international academic community to familiarise with the new discourse and acquire practical knowledge of the family doctors’ role in the system by attending training courses or gaining work experience abroad. At the same time, they transferred this identity to their colleagues within their national context. Specifically, they used their practical experience and professional knowledge to blend the new role-identity of family doctors into the existing context and to justify the change of approach. However, in Lithuania the lower status of intellectual leaders as theorists did not allow them to promote the new role of family doctors as exclusive in primary care.
Concentration of theorising agents: the ability of intellectual leaders to channel resources and maintain high commitment

The possibility to identify a centre of the field was key for the logic elaboration process, particularly in the creation of new organisational forms and governance arrangements. The presence of a “catalyser” of the reform increased the chances of generating a common sense of self and contemplating a homogeneous set of ideas among the theorisers and the recipients. Specifically, the internal density of theorisers and their consequent ability to convey support and legitimacy to the change varied in the two contexts.

In Estonia, emphasis was placed on having an internal, small, and really active group of academic doctors who worked to overcome the weaknesses of the previous system. The strong intellectual leaders, with academics occupying a pivotal role throughout the reform process, actively involved practitioners in preparing the new curricula for the family medicine training and, with their collaboration, were able to create a single professional body. The university and the professional association maintained a high level of cooperation, which derived from the constant intention to promote a homogeneous idea of family medicine.

“There was a very close collaboration between the university and the Society of Family Doctors, [...] geographically, but also ideologically. [...] This is a continuation of a tradition in Estonia that the head of the professional association, never mind what specialty, is the head of the specialty at the University or has a professorship [...] And it is a tradition that the president of the association is also a leader in the specialty in the country. Therefore, we have always had a very good cooperation, and we will continue to have it.” (Estonia, Tartu University)

The concentration of efforts ensured the promotion of a clear vision and a constant attempt to engage other relevant actors to ensure their commitment to the change. In Estonia, the uniform group of theorising agents linked family medicine to the emerging decentralisation of the state and privatisation of all sectors and found the steady support of political leaders, in the central government and in most local municipalities. To further underline the innovative character of family medicine, intellectual leaders in Estonia explicitly recalled pre-existing traditions of healthcare service delivery
structures and referred to the re-introduction of independent general practitioners, as they existed in the country before the Soviet occupation.

In Lithuania, neither the university nor other actors seemed to take over the role of coordinating the effort to promote the family medicine reform. Intellectual leaders were not able to assure stable commitment of other stakeholders to the reform. First of all, there were two academic centres in Lithuania, one in Vilnius and one in Kaunas, and they did not always speak with a clear, common voice. They also originated two professional associations, which fostered occasional disagreement and posed internal threats to the actual theorisation process. The two academic centres helped train doctors in family medicine, but did not lead the process towards a single possible framing of primary care. Given the dispersion of intellectual leaders and, subsequently, of professional associations, together with the unstable political arena, no constant and effective attempts were made to promote a comprehensive change in the field. Actors did not visibly link new identities and practices to specific organisational forms or governance arrangements.

“There are a lot of strategies and a lot of laws just to develop primary healthcare. The professional associations developed a lot of documents and the Parliament supported them, but in reality it is only on paper. [...] It depends on the politicians and the political will also at the local level...” (Lithuania, City Government)

In Lithuania, the emphasis was placed more on the production of legal acts and the identification of possible ways to implement them rather than on the bottom-up formation of a new identity that was commonly embraced by all professionals within the field and endorsed through specific and coherent organisational forms, governance structures, and practices.

**Socialisation of practitioners to the new logic: training of professionals and enactment of practices**

A strong emphasis was placed on training practitioners over the whole reform process, from the destabilisation to the adjustment and, most importantly, the consolidation
phase. This was deemed relevant in order for the practitioners to identify with the new role and familiarise with the new organisational forms, governance arrangements, and practices. The role of intellectual leaders was indeed central for organising residency programs through which the reconstructed identity was communicated to the junior doctors:

“During the Soviet period we didn’t have such kind of healthcare as primary healthcare. So we had to create everything and we started from human resources. It meant that our universities participated in the reform by educating physicians and nurses first of all; and I can’t tell you exactly, maybe in 1993, we reformed the training, [introducing] residency. So a special program for GPs was created and we started to educate doctors to become GPs. And together with that, we had another program for the retraining of paediatricians and internists, and also other doctors who wanted to become GPs. So the University taught them what family medicine is, what they have to do as family doctors, and so on. And they started a community of doctors [...] until we had enough GPs and stopped retraining them.” (Lithuania, Ministry of Health)

Intellectual leaders who trained the practitioners had the tools to transfer them the ideas and principles of family medicine and to show them how these concepts practically worked.

In Lithuania, although the programmes started around the same time as in Estonia, the emphasis was given to the fact that initially the family medicine training was delivered by doctors who trained and practiced in other specialties. The creation of a participatory process through which trainers and trainees could cooperate and learn from each other through day-to-day practices was less evident. This showed the importance of having committed role models, who really believed in family medicine, for transmitting the new identity to the targeted community of professionals.

“But the trainers were taken from the other specialties [...] We do this also now, but at that time we didn’t have any [other] possibilities because we didn’t have any family doctors. We just collaborated with some outpatient primary care units, who were friendly to us, and they, how to say, trained our doctors [...] But after that of course we started to use our already functioning family clinics, like family medicine institutions. And now we do
mainly family medicine rotation in these clinics with family doctors.”
(Lithuania, Kaunas University)

Training was necessary not only to socialise practitioners to the new identity, but also
to construct the relationship between family medicine and other specialties and further
build the legitimacy of the new professional role through micro-level processes of
learning.

“But lately the family doctors have proven more that they are a necessity
and many specialists of course have relationships with family doctors as
equals. And residency helped this process.” (Estonia, family doctor)

In Estonia more than in Lithuania a strong emphasis was placed on retraining
programs for family doctors, also thanks to the introduction of incentives from the
Estonian Health Insurance Fund. As a result, in Estonia about 85% of the practicing
doctors voluntarily decided to retrain. In Lithuania the 20% of the previously working
doctors who did not retrain kept practicing in parallel to the emerging system of family
doctors in “transition teams” — consisting of an internist, a gynaecologist and a
paediatrician working in the same practice. These strategic choices of the countries
revealed different attitudes towards family medicine. The emphasis on the retraining
programs stresses that the origin of the socialisation process stemmed from practical
problems, familiar to the first-contact doctors. These well-known problems originated
from the consideration that, during the last phases of the Semashko system, patients

“were shopping around, not knowing where to go and visiting a lot of
doctors just to get to the right one” (Estonia, Ministry of Social Affairs).

A focus on the training of new graduates, as in Lithuania, seemed to reflect the
awareness and the acceptance of the fact that not all doctors would wish to embrace
retraining and practice as family doctors. As a consequence, new elements linked to
family medicine would be inserted on top of the already existing principles and roles,
which were linked to a specialisation logics and which would still be allowed in primary
care. Hence, the primary care subfield would be made up of partially conflicting
principles and models.
CHAPTER V. Discussion: implications of the research findings for the study of institutional field-level change

This study expands existing theories on institutional change. It explores how field change unfolds in different contexts. It questions the prevailing institutional theory approach that grounds explanations of change on shifts in dominant logics or conflicts between existing paradigms. It discovers that change may in fact occur through elaboration of field-level logics. Logic elaboration is essentially a process of construction of (and socialisation to) new identities, organisational forms, governance arrangements, and practices, which restructure the existing logic in a field. New beliefs and practices belonging to a new paradigm do not simply replace current beliefs and practices. Actors need to embed them in the existing context; actors recombine old and new principles and revise existing overarching logics. In so doing, they alter the relationships between all those enacting such field-level logics and restructure the configuration of the field. Logic elaboration may unfold either as a grafting or an appending process, depending on specific societal and field-level factors.

The findings of this work suggest a continuous view of institutional change. Change does not only occur because of shifts in the dominant logic or conflicts between logics of different institutional orders. Logics appear to be toolkits, where principles and practices can be inserted, modified or removed in different ways by actors in the field. Since logics are not fixed, they may encompass beliefs and practices that present some degrees of contradiction, depending on the specific cultural context. They may be more or less compatible and integrated with other logics in the field. Logics emerge as identity-centred frameworks, which can however variably accommodate different identity claims, justify organisational forms and governance arrangements, and support specific practices. The process of logic elaboration allows to understand how these internal elements of logics are combined and linked.

Since through logic elaboration, logics can encompass potentially conflicting elements, groups within a social actors that is associated with a logic can enact different elements of such a logic; hence, social actors may not be completely homogeneous. As a matter
of fact, they consist of multiple subgroups, each embracing a specific identity; these identities are incorporated within the overarching logic, which variably connects them and tightly or loosely couples them with particular practices. Finally, logic elaboration and partial fragmentation of social actors originate layers within the field, complicating structures, relationships and power distribution among the actors.

**INSTITUTIONAL CHANGE THROUGH LOGIC ELABORATION: GRAFTING AND APPENDING PROCESSES TO RESTRUCTURE FIELDS**

With the aim of expanding current institutional theory research on field-level change, this study seeks to explore how institutional change processes unfold in different contexts. It examines the same field in two countries to understand how specific field configurations originate from the process of logic elaboration. It focuses on the evolution of a central logic in the field, namely the professional logic. It finds that processes of logic elaboration unfold differently in each environment, reflecting context-specific dynamics.

Through a **grafting** process, principles of the new holistic logic are **grafted** within the old specialisation logic. In Estonia, family medicine permeates the newly created primary care subfield, and the work of family doctors in primary care complements that of the specialist doctors in secondary care. Grafting may revise a logic by incorporating new elements that are clearly and coherently connected to the existing ones. The overarching professional logic has been elaborated by expansion of the specialisation logic to encompass new principles of a more holistic and patient-centred view of medicine. This study refers to the logic elaborated through grafting as one of **complementary specialisations** (see Table 3.1).

Grafting is theorised by a highly regarded and cohesive group of intellectual leaders, who endorse coherence and homogeneity in the newly created primary care subfield. They reshape actors’ relationships so that functions and roles of professionals in different parts of the field complement each other and are well-integrated.

Through an **appending** process, principles of the holistic logic are **appended to** the specialisation logic. In Lithuania, family medicine and other first-level specialties are all
Legitimate in primary care, and family doctors simply coexist with old service providers in primary care. Appending may revise a logic by inserting new elements within existing frames without efforts to link or justify relationships between these two. The overarching professional logic has been elaborated by a collection of the specialisation logic and new principles of a more holistic and patient-centred view of medicine. This study refers to the logic elaborated through appending as one of coexisting specialisations (see Table 3.1).

Appending is theorised by a number of intellectual leaders, who frame a new identity and socialise practitioners to it, but allow for identity, organisational, governance, and practice variation among actors and heterogeneity in the newly created primary care subfield. They reshape actors’ relationships so that functions and roles of professionals in different parts of the field coexist, but are not completely harmonised.

Two sets of factors fundamentally influence logic elaboration, generating either grafting or appending. These are related to the societal (macro) level and to the field (meso) level. Societal level factors are the flexibility to accept plurality (e.g. identity plurality) and the ability to synthesise conflicts. Actors in one context may be more willing to accept and accommodate multiple identities and practices within an overarching logic. In another environment, they may reject all those identity claims and practices which do not precisely conform to the existing ones. In addition, actors may be more or less flexible in accommodating such plurality of identities and practices and may strive to link them to different extents. Field level factors relate to the legitimacy of theorisers within the field and their status within the society; to the possibility to identify a centre of the field, where theorisers are located, and from which they are able to channel resources and maintain high commitment to the change; and to the socialisation process of practitioners to the new role-identity. The socialisation process is key for logic elaboration, because it spreads the new ideas into the field and activates micro-processes of interactions between those enacting different paradigms. Therefore, it allows to reshape the new identity and practices from the bottom of the field.
UNDERSTANDING FIELD CHANGE IN VIEW OF THE FACTORS INFLUENCING LOGIC ELABORATION

Reflecting on these findings, this section presents some considerations regarding field-level institutional change. These suggestions need to be further investigated and tested in different contexts. However, they offer new insights for future research on institutional logics and change.

The ability of a society to synthesise conflicts and the flexibility to accept multiple perspectives may be related to the extent of change. A higher ability to synthesise conflicts may be associated with more radical processes of change. Since actors are not comfortable with openly contrasting principles and seek solutions to conflicts, they may embark on radical reforms so that competing viewpoints are either eliminated or merged. A lower ability to synthesise conflicts may be associated with less radical processes of change. Since actors are comfortable with openly contrasting principles and do not seek exclusive solutions to conflicts, they may leave competing viewpoints to permeate the field, and actors will be free to choose among them.

A higher flexibility to accept plurality may be associated with less radical processes of change. Since actors do not need to strive for imposing only one dominant identity, they would share a field in which multiple identities are legitimate and variably related. A lower flexibility to accept plurality may be associated with more radical processes of changes. Since actors need to strive for legitimating one and only one identity, they would engage in stronger theorisation and socialisation processes.

The flexibility to accept pluralistic views and the ability to synthesise them may be connected to the delegitimation of principles related to existing paradigms. Where flexibility is low and synthesis is high, i.e. in grafting processes, newly institutionalised identity claims, organisational and governance structures, and practices may require a rejection of previous identities or practices in a specific part of the field. However, actors would try to combine the new and the old in an integrated synthesis. While delegitimating old claims in a specific part of the field, actors would encourage those enacting old logics to further identify with them in other parts. However, they would stress the importance of maintaining coherence and integration between these claims and between the different parts of the field. This strategy would increase legitimisation of
the principles related to a new logic, even when they are introduced through radical processes.

Where flexibility is high and synthesis is low, i.e. in appending processes, new and old institutionalised identity claims, structures and practices may coexist in the field. Actors would maintain both and would not feel the need to justify the connections between them. More than delegitimising old claims, they would try to create voids for them to feel. They would allow for the autonomous choice of the preferred identity and practices and would rely on micro-level processes to rework relationships between those enacting different principles. This strategy would increase legitimation of the new identities and practices among the specific audience that chooses them.

Therefore, flexibility to accept multiple perspectives and ability to synthesise partially contrasting views may impact on the way a specific institutional environment is structured, affecting its level of complexity. These characteristics may be relevant in understanding how collective actors and organisations respond to complexity and to the existence of pluralistic paradigms (Greenwood, Raynard, Kodeih, Micelotta & Lounsbury, 2011; Pache & Santos, 2010).

Legitimate actors, although not necessarily the most powerful ones, are likely to promote the change. This reflects findings of previous studies (Greenwood & Suddaby, 2006) arguing that central actors behave as institutional entrepreneurs and initiate change. The examined cases hint to the fact that not only the legitimacy that theorisers hold in the field, but also their status and legitimacy within the broader society may be a relevant factor in processes of institutional change. Academics in Estonia, who are respected within the community because of a long history of the universities, are able to lead the process more than academics in Lithuania, who do not enjoy the same social status because of a shorter history of the universities in the country.

If theorisers are highly concentrated in a field, radical change is more likely to happen because they would be able to construct a more coherent view and convey resources to their purpose. If it is not possible to identify such a centre of the field and if theorisers are not concentrated, change may still occur, but it is less likely to be radical. The dispersion of theorisers does not allow for normative, regulative and cultural resources to be mobilised in a comprehensive fashion; pluralistic perspectives are more likely to emerge and attract a portion of the available resources.
Socialisation processes of practitioners to new principles are required in order for any change to occur in a professional field. It is through socialisation that a new identity is understood and internalised by those who are supposed to enact it; and it is through socialisation that such identity becomes associated with specific practices. When this process explicitly targets groups of individuals who have previously been socialised to a different identity, socialisation is more likely to perceive the distance between the old and the new identity. The old identity is progressively eradicated and the new one receives increasing legitimation in the field. When socialisation targets predominantly groups of individuals who have not been previously socialised to another professional identity, new and old identities are more likely to be equally legitimate and coexist in the field. The system will naturally evolve and perhaps the old identity may eventually disappear once its holders exit the field.

**IMPLICATIONS OF THE FINDINGS AND CONTRIBUTIONS OF THE RESEARCH**

This study contributes to existing knowledge of the processes by which field-level institutional change unfolds in different contexts. It questions the extant institutional theory approach to study change, which relies on explanations based on shifts in dominant logics or conflicts between paradigms. It discovers that change may in fact occur through elaboration of field-level logics, which is a process of grafting or appending new identities, organisational forms, governance structures, and practices, and place them within an existing logic in the field. Therefore, it offers several contributions to the neo-institutionalist literature.

**Reconceptualisation of logics: logics as toolkits**

Field-level logics need to be reconceptualised to include an element of internal variation and evolution. To date, they have been perceived as rather monolithic and static. From the current studies logics seem to present fixed dimensions (e.g. Thornton & Ocasio, 1999) which are possessed at the broader, societal level and which are
translated in all fields, although perhaps at different times. However, we don’t know if and how logics play a role in all fields, and what are the conditions and the ways in which broader logics are applied to — and reshaped within — fields. Given the diversity of fields, we have to assume that some broader logics are enacted in some fields and not in others — at least not to the same extent. In addition, given the diversity of environments, we need to accept that even within the same field there may be contextual variations in the ways of interpreting ideas and justifying practices even when they are expression of the same institutional order (Lounsbury, 2007). However, if we adopt a rigid conceptualisation of logics, as it has been the case so far, we cannot account for such diversity.

We need to embrace a more fluid and evolutionary conceptualisation of logics to understand if and how logics change and interact in a specific context. In this regard, the idea of logics as repertoires of beliefs (Townley, 1997) or cultural toolkits (Swidler, 1986) could allow to incorporate such insights. Conceptualising logics as cultural toolkits, from which actors can draw to theorise new institutions, means conceiving them as made up of multiple parts and linkages, which may be revised over time. This can help uncover the process through which logics change internally and introduce an element of flexibility in the characterisation of logics. It can also help us define logics more precisely and describe their characteristics, including essential features — role-identity, organisational forms, governance arrangements, and practices —, and ancillary elements.

At the field level, actors are influenced not only by one logic, but by multiple logics, which are not necessarily in conflict and may coexist for a long period of time (Dunn & Jones, 2010). While embracing a particular logic, actors may see the potential for modifying it. They may start enacting and progressively incorporating into the existing logic specific ideas or practices of another logic, which they perceive as compatible with the original one. The contextual factors uncovered in this research, such as the flexibility to accept multiple perspectives, identities or practices, and the ability to synthesise these, are important in understanding the mechanisms of agency on such processes of logic elaboration. They may also play a role in influencing perception of compatibility between different paradigms, identities and practices and in shaping specific organisational responses to institutional pluralism (Kraatz & Block, 2008; Pache & Santos, 2010). Finally, these factors may help understanding apparent
contradictions in practices within and across organisations and variations in the enactment of logics at the micro level.

The idea that societal conditions in each nation influence processes of social construction is recognised also by other streams of research. One of these streams, which draws upon developments of Douglas North’s conceptualisation of institutions in comparative political economy, is the historical institutionalism and, specifically, the varieties of capitalism literature. This approach maintains that modes of organising relationships between actors vary systematically across nations (Hall & Soskice, 2001). The broader socio-cultural substratum supports the specific solutions that each nation poses to particular issues of coordination among and inside firms. The varieties of capitalism literature emphasises that the creation of a particular industry results from and reflect each nation’s political order (Dobbin, 1994). Social activity is influenced by the cultural prescriptions that ground all political processes in a country. In view of the centrality of national cultural heritage for understanding cross-country differences in processes of change, this study also aims to capture the distinctive context-specific values and characteristics of the Estonian and Lithuanian societies. However, as most of the neo-institutional theory studies, this research focuses on field dynamics influenced by societal factors; the varieties of capitalism literature remains predominantly focused on comparisons between societies at the national level (Feldmann, 2007; Morgan, Campbell, Crouch, Pedersen, & Whitley 2010).

Actors construct fields in ways that endorse the taken-for-granted approaches in any decision-making process in a particular spatial context. Previous work on translation of institutions across countries (see Sahlin & Wedlin 2008 for a review) elaborates on the idea of national institutions influencing processes of change. The specific approaches to tackle and solve the problems that a nation inherits from its political history will generate variations across fields and across logics. This explains why the same logic in different contexts may look different — either because it comprises different elements or because these elements are combined in different ways. In this regard, local and community-related dynamics (Greenwood et al., 2010) may also play a role in originating such variation. When actors engage in translation and editing of logics from one context to another, not only societal and field factors, but also micro level mechanisms may affect the outcome of this process. This thesis identifies which societal and field-level factors contribute to restructure logics in different environments.
Future research may supplement these findings by focusing on local dynamics of logic elaboration.

**Logic elaboration as a process of institutional field-level change through grafting and appending**

Previous work has highlighted the complexity of the institutional environment (Greenwood et al., 2010) and the influence of institutional contradictions (Friedland & Alford, 1991) on social action. Studies on logics have started to take pluralism into account, predominantly looking at changes in the balance of rival logics in a field (Reay & Hinings, 2009). However, pluralism may also influence internal alterations of logics. We need to consider that, despite defining durability as institutions, field-level logics change over time. They may be institutionalised and become dominant in a field, as well as being deinstitutionalised and exiting a field, and perhaps being re-institutionalised in a later stage (Scott 2001). Logics deriving from the same order may be translated differently in two, or more, geographical contexts (Lounsbury, 2007); they may also be combined in different ways. They are elaborated through the reconstruction of identities, organisational forms, governance arrangements, and practices belonging to different, more or less comparable, paradigms. In the examined cases, a professional logic of specialisation is elaborated differently in the two countries by the introduction of principles, identities, organisational forms, governance structures, and practices traditionally associated with a logic of holism. The elaborated field logic accommodates such new principles in different ways, but it is still the same logic.

The study builds upon the most recent theoretical developments in the field. Scholars have started moving away from the idea that change derives from shifts in dominant logics, as earlier empirical studies argued (Rao, Monin, & Durand, 2003; Scott et al., 2000; Thornton & Ocasio, 1999; Thornton 2002). Recently, scholars have analysed change as emergence of new logics through sensemaking (Nigam & Ocasio, 2010) or as attempts to settle conflicts between competing logics (Purdy & Gray, 2009; Reay & Hinings, 2009). Some have highlighted strategies for diffusion of practices associated to new logics (Purdy & Gray, 2009), including transformation, grafting, bridging and exit. Others recognise that logics are not necessarily competing and may coexist in the
same field for long periods of time (Dunn & Jones, 2010). While this study assumes that these processes occur also in the examined cases, it supplements this body of research with a closer attention to the dynamics that internally modify a logic in a field. The findings show how, over time, a professional logic is elaborated through processes of grafting or appending. However, this thesis expands previous work by looking at ways in which principles of logics related to the same institutional order are combined and it highlights the phases of the logic elaboration process. Grafting and appending are processes centred on the reconstruction of identities and roles, which are then linked to organisational forms, reinforced by governance arrangements, and enacted through practices. Furthermore, the research uncovers the context-specific factors that influence the mechanisms through which actors reconstruct identities, roles, organisational forms, governance structures, and practices vis-a-vis the existing ones.

This thesis argues that processes of field-level change may occur through elaboration of logics, via grafting or appending. The term “grafting” appears in previous studies on identity (Nag, Corley, & Gioia, 2007) and institutional change (Purdy & Gray, 2009), whereas “coexistence” appears in the logics literature (Dunn & Jones, 2010). However, these words are used in this research because — and to the extent that — they are grounded in the data. Logic elaboration has been introduced inductively in this research: its importance for the reform process is derived from the data analysis rather than from a priori hypotheses formulated during the initial set up of the study. The process of logic elaboration is close to that of theorising (Strang & Meyer, 1993; Greenwood et al. 2002) an institutional change. To some extent, the two overlap, because they concern the framing and justification of institutional elements. However the focus of the theorisation process is on the creation and legitimation of institutions, whereas that of elaboration is on the incorporation of new ideas into an existing framework. Logic grafting and appending do not describe a change that is external to a given logic, which is either a shift in the dominant logic (Scott et al., 2000) or a modification of the balance between logics (Reay & Hinings, 2009; Purdy & Gray, 2009). They emerge as processes of internal elaboration of a logic. In addition, theorisation emerges as an important phase for constructing identities and roles and acquiring legitimacy; however, personal networks, peer-to-peer interactions and daily practices, especially through socialisation processes, are the vehicles for consolidating legitimacy and constantly redefining identities and roles.
Central to processes of logic elaboration is the reconstruction of roles and identities, which has been seldom addressed by previous studies (Greenwood et al., 2002; Rao et al., 2003). Institutional theory and identity research are often depicted as antithetical (Glynn, 2008); however, they may benefit from a closer integration. In empirical investigations, logics emerge as identity-centred claims that are enacted through specific practices and protected by particular organisational forms and governance arrangements. Consequently, a more attentive look at the identity perspective may enhance our understanding of logics. Some scholars have attempted to introduce an institutional perspective in the identity literature when addressing intra-organisational processes and conducting analyses at the micro-level (Chreim, Williams, & Hinings, 2007). Studies on organisational identity may help institutional scholars uncover organisational responses to multiple institutional demands by showing how resistance to change may derive from identity claims (Fox-Wolfgramm et al., 1998) or by illustrating how managers deal with multiple identities within organisations (Pratt & Foreman, 2000). Furthermore, institutional research on logics, especially related to professionals, may benefit from studies on the construction and reconstruction of professional identity. These may offer insights on the issue of decoupling between identities and practices (Pratt, Rockmann, & Kaufmann, 2006). Studies on the enactment of a professional role and on the concept of professional role-identity (Chreim et al., 2007) — which embraces both the individual’s self-definition as a member of a profession (identity) and the interaction structure in a given setting (role) —, may be useful in better understanding individual and micro-level action on professional logics.

**Fields: stratification and homogeneity**

The internal elaboration of logics activates processes of field-level institutional change that fundamentally restructure the organisation of the field. Logic elaboration creates space for a new subfield, redefines the field goals and modifies the relationships between the actors within the field. Since it involves the construction of new elements and their connection to existing ones, logic elaboration originates several layers of identities, structures and practices as new ideas are introduced. These strata are
reflected in the configuration of the field, which contains multiple subfields that are variably linked in order to reach the ultimate goal of the field. This finding reflects previous empirical studies conducted in advanced economies which argue that institutional change occurs through layering (Streeck & Thelen, 2005) or sedimentation (Cooper et al., 1996) of institutions.

During logic elaboration, field actors may not necessarily contest the common goal around which the field revolves. Grafting and appending only partially revise the meaning associated with goal of the field (Hoffman, 1999). For example, in the healthcare field, actors cooperate to assure that the population is healthy. In the examined case studies, the process of logic elaboration has not altered this goal; however, the introduction of new principles has broadened the meaning of healthiness. The introduction of family medicine created a culture of prevention and comprehensiveness in approaching each individual patient. This affected the way health was conceived by all actors in the field, which started to embrace a broader idea of health encompassing well-being and living a quality life. However, professionals other than those in primary care maintained a strongly specialised logic, which remained in place at the field level.

Change emerges as a process of construction and constant alteration of nested elements that generate embedded field structures. The specific cultural prescriptions that shape logic elaboration allow for the emergence of different structures, organisational forms, power balance in the two case studies. These may be tightly or loosely coupled and, as such, originate a more or less homogeneous composition and “sedimentation” (Cooper et al., 1996) of the field. Grafting processes originate more homogeneous subfields and more structured and ordered fields. The complementarity between identities and roles of actors in different subfields allows for greater overall integration of the field, with structures, relationships and power balances well defined and coordinated. Appending processes originate more heterogeneous subfields and more chaotic fields. The coexistence of identities and roles as viable alternatives allows for greater fragmentation, with structures, relationships and power balances that follow parallel developments.

This study argues that an outcome of logic elaboration is the restructuration of the field through the creation of layers or subfields. Therefore, future analysis of field-level changes would need to account for the existence of such layers. These may be
originated by changes in the blend of logics (e.g. introduction of a market logic in a field that was dominated by State and professional logics). However, the research shows that subfields may also be created by elaborating existing logics and reconstructing principles of old and new paradigms associated with the same institutional order.

**Actors and subgroups of actors: holding multiple identities while embracing the same overarching logic**

Logic elaboration influences the composition of a social actor and the internal relationships between its subgroups. Generally, institutional theory has as yet considered actors as unitary entities that share a common belief system and related material practices, i.e. the same logic. For example, doctors have been regarded as the medical professionals, who follow a given professional logic. However, doctors do not form a uniform group. This collective social actor embraces a multitude of subgroups of different doctors, such as family doctors, surgeons, gynaecologists, or paediatricians. They all share a common logic, which guides them as professionals in the field. However, within it, each subgroup holds a more specific professional identity, which defines their belonging to that particular subgroup and not to others. This conceptualisation reflects the “normative fragmentation of the professional logic” (Kitchener, 2002, p. 414). Recent work has considered the decreasing homogeneity within professional groups. This may be related to different social and economic background of members and to differentiation between specialty groups inside occupations (Leicht & Fennell, 2008).

As layers of principles and practices are constructed and reconstructed through logic elaboration, elements of logics become nested and are variably embraced by specific groups of individuals, who use them to reshape the field or some parts of it. Each institutional actor consists of several subgroups, which share a common overarching logic, but which maintain more specific identities that define membership to that subgroup and that are variably connected by the overarching logic. This idea is consistent with, and made possible by, the conceptualisation of logics as identity-centred toolkits. Accepting this view allows to advance considerations of how multiple
identities are accepted and variably linked within the same logics by those actors who relate to that logic.

In this regard, the concept of collective identities to some extent overlaps with that of logics. Both refer to shared ideas and associated practices. However, from my point of view, logics are sets of cultural beliefs and rules that structure cognition, guide decision-making, and shape practices and actors’ interactions within a given institutional field (Lounsbury 2002, 2007). They provide cultural toolkits that actors employ to recombine identities (Glynn, 2008). Logics are identity-centred paradigms and can accommodate different shades of such identity claims. Collective identities have been defined as “groups of actors that can be strategically constructed and fluid, organised around a shared purpose and similar outputs” (Wry, Lounsbury & Glynn 2011, p. 449). Perhaps, the concept of logics more closely looks at the higher societal orders and prescriptions that shape social action; collective identities relate more to membership of, and belonging to, a particular social group, which consists of a variety of actors. Future research might shed light on how the two concepts are related — explaining the reasons why we need to maintain both constructs — and clarify why and how researchers may want to adopt one or the other. It may be that collective identities define the actors’ mutual roles for achieving a given goal, while institutional logics focus more on the shared principles and meanings that ground and embrace these roles as well as the corresponding material manifestations. Perhaps collective identities may represent a “bridge” for actors embracing different logics and embarking on a collaboration project for which they need to develop a specific overarching identity, without destroying their original identities (Reay & Hinings, 2009).

**Intellectual leaders and institutional change: the key theorising agent in highly-professionalised fields**

This study emphasises the role of academics and university educators — referred to as *intellectual leaders* — as the theoirisers of the change and the most important institutional entrepreneurs (DiMaggio, 1988) in the examined processes of logic elaboration. Not only do they frame identities drawn from a new paradigm, but they
construct training programs to socialise those who are supposed to enact them to the new roles and practices.

Institutional studies have argued that both central and peripheral actors may initiate change. Some claimed that fringe players, who are newer or less powerful in a given field, are more likely to introduce innovations, since they are less likely to be sanctioned for their innovative behaviour (Leblebici et al., 1991). Later, additional work discovered that actually it is the most powerful and central actors, in a boundary-bridging and/or misaligning location, who are more capable of catalysing change (Greenwood & Suddaby, 2006). In line with this stream of work, scholars have looked at those actors that were deemed to be key in influencing institutionalisation processes and policy making. Attention has been devoted predominantly to regulatory agencies, such as the State and the professional associations (Greenwood et al., 2002), as theorising agents. Studies on field logic in the healthcare sector have argued that the transformation in the field has generally been prompted by the State and opposed by the professionals (Reay & Hinings 2005). However, this study discovers that professionals and especially intellectual leaders may be in fact those who initiate the reform process, frame the new concepts, and channel the attention of other actors on a specific issue. They are able to identify an opportunity for change (Dorado, 2005) and socialise the targeted actors in the field to this new identity through residency programmes (Pratt et al., 2006). Through socialisation, intellectual leaders communicate a new identity to the practitioners and teach them specific practices. Residency training allows practitioners to start enacting what they have learnt and to establish and reshape relationships with other professionals in the field.

This study draws attention to the fact that institutionalisation processes may be initiated by actors who have not been previously investigated. Political processes and policy changes, such as the healthcare reform analysed in this thesis, are increasingly driven by actors outside the traditional political arena. This is in line with a growing body of institutional studies on social movements (see Schneiberg & Lounsbury 2008 for a synthesis), which emphasise collective action as a motor for change. However, institutional theory has so far ignored the action of intellectual leaders in institutional processes. This is rather paradoxical because intellectuals and academics are

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13 Socialisation was a key process in the old-institutionalism literature; however, it has been overlooked by neo-institutionalist studies.
supposed to be bright thinkers, constantly open to new ideas. They work in close cooperation with other colleagues and experts from various fields and are exposed to different contexts. It seems, therefore, reasonable to identify them as those most able to conceptualise and promote change.

In addition, intellectual leaders are likely to control socialisation processes and mechanisms via university training or continuing professional education. This is especially true in highly professionalised scientific fields, such as medicine, because the socialisation process takes a formal, well-established fashion. As such, intellectual leaders appear to be the most relevant type of *institutional entrepreneur* and *theoriser* in the elaboration of logics in professional fields. A closer look at other types of theorisers not previously considered by institutional scholars may uncover specific dynamics of change, different from those already known in the existing literature.

### Institutional change in non-Western contexts

This research extends the investigation of institutional change processes to contexts that have not been previously included in theoretical formulations. To date, the majority of the institutional theory literature has concentrated on Western countries, mainly the United States and Canada, and has looked at changes in mature fields (e.g. Reay & Hinings, 2005, 2009; Greenwood & Suddaby, 2006). Very few studies have focused on other settings, such as, for instance, Middle-Eastern countries (Lawrence et al., 2002; Zilber, 2002, 2006) or emerging fields (Maguire et al., 2004; Purdy & Gray, 2009). Moreover, several studies set in Western contexts and focused on explaining institutional effects of shifts in logics point to healthcare, a highly institutionalised field, as a relevant area of research (Thornton & Ocasio, 1999). They predominantly explore the organisational responses to changes from professional and state logics to more managerial and market logics (Ruef & Scott, 1998; Scott et al., 2000). They have generally considered hospital settings (Reay & Hinings, 2005), funding patterns of interest associations (Galvin, 2002), or medical education (Dunn & Jones, 2010).

Although Friedland & Alford (1991) specifically observe that logics are the organising principles of Western societies, they extend their argument to socialist societies when
discussing the potentially interdependent and contradictory nature of institutions. They claim that societal crises, as the one that led to the dissolution of the U.S.S.R., may stem from both external contradictions between institutions and externalisation of internal contradictions. Moreover, in post-Soviet countries even the main institutional orders underwent a profound revision, experiencing change during the transition period. In numerous cases, “it was not only a matter of remembering the new but also forgetting the old” (Czarniawska, 2002: 165). Therefore, often the attempt to construct new orders and logics is here coupled with the assumed necessity to detach from the communist-type, “alien” institutions and demolish the correspondent values and practices. One could argue that the institutions underpinning these systems are relatively unstable, as those of emerging fields (Tracey, Phillips, & Karra, 2007); tensions and conflicts between institutions may strongly characterise such settings and fields in crisis (Hardy & Maguire 2008; Maguire et al., 2004). However, the dynamics of institutional change have not been previously investigated in these contexts.

For this reason, we have very limited knowledge of field-level changes in non-Western countries. We hardly hold any information on contexts that underwent processes of radical change at all levels at the same time. Such radical changes invested Central-Eastern European countries following the collapse of the Soviet Union. Within these settings, even the fields that have traditionally been recognised as mature and highly institutionalised, such as healthcare (Thornton & Ocasio, 1999), underwent a profound transformation. These contexts are undoubtedly fruitful for the study of processes of social change.

This in depth case study shows that the complexity of institutional processes is here amplified by the introduction of assumptions and ideas from Western contexts. Processes of change are fundamentally characterised by the attempt to merge such new perspective in the existing environment or reconstruct fields that more closely reflect the new paradigms. However, countries behaved differently during the transition period. The comparative analysis of two post-Soviet countries presented in this thesis illustrates specific conditions that emerge from the particular socio-cultural environment and influence the unfolding of change.

Future studies may focus on these and other non-traditional settings to further expand knowledge of institutional processes. They may discover that such processes can take
other forms in those contexts and explore ways of integrating traditional and new explanations of institutions and change.
CHAPTER VI. Conclusion: contributions of the study and suggestions for future research

CONTRIBUTIONS OF THE RESEARCH TO INSTITUTIONAL THEORY

This research expands current institutional theory research on field-level change and makes several theoretical contributions to this stream of literature. First, the study introduces and develops the notion of logic elaboration by examining institutional change in two societal contexts. Second, the research expands our understanding of logics as toolkits, whose elements can be variably combined in a specific field. Third, it identifies key contextual factors that shape and impact upon the trajectory of change towards logic elaboration.

This study analyses logics originating from the same institutional order, the professional order. The literature has so far focused on understanding how logics coming from different institutional orders shifts or are blended in a field. Analysing the healthcare field, studies explains how the dominant logic shifts from a professional logic, to a state logic, to a market logic (Scott et al., 2000), and finally to a democratic logic (Blomgren & Sahlin, 2007). This thesis shows that the elaboration of principles belonging to different conceptualisations of logics originating from the same institutional order may also lead to field-level change. This extends previous work, indicating that logics deriving from the same order can be translated differently in two, or more, geographical contexts (Lounsbury, 2007). The research illustrates that principles of such logics can coexist in the same context and within the same field and explains the specific processes through which they are elaborated.

When studied empirically, logics appear to be cultural toolkits (Swidler, 1986), whose elements can be variably combined by actors in the field. This conceptualisation of logics helps uncover the process through which logics change internally and introduce an element of flexibility and potential complementarity in the characterisation of logics. It also allows us to reflect on which elements of a logic are essential and which are ancillary, thus helping clarify the definition of institutional logics.
This work illustrates that logic elaboration is a context-specific process of change. Societal and field-level factors contribute to the unfolding of the process. Ability to synthesise conflicts and flexibility to accept pluralistic perspectives vary across societies. The legitimation and concentration of theorisers in a field, as well as the socialisation of practitioners to new principles, differ across fields. These factors influence the way in which principles of different paradigms are combined, consequently reshaping the configuration of the field.

As a consequence of logic elaboration, fields and collective actors present different degrees of internal heterogeneity. Fields appear to be layered in subfields, within which actors have specific identities that are variably linked within an overarching field-level logic. The process of logic elaboration constructs and reconstructs principles and practices that then become stratified and nested. These identities and practices are variably embraced by specific groups of individuals, who use them to reshape a particular field or some parts of it — originating the “normative fragmentation of the professional logic” (Kitchener, 2002: 414). This conceptualisation helps understand how actors conceptualise their roles and enact relationships within the field (Wooten & Hoffman, 2008).

The study points to the role of intellectual leaders as theorisers of field-level change in a mature and highly professionalised field. Previous institutional work grounded on healthcare settings, has demonstrated changes in logic that are promoted by the State and imposed on the professionals. This research explains that, in fact, institutional change in highly professionalised fields is more likely promoted by intellectual leaders, who act as theorisers (Greenwood et al., 2002) and institutional entrepreneurs (DiMaggio, 1988; Dorado, 2005). Intellectual leaders rely on their nature as academics and practitioners to theorise institutions and diffuse those institutions in the field by controlling the socialisation of practitioners to the new identities.

The findings of this work show that socialisation processes are fundamental in substantiating field-level change in professionalised fields. Authors have argued that theorisation, as opposed to reliance on relational networks, is necessary to frame, justify, legitimise and diffuse novel institutions (Strang & Meyer, 1993; Greenwood et al., 2002). This study clarifies that socialisation of practitioners in highly professionalised fields is the process that allows the theorised institutions, identities
and practices to be transmitted to actors at the micro-level. This links the theorisation to the enactment and further elaboration of institutions through relational networks.

This study presents a comparative analysis of the same field in two countries and investigates institutional processes in settings not previously examined by institutional scholars. It emphasises the importance of conducting comparative studies for capturing contrasts and differences in the unfolding of institutional processes grounded in specific cultural contexts. It argues that non-traditional empirical settings, such as post-Soviet countries, offer examples of more radical changes than those already studied in Western contexts. Finally, it emphasises that, in consideration of the transformation of all major institutions after the collapse of the Soviet Union and the assimilation of Western institutions, these settings present a greater complexity than other countries. The context-specific processes underpinning change in these settings require further empirical and theoretical investigation.

**LIMITATIONS OF THE STUDY**

This research has some limitations. These mostly relate to the empirical settings of the study.

The researcher had to face a language barrier. Since she did not speak either Estonian or Lithuanian, she had to rely on the English language for conducting interviews and analysing documents. English was neither the interviewees’ first language nor the research’s. She did not have access to documents in original languages, such as laws, newspapers or academic journals. Some informants talked her through some original documents or their personal notes during the interviews. This may have introduced a bias in the understanding of the process. However, most official documents and internal reports benefited from an accessible English translation. In addition, the people who participated in the change process and some of the practitioners were fluent in English. The researcher could access all the main leaders of the reform and those who were involved in its implementation. This allowed her to gain a broad understanding of the unfolding of the events and of different perspectives held by actors in the field.
The researcher did not live in either Estonia or Lithuania for a long period of time. Therefore, she was not embedded in the Estonian and Lithuanian culture. While this was undoubtedly a drawback, it could also be considered as an advantage. Since she was new to the countries and to my informants, she looked at them with a fresh mind, without preconceptions or constructed *a priori* assumptions about them. As a result, she was able to perceive the differences between the two cases more promptly and “objectively”.

Although Estonia and Lithuania shared some common traits with other post-Soviet countries, they are indeed unique. Estonia, Lithuania and most of the Central-Eastern European countries were part of the U.S.S.R. for about half a century. This experience undoubtedly influenced the countries’ institutions and marked them with some commonalities. However, previous past history may have shaped profound differences between the former U.S.S.R. countries. Despite being geographically close and constantly associated as “the Baltic states”, Estonia and Lithuania were, and still are, profoundly different. They hold different religious beliefs, have different ethnic compositions, speak different languages, and carry different economic fundamentals. These critical political, economical, and socio-cultural characteristics did not disappear during the period that the countries spent under the U.S.S.R. and certainly re-emerged once the countries gained political independence. As a result, national characteristics have to be taken into account when studying these (as well as any other) settings, because we cannot assume that only the most recent history shapes social action and institutions in a given context.

These arguments have to be taken into account in considering the transferability of the findings of this research to other contexts. The theoretical arguments advanced in this thesis regarding the process of logic elaboration can indeed be applicable to other contexts. However, some additional societal or field-level factors may emerge in further investigations of new settings, thus expanding the theoretical model presented in this thesis. Such factors may differ depending on the specific context. The study of logic elaboration in transition countries may reveal important aspects or characteristics that are not present in Western settings or in developing countries.
ALTERNATIVE EXPLANATIONS OF THE PROCESS OF CHANGE

While maintaining that the process described is indeed a change in institutional logics, this section presents some possible alternative explanations and the reasons for their rejection.

In line with a resource dependence approach (Pfeffer & Salancik, 1978), it could be argued that the healthcare field evolved in divergent directions in the examined contexts because of pressures exerted by the actors holding the necessary resources to promote and implement the change. These actors range from international organisations, which grant financial resources; to academic partners in other countries, which offer knowledge and human capital; to central governments, which confer political support; and finally to supranational bodies, which convey international legitimation. However, Estonia and Lithuania held the same position vis-a-vis these actors. Despite different economic growth trends in the two countries, Estonia and Lithuania received the majority of funds for healthcare reforms from international organisations, mainly the World Bank and, later on, the European Union. Estonian and Lithuanian doctors were originally trained abroad, mainly in Finland, Denmark, Canada, and the UK. A dialogue was maintained between Estonia, Lithuania and other countries in the Nordic region to share experiences of reform and facilitate cooperation for research and training. This generated a number of initiatives, such as the Northern Dimension Partnership in Public Health and Social Well-Being. Estonian and Lithuanian governments did not give priority to healthcare reforms, although political influence was stronger in Lithuania than in Estonia during the change process. Governments in both countries aimed to ensure international visibility by adopting similar policies, which were legitimate in the eyes of the Western European countries and their international and supranational partners, such as the European Union. Availability of human resources and internal capacity was also comparable in the two systems. Estonian and Lithuanian doctors had to be equally trained in family medicine and needed to acquire specific professional competences. Local municipalities had to build expertise in handling decentralised responsibilities related to primary care. Since the two countries were subject to similar external pressures while counting on similar internally available resources, resource dependence arguments would not truly explain
differences in the reform processes and their outcomes in terms of divergent field configuration.

The role of individuals is undoubtedly important in the process of change. In order to explain why actors are able to change the very institutions that shape their thinking and acting (Holm, 1995; Seo & Creed, 2002), institutional scholars have referred to the concept of institutional entrepreneurship (DiMaggio, 1988; Dorado, 2005; Greenwood & Suddaby, 2006). Institutional entrepreneurs identify opportunities for change and promote social action to modify current institutions. Institutional theory has devoted attention to study the centrality of personalities in driving change. However, it could be argued that very few examples of institutional change driven solely by individual actors can be found. More generally, the collective process of entrepreneurship brings about change (Hardy & Maguire, 2008). This study finds that individuals are indeed key for advancing institutional processes. Particularly, in the examined case studies, the legitimacy associated with specific intellectual leaders and directors of university departments conferred legitimacy to the new professional role-identity that they consciously promoted. However, individual efforts by themselves cannot explain the change and the differences between the processes in the two cases. Informants clearly stated that a number of co-occurring factors allowed for the change to happen. Despite identifying intellectual leaders as key theorists, they referred to a multiplicity of actors who contributed to the outcome of the process. As a result, personalities as well as a collection of social actors and contextual factors make institutional change possible and shape its dynamics.

SUGGESTIONS FOR FUTURE RESEARCH

In conclusion, this study suggests some possible lines of future research which may advance our understanding of institutional processes in view of the findings presented in this thesis.

Logics offer stable frameworks upon which actors organise societies. However, a more fluid and evolutionary conceptualisation of logics would allow for a better account of processes of social construction, such as logic elaboration. Logics are repertoires (Townley, 1997) or cultural toolkits (Swidler, 1986); these are made up of multiple parts
and linkages that can be revised over time. Their elements may be used in varying configurations to solve specific problems. A more flexible and context-specific interpretation of logic could help scholars understand if and how logics evolve and interact in a specific environment. This would allow for an account of the differences in compatibility of logics in a given temporal and spatial context. It could also help understand apparent contradictions in practices within and across organisations.

Logics emerge as identity-centred frameworks. As such, a more attentive look at identity studies can enhance our understanding of logics. Studies on organisational identity can help institutional scholars uncover organisational responses to multiple institutional demands by showing how resistance to change derives from identity claims (Fox-Wolframmm et al., 1998) or by illustrating how managers deal with multiple identities within organisations (Pratt & Foreman, 2000). Especially when related to professionals, institutional research on logics can benefit from a closer link with the literature on construction and reconstruction of professional identity (Chreim et al., 2007). More generally, identity and role may be useful concepts for better understanding micro-foundations of institutions and individual action on field-level logics.

While this research finds that identity and role can be considered key elements around which logics revolve, in line with hints from previous studies (Rao et al., 2003; Lok, 2010), other elements could be important for characterising logics. For example, this study emphasises the centrality of organisational forms, governance arrangements, and practices. Perhaps, logics consist of core and ancillary elements (see Dacin and Dacin, 2008 on institutionalised practices) and, while ancillary elements are more commonly eroded, the core elements tend to remain more stable over time and survive potential challenges. However, the internal composition of logics requires further theoretical and empirical investigation. This would help scholars clarify the definition of institutional logic.

Future studies should carefully consider issues related to homogeneity of fields and actors, in view of the conceptualisation of logics as toolkits. Analyses of field-level change need to account for the existence of layers of institutions originating from the elaboration of logics. As principles, identities, organisational forms, governance structures, and practices are constructed and variably connected during processes of logic elaboration, the organisation of the field and the internal composition of actors are
restructured. Logic elaboration adds to the complex dynamics through which fragmented actors reconstruct their relationships and reshape the field. However, some fields and actors in specific settings can appear more stratified than in others because of particular context-specific factors and processes. Authors should conduct comparative studies to uncover the motivations underpinning these differences.

Institutional studies could explore the role of non-traditional actors in promoting field-level change. This thesis demonstrates that, because of their links to the international academic community and their practical knowledge of the field, intellectual leaders are able to combine theorisation of new identities with socialisation of new practitioners. Intellectual leaders emerge as the most important theoriser in a highly professionalised field. However, in other contexts, such as emerging fields, other actors could act as institutional entrepreneurs. A closer look at other types of theorisers could uncover specific dynamics of change that are different from those already known from existing literature.

Finally, future work may focus on exploring non-traditional contexts and generating new theoretical concepts on field-level change. In this regard, post-Soviet countries may offer interesting insights to researchers, because conflicts between paradigms are more powerful and apparent as a result of the transition from communist to market economies and democratic systems. Expanding the analysis of logics to include these settings could help identify the historical (Friedland & Alford 1991) and spatial limits of logics and compare the different institutional conditions within or between these societies that led to specific processes of change in particular fields (Scott et al. 2000).

Given the specificity of institutional processes, insights from those studies could require a revision of some of the main theoretical constructs of the neo-institutional literature. If we take this approach seriously, we need to consider that processes and concepts which have emerged from institutional studies conducted in Western countries could take other forms when analysed in non-Western contexts. Given the different socio-cultural heritage of each nation, the study of countries in Central-Eastern Europe, Africa, Central and South America, and Asia, could shed light on new institutional orders, paradigms and processes that current theoretical accounts do not include. Future work may indeed focus on incorporating theoretical insights generated by research in those contexts. Furthermore, scholars may elaborate concepts such as
institutional logics, institutional entrepreneurs, or institutional work, that currently dominate the scholar debate, by extending theories to account for such variation.

Through the analysis of such settings and the conduction of comparative studies, the institutional theory literature could further contribute to identify the specific national factors affecting social processes. This might offer insights for other streams of literature, such as the international business literature. Multinational organisations face challenges in operating across countries and adopt strategies for coordination between branches that are essentially shaped by national contexts (Morgan & Kristensen, 2006). An understanding of the context-specific factors that influence institutional processes could help create more appropriate solutions to those issues.
References


Miles, M.B. & Huberman, A.M. 1984. Qualitative data analysis: a sourcebook of new methods. SAGE.


Osborne, D., & Gaebler, T. 1992 Reinventing government: how the entrepreneurial spirit is transforming the public sector. Addison-Wesley.


**Electronic resources**


The WHO Health For All Database & the Global Health Observatory Database: [http://apps.who.int/ghodata/](http://apps.who.int/ghodata/) Accessed on 8 October 2010.

Appendices

Appendix A: Interview schedule

1. Version for policy makers, policy analysts, health insurance managers, and academics

The process of change in health system: restructuring primary care in the Baltic States.

The aim of the research is to analyse the reform process in primary healthcare, from the early 1990s until the recent developments, focusing on the context-specific factors and the role of the professionals that contributed to the evolution of the ideas behind the system’s organisation and to the changes in the service delivery structures and practices.

I would like to thank you very much for taking the time to help me with my research.

Notes:

When answering the questions, please refer to your experience as a policy analyst, policy maker, manager, academic, medical student/resident, and practicing doctor. Each question is followed by a sub-set of questions that are intended to give you additional information to formulate your answers; however, please feel free to expand your thoughts and include anything you consider relevant to the topic, even if the questions do not mention it directly. Please note that when I refer to quantity or numbers, there is no need for you to report the precise numbers if you don’t have them; a realistic assumption of the size or amount would be equally helpful.
• Would you briefly outline your background?

• Based on your experience, would you describe the reform process in primary care?
  
  o Could you tell me more about the Estonian/Lithuanian context at the time when the reform started? How has it changed over time and how has this change influenced the development of the primary care system?
  
  o To what extent has the reform process changed over time?
  
  o Which were the drivers of the reforms? Which were the key factors that enabled the reform process and which those that hindered it? How did these factors contribute to shape the change?
  
  o Which were the key reform objectives? Would you say that these have been achieved and to what extent? Why? Have they (not) been achieved uniformly in every region?

• What has been changed in the primary care system (and in the healthcare system in general)?
  
  o Why do you think it was decided to modify it? What were the ideas and principles behind it? Why was it modified in this particular way?
  
  o How has the organisation of the primary healthcare system changed? Have new organisational forms and mechanisms (e.g. purchaser-provider split and contracting; restructuring of existing healthcare institutions or creation of practices for providing exclusively primary care; public/private ownership of service delivery structures) been introduced during the reform process?
o How has the governance of the system changed? How have roles and responsibilities of the actors involved (e.g. Ministry, counties, municipalities, managers, doctors) been modified?

o Did other parts of the health system change? What contributed to this process? Have the changes in primary care affected it?

- Which actors have been relevant in the reform process? Which actors championed and/or supported the reforms? Which actors opposed the reforms?

o Why did they support or oppose the reforms? What did the reforms represent for them?

o Were the reforms driven internally? By who? Did external actors (e.g. international agencies) participate in the process?

o What was the role of these different actors? Has their role changed during the process? How did they contribute to shape the principles and the concepts underlying the reforms? What did they do to champion or oppose the reform?

o How have they managed their role within the reform process? Were there any collaborations or clashes between the actors? How did these contribute to shape the reforms? How are these collaborations changing over time?

o Has resistance to change been experienced? How has it been dealt with? Has opposition been resolved?

- How do different stakeholders perceive the reforms that have been implemented?

o Which elements of the reforms have been most commonly accepted and which criticised? By which stakeholders? Why?

o How is the work of family doctors perceived and valued by the other specialists? And by the patients?
Has the (financial and social) status of family doctors varied compared to the primary care doctors in the Semashko system? Has this changed over time?

What are the perceived benefits and drawbacks of the reforms?

2. Version for practice/polyclinic managers, practitioners and residents

The process of change in health system: restructuring primary care in the Baltic States.

The aim of the research is to analyse the reform process in primary healthcare, from the early 1990s until the recent developments, focusing on the context-specific factors and the role of the professionals that contributed to the evolution of the ideas behind the system’s organisation and to the changes in the service delivery structures and practices.

I would like to thank you very much for taking the time to help me with my research.

Notes:

When answering the questions, please refer to your experience as a medical student/resident and as a practicing doctor. Each question is followed by a sub-set of questions that are intended to give you additional information to formulate your answers; however, please feel free to expand your thoughts and include anything you consider relevant to the topic, even if the questions do not mention it directly. Please note that when I refer to quantity or numbers, there is no need for you to report the precise numbers if you don’t have them; a realistic assumption of the size or amount would be equally helpful.

Before starting to answer the questions, please briefly outline your background:
• When and where did you attend the Medical School and Residency?

• Did you study or practice abroad?

• When and where did you start practicing? Which type of practice was it (for instance, solo practice or group practice)?

• In your training/beginning of practice, was your supervisor a retrained doctor in Family Medicine (that is, did he/she graduate from Medical School when the Semashko system was in place)? If so, what was his specialty before (for instance, internist, paediatrician, or gynaecologist)?

• In which institution are you practicing now? Where is it? Which type of practice is it?

• If you can share the information, how big is your patient list and what is its composition (for instance, 50% adults and 50% children; 60% women and 40% men; 70% “healthy” patients and 30% patients with chronic diseases)?

• Why did you choose to specialise in Family Medicine?
  o What were your main motivations and expectations when you chose your specialty?
  o If you trained before the introduction of Family Medicine, what kinds of changes did you notice in the approach to the training and the trainers? Would you give me some examples?
  o Do you see the positive aspects that made you choose Family Medicine in your everyday work? What do you like more about your job? What do you like less?
  o What are the difficulties or problems associated with your profession nowadays? Do these influence your everyday work? How do you think you could manage these problems?

• Could you describe your typical working day? What sorts of decisions do you have to make in your everyday work?
How independent do you feel in taking clinical decisions (for instance, in referring a patient to a specialist or in treating them yourself)? Do you take managerial/organisational decisions?

Do you employ any tools to help you take managerial decisions (for instance, statistics by the Insurance Fund or the Ministry to compare your practice results to others)? Do you use any particular software to help you prepare and send your reports? Do you find it useful?

What is the role of the nurses and/or other health professionals in your practice? Do they perform independent tasks? What kinds of responsibilities do they have?

If you practiced before the introduction of Family Medicine, did you perceive any changes in your work and working practices (for instance, the range of procedures or tasks you perform, or the number/frequency of referrals)? Would you give me some examples?

- How do you think your colleagues in other specialties understand and consider the role of family doctors?

- Which specialties do you consider closer to you and which specialists do you work closer with (for instance, requesting/giving advice or referring patients to them)?

- Would you say the relationships between you and your colleagues in other specialties have changed over time? How? Why? How do you think it affected the relative status of doctors within the society and the opinions of the patients about the family doctors’ work?

- What do you think is the opinion that your patients have about the role of family doctors?

- Do they seem satisfied with the services? Do they often request to see other specialists?
o Would you say the consideration that your patients have of family doctors has changed over time? How? Why? Would you say that this reflect the opinion of the general public?

o If applicable, how are patients responding to health education/prevention? Are people’s health-related habits changing?

• What is your relationship with other family doctors or managers in your practice? And outside?

o Do you belong to a Professional Association? What is your opinion about its policies and activity? Are you involved in them? Do you think it well represents your interests and point of view or would you like it to support other issues or do something differently?
### BOX B.1: The Republic of Estonia

#### POLITICAL SYSTEM

**Date of independence:** 20 August 1991.

The Baltic States were militarily occupied by and politically annexed to the Soviet Union in 1940 under the terms of the Molotov-Ribbentrop Pact (the Treaty of Non-Aggression between Germany and the Soviet Union), signed on 23 August 1939. After a short period of Nazi Germany occupation that started in June 1941, the Soviet Union regained control of the Baltics in May 1945. The annexation of the Baltic States to the U.S.S.R. in the 1940 has been considered illegal by the Baltic States themselves, the European Union and other Western countries, such as the USA, while the U.S.S.R. never formally acknowledge its presence as an occupation of independent countries, considering the Baltics as constituent republics of the U.S.S.R.

**Year of UN Entry:** 17 September 1991.

**Year of EU entry:** 2004.

Estonia applied to join the European Union in November 1995 and became an official member on 1st May, 2004.

**Current political system:** Republic.

Estonia is a Parliamentary Democracy, with a unicameral system. Its legislative body is called the *Riigikogu*.

**Historical background:** Danish, Germans, Swedish, Polish and Russian rulers.
### ADMINISTRATION

**Administrative division:** counties.

Estonia is divided into 15 administrative regions, called counties, and over 194 rural municipalities and 33 towns.

**Capital city:** Tallinn.

**Total area:** 45,000 km².

**Currency:** Estonian Kroon (EEK).

The Estonian Kroon is pegged to the Euro at the exchange rate of EUR 1 = EEK 15.6466. Estonia will be part of the EURO area from 2011 and from 1 January 2011 the Euro will substitute the Estonian Kroon as official currency.

**Population:** 1.34 million.

### SOCIETY AND CULTURE

**Ethnic composition:** Estonian — 75%, Russian — 25%.

**Official EU language:** Estonian (spoken by 82% of the population).

The Estonian language is closely related to Finnish, but it bears no resemblance to the languages of the other Baltic republics or to Russian. Other official EU languages by 1%, Russian 7%, and other non-official EU languages by 11%.

**Religion:** predominantly atheist (approximately 70% of the population)

Less than 1 in 3 people declares to belong to a Church. About 15% are Lutheran and 14% Orthodox.
**ECONOMY**

**GDP per capita:** US$: 17,454 (2008)

**HEALTH SYSTEM AND HEALTH INDICATORS**

**Health and health system:** The Ministry that is responsible for healthcare is the Ministry of Social Affairs.

**Health expenditure as a percentage of GDP** (HE/GDP): 5.37% (2007).

The average HE/GDP in 2007 was 9.7% in the EURO area, 11% in the OECD, and 5% in Russia.

**Health Expenditure per capita:** US$ 837 (2007).

The average per capita Health Expenditure in 2007 was US$ 3,695 in the EURO area, US$ 4,618 in the OECD, and US$ 492 in Russia.

**Life expectancy at birth** (LEAB): 80 (f), 69 (m) (2008)

The average LEAB in the EURO area was 84 among female and 78 among male in 2008.

Sources: The World Health Organisation Regional Office for Europe; The European Union portal.
**BOX B.2: Republic of Lithuania**

**POLITICAL SYSTEM**

**Date of independence:** 11 March 1990.

Lithuania was the first occupied Soviet Republic to re-gain political independence. The Baltic States were militarily occupied by and politically annexed to the Soviet Union in 1940 under the terms of the Molotov-Ribbentrop Pact (the Treaty of Non-Aggression between Germany and the Soviet Union), signed on 23 August 1939. After a short period of Nazi Germany occupation that started in June 1941, the Soviet Union regained control of the Baltics in May 1945. The annexation of the Baltic States to the U.S.S.R. in the 1940 has been considered illegal by the Baltic States themselves, the European Union and other Western countries, such as the USA, while the U.S.S.R. never formally acknowledge its presence as an occupation of independent countries, considering the Baltics as constituent republics of the U.S.S.R.

**Year of UN Entry:** 17 September 1991.

**Year of EU entry:** 2004.

Lithuania applied to join the European Union in December 1995 and became an official member on 1st May, 2004.

**Political system:** Republic.

Lithuania is a semi-Presidential Democracy, with a unicameral system. Its legislative body is called the **Seimas**.

**Historical background:** Polish rulers.
ADMINISTRATION

Administrative division: counties.

The country is divided into 10 counties spanning the country's 60 administrative districts and towns.

Capital city: Vilnius.

Total area: 65,000 km².

Currency: Lithuanian Litas (LTL).

The Lithuanian Litas is pegged to the Euro at the exchange rate of EUR 1 = LTL 3.4528.

Population: 3.4 million.

Largest Cities by population (July 14, 2005): Vilnius — 542,200; Kaunas — 378,000; Klaipėda — 192,900; Šiauliai — 133,800; Panevėžys — 119,700.

SOCIETY AND CULTURE

Ethnic composition: Lithuanians — 83.5%, Polish — 6.7%, Russians — 6.3%, Belarusians — 1.2%, others — 2.3%.

Lithuania is home to as many as 115 ethnic groups. Based on ethnic composition, Lithuania is the most indigenous of all the Baltic countries.

Official EU language: Lithuanian.

The Lithuanian language belongs to the family of Indo-European languages.

Religion: predominantly Roman Catholic (approximately 80% of the total population).

Other confessions include Orthodox, Old Believers, Lutheran, Reformat, Judaist, Sunni, Karaite and other communities.
ECONOMY


HEALTH SYSTEM AND HEALTH INDICATORS

Health and health system: The Ministry that is responsible for healthcare is the Ministry of Health.


The average HE/GDP in 2007 was 9.7% in the EURO area, 11% in the OECD, and 5% in Russia.


The average per capita Health Expenditure in 2007 was US$ 3,695 in the EURO area, US$ 4,618 in the OECD, and US$ 492 in Russia.

Life expectancy at birth (LEAB): 78 (f), 66 (m) (2008)

The average LEAB in the EURO area was 84 among female and 78 among male in 2008.

Sources: The World Health Organisation Regional Office for Europe; The European Union portal.
**Appendix C: Alma Ata Declaration (1978): health systems focused on primary care**

According to the Alma Ata Declaration on Primary Health Care (1978) (emphasis added):

“Primary health care:

1. reflects and evolves from the *economic* conditions and *sociocultural* and *political* characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services *research* and public health experience;

2. addresses the main health problems in the *community*, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: *education* concerning prevailing health problems and the methods of preventing and controlling them; *promotion* of food supply and proper nutrition; an adequate supply of safe water and *basic sanitation*; *maternal and child health care*, including *family planning*; *immunization* against the major infectious diseases; *prevention* and control of locally endemic diseases; appropriate *treatment of common diseases* and injuries; and provision of *essential drugs*;

4. involves, in addition to the health sector, all related sectors and aspects of *national and community development*, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual *self-reliance and participation* in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of *comprehensive health care* for all, and giving priority to those most in need;

7. relies, at local and referral levels, on *health workers*, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health *needs of the community.*"
## Appendix D: Data coding

**Table D.1: Data structure and coding process**

<table>
<thead>
<tr>
<th>A.</th>
<th>IDEAL TYPES OF PROFESSIONAL LOGICS AND MODES OF LOGIC ELABORATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First Order Categories</td>
</tr>
<tr>
<td>Early specialisation</td>
<td>Core idea</td>
</tr>
<tr>
<td>Doctor as a provider of treatment</td>
<td>Role-identity</td>
</tr>
<tr>
<td>Limited responsibilities</td>
<td></td>
</tr>
<tr>
<td>Impersonal doctor-patient relationship</td>
<td></td>
</tr>
<tr>
<td>Relative attractiveness of specialties</td>
<td></td>
</tr>
<tr>
<td>Centralisation</td>
<td>Governance structures</td>
</tr>
<tr>
<td>Hierarchy and direct control</td>
<td></td>
</tr>
<tr>
<td>Formal line of command / Limited autonomy of first contact doctors</td>
<td></td>
</tr>
<tr>
<td>Fragmentation of care</td>
<td>Organisational forms</td>
</tr>
</tbody>
</table>
### A. IDEAL TYPES OF PROFESSIONAL LOGICS AND MODES OF LOGIC ELABORATION

<table>
<thead>
<tr>
<th>First Order Categories</th>
<th>Second Order Categories</th>
<th>Theoretical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blurred boundaries between primary and secondary care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus on inpatient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision of episodic treatment</td>
<td>Practices</td>
<td></td>
</tr>
<tr>
<td>Increment the activity of secondary care (referrals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensiveness of care for the person</td>
<td>Core idea</td>
<td>Logic of holism</td>
</tr>
<tr>
<td>Doctor as guarantor of well-being</td>
<td>Role-identity</td>
<td></td>
</tr>
<tr>
<td>Preventive and advisory function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expanded responsibilities / increase attractiveness of family medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centrality of doctor-patient relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decentralisation</td>
<td>Governance structures</td>
<td></td>
</tr>
<tr>
<td>Accountability for a patient list</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managerial responsibilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual responsibility for patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## A. IDEAL TYPES OF PROFESSIONAL LOGICS AND MODES OF LOGIC ELABORATION

<table>
<thead>
<tr>
<th>First Order Categories</th>
<th>Second Order Categories</th>
<th>Theoretical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrality of strong primary care organisations</td>
<td>Organisational forms</td>
<td></td>
</tr>
<tr>
<td>Separation between primary and secondary care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracting mechanisms, independent organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus on outpatient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assuring continuity and coordination of care</td>
<td>Practices</td>
<td></td>
</tr>
<tr>
<td>Managing patient lists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complement</td>
<td>Grafting</td>
<td>Elaboration of logic</td>
</tr>
<tr>
<td>Coexistence</td>
<td>Append</td>
<td></td>
</tr>
<tr>
<td>Changing relationships with service users</td>
<td>Revision of relationships</td>
<td>Field restructuring</td>
</tr>
<tr>
<td>Changing the way of thinking about health</td>
<td>Revision of the field goal</td>
<td></td>
</tr>
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</table>
### B. PHASES OF THE PROCESS OF LOGIC ELABORATION

<table>
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<th>First Order Categories</th>
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<th>Theoretical Categories</th>
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<tr>
<td>Doing something new</td>
<td>Desire to appear different</td>
<td>Motivating change</td>
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<tr>
<td>Resource constraints</td>
<td>Opportunity identification</td>
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<tr>
<td>Theorisation void</td>
<td>Gaining legitimacy among the international community (professional and political)</td>
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</tr>
<tr>
<td>Engaging in international discourse</td>
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<td></td>
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<tr>
<td>Definition of professional competences</td>
<td>Constructing identity claims</td>
<td>Reconstruction of role-identity</td>
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<tr>
<td>Revisiting doctor/patient relationships</td>
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<tr>
<td>Use of practical knowledge to theorise</td>
<td>Restructuring a role within the environment</td>
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<tr>
<td>Communicating new identity to practitioners</td>
<td></td>
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<tr>
<td>Empowerment of professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legitimising representatives of the new profession</td>
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<td></td>
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<tr>
<td>Physical breakout between new and old structures</td>
<td>Formal separation of the emerging and existing forms</td>
<td>Creation of innovative organisational forms</td>
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<tr>
<td>Enabling actual changes through formal structures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Order Categories</td>
<td>Second Order Categories</td>
<td>Theoretical Categories</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Endorsing new roles through formal structures</td>
<td>Reinforcing identity through organisational forms</td>
<td></td>
</tr>
<tr>
<td>Legitimation of new role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust on other new organisational forms</td>
<td></td>
<td></td>
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<tr>
<td>Decentralisation of responsibilities</td>
<td>Redistribution of responsibilities</td>
<td>Restructuring of governance arrangements</td>
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<tr>
<td>Promoting independent decision-making</td>
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<td></td>
</tr>
<tr>
<td>Creating incentives for increasing doctors’ responsibilities</td>
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<td></td>
</tr>
<tr>
<td>Connection between decision-making models and organisational forms</td>
<td>Supporting identities and organisational forms through governance structures</td>
<td></td>
</tr>
<tr>
<td>Strengthening identity through governance arrangements</td>
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</tr>
<tr>
<td>Endorsing new roles through new practices</td>
<td>Transmission of practices</td>
<td>Enactment of new practices</td>
</tr>
<tr>
<td>Enhancing specialists’ identity</td>
<td>Reconstruction of boundaries between professions</td>
<td></td>
</tr>
<tr>
<td>Peer recognition/legitimation</td>
<td></td>
<td></td>
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<tr>
<td>Persistent resistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice differentiation</td>
<td>Association of practices to organisational forms</td>
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</table>
### B. PHASES OF THE PROCESS OF LOGIC ELABORATION

<table>
<thead>
<tr>
<th>First Order Categories</th>
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<th>Theoretical Categories</th>
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<tr>
<td>Reflection of approaches into practices</td>
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<td>Resource-related power</td>
<td>Perceived power contestation</td>
<td>Counter-theorisation</td>
</tr>
<tr>
<td>Patient-related power</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decrease in service quality</td>
<td>Deterioration of professional standards</td>
<td></td>
</tr>
<tr>
<td>Discrediting professional competence of challengers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complement</td>
<td>Grafting/Appending</td>
<td>Elaboration of revised logic</td>
</tr>
<tr>
<td>Coexistence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing relationships with service users</td>
<td>Revision of relationships</td>
<td>Field restructuring</td>
</tr>
<tr>
<td>Changing the way of thinking about health</td>
<td>Revision of the field goal</td>
<td></td>
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188
## C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION

<table>
<thead>
<tr>
<th>First Order Categories</th>
<th>Second Order Categories</th>
<th>Theoretical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperation and concertedness</td>
<td>Nature of decision-making process</td>
<td>Ability to synthesise conflicting positions</td>
</tr>
<tr>
<td>Practical and pragmatic approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ideological and political drivers</td>
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<td></td>
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<tr>
<td>Entrepreneurial attitude</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conservative attitude</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal and external awareness</td>
<td></td>
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<tr>
<td>Internal focus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radial change</td>
<td>Gradualness of change</td>
<td></td>
</tr>
<tr>
<td>Incremental change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid implementation</td>
<td></td>
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<tr>
<td>Sluggish implementation</td>
<td></td>
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</tr>
<tr>
<td>Creating internal consistency</td>
<td>Tolerance to differences</td>
<td>Flexibility to accept pluralistic perspectives</td>
</tr>
<tr>
<td>Creating alternative visions</td>
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</table>
### C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION

<table>
<thead>
<tr>
<th>First Order Categories</th>
<th>Second Order Categories</th>
<th>Theoretical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convergence to one model</td>
<td></td>
<td></td>
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<tr>
<td>Freedom of choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consistency of links between theorisation and practices</td>
<td>Degree of coupling between ideas and practices</td>
<td></td>
</tr>
<tr>
<td>Providing tools to enact new roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of the universities</td>
<td>Societal prestige</td>
<td>Legitimacy of theorisers</td>
</tr>
<tr>
<td>Socialisation centre</td>
<td>Field recognition</td>
<td></td>
</tr>
<tr>
<td>Personalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership roles</td>
<td></td>
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</tr>
<tr>
<td>Legitimation of the new profession in the academic community</td>
<td></td>
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</tr>
<tr>
<td>Homogeneity of vision</td>
<td>Internal density of theorisers</td>
<td>Concentration of theorisers in the field</td>
</tr>
<tr>
<td>Internal threats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement of practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conveying political commitment</td>
<td>Ability to ensure support</td>
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</tbody>
</table>
## C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION

<table>
<thead>
<tr>
<th>First Order Categories</th>
<th>Second Order Categories</th>
<th>Theoretical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowing for local variations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquisition of technical competences</td>
<td>Training as transmission of identity</td>
<td>Socialisation process</td>
</tr>
<tr>
<td>Creation of a community of professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influence of role models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reciprocal learning</td>
<td>Training as reconstruction of relations</td>
<td></td>
</tr>
<tr>
<td>Gaining trust and legitimacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing cooperation between practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource-related power</td>
<td>Perceived power contestation</td>
<td>Counter-theorisation</td>
</tr>
<tr>
<td>Patient-related power</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decrease in service quality</td>
<td>Deterioration of professional standards</td>
<td></td>
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<tr>
<td>Discrediting professional competence of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>challengers</td>
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### Table D.2: Coding examples

<table>
<thead>
<tr>
<th>First Order Categories</th>
<th>Illustrative quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. IDEAL TYPE OF PROFESSIONAL LOGICS AND MODES OF LOGIC ELABORATION</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Logic of specialisation</strong></td>
<td></td>
</tr>
<tr>
<td>Early specialisation</td>
<td>“The Soviet University was [based on] early specialisation, we had different doctors, paediatricians, internists, so it was a bit different from what it is now.” (Estonia, Tartu University)</td>
</tr>
<tr>
<td>Doctor as a provider of treatment</td>
<td>“Primary care in the Soviet system was not list-based, it was based on geographical locations…the doctors were there, we did some preventive work, some treatment, but of course the doctors were not the most brilliant there. However, usually the polyclinics were not very-well equipped if you looked at the competences of the primary care doctors. Some of them were very good, but you had to be lucky. So if you wanted to get treatment you needed to get to the hospitals somehow. And patients wanted to go to the specialists, who were those who provided treatment.” (Estonia, Ministry of Social Affairs)</td>
</tr>
<tr>
<td>Limited responsibilities</td>
<td>“At that time we considered some problems that we inherited from the Soviet period. One is maybe a too marked division of work between the doctors in the health system. Those first-contact doctors, like the therapists or district paediatricians were marginalised, because their only function was just to send people to specialists and to fill in papers required for bureaucratic reasons.” (Lithuania, Health Policy Senior Researcher)</td>
</tr>
<tr>
<td>Impersonal doctor-patient relationship</td>
<td>“If a healthcare institution, like the polyclinics, has a big flow of patients who are moving in and out, doctors do not have an personal, close relationship with the patients, because the institution is too big and it has to generate activity and doesn’t care about the patients too much.” (Lithuania, Family Practice Manager)</td>
</tr>
<tr>
<td>Relative attractiveness of specialties</td>
<td>“Primary care doctors were not really popular doctors, because first you wanted to become a neurosurgeon; then, when you couldn’t, you wanted to become a cardiologist; and, when you couldn’t, then the very last choice was primary care.” (Estonia, Ministry of Social Affairs)</td>
</tr>
<tr>
<td>First Order Categories</td>
<td>Illustrative quote</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>A. IDEAL TYPE OF PROFESSIONAL LOGICS AND MODES OF LOGIC ELABORATION</strong></td>
<td></td>
</tr>
<tr>
<td>Centralisation</td>
<td>&quot;Before the independence, during the Soviet period, we had a very centralised system and within it, for the health system, the main actor was the municipality, particularly the major and the municipality doctor, and in rural municipalities the head doctor of the local hospital. And all the money — all public money — was in their hands.&quot; (Lithuania, Territorial Patient Fund)</td>
</tr>
<tr>
<td>Hierarchy and direct control</td>
<td>“The head of big hospitals or polyclinics decided how many money was going for which speciality...and you can see for primary care [there was very little]. […] One idea on how to get more money is that primary care doctors have send [patients] to the specialists, so they direct their work.” (Lithuania, Vilnius University)</td>
</tr>
<tr>
<td>Formal line of command / Limited autonomy of first contact doctors</td>
<td>“Before this [=family medicine] we had big, huge polyclinics and the head doctors really controlled the situation and doctors had little to say how they thought the system could be better, how the patient could be treated better, [how] the service could be more user-friendly.” (Estonia, Ministry of Social Affairs)</td>
</tr>
<tr>
<td>Fragmentation of care</td>
<td>&quot;And in primary healthcare there were district doctors, district paediatricians, district gynaecologists, and then we had different, separate we called them dispensaries, for example a special system for diabetic people, dispensaries for tuberculosis and lung diseases, dispensaries for dermatology/skin, and sexually transmitted diseases…so this was the fragmentation. Plus, there was a special system according to your working place, so the big factories had their own polyclinics […] This was parallel, and [...] information was not coordinated between these institutions, so the district doctors didn’t know what was happening in these institutions.” (Estonia, Tartu University)</td>
</tr>
<tr>
<td>Blurred boundaries between primary and secondary care</td>
<td>“We have to think about what was a polyclinic in the ‘80s and in the Semashko system. The polyclinics were owned by hospitals, always. The polyclinics were headed by the head doctors, who were accountable for financial management. The financing was blurred, the boundaries were blurred; it was not clear how resources were distributed.” (Estonia, World Health Organisation)</td>
</tr>
<tr>
<td>Focus on inpatient care</td>
<td>“We inherited a high number of hospitals and a huge bed capacity from the Soviet system. Of course the number of hospitals was reduced, because the focus is not inpatient care anymore, but we still have a lot of small hospitals.” (Lithuania, Ministry of Health)</td>
</tr>
</tbody>
</table>
First Order Categories | Illustrative quote
--- | ---
Provision of episodic treatment | “Doctors who worked as either general practitioners in polyclinics or internists or paediatricians were in a system in which they started working at 8 o’clock and closed the door at 5 pm, and if possible then earlier. And just provided some sporadic treatment to some patients, not their patients, but mostly referred them [to the specialists].” (Estonia, Health Policy Senior Researcher)
Increment the activity of secondary care (referrals) | “It used to be that the primary care doctors really saw the patients and just referred them to the polyclinic specialists and then the polyclinic specialists were really taking care of the patients, basically.” (Estonia, Ministry of Health)
Comprehensiveness of care for the person | “Usually the problem with the specialist is that everyone is looking at a single part of the body. The idea with the GP was that the family doctor would look at the person as a whole, with maybe a more holistic approach. The family doctor is the only doctor who looks at everything and not only at one part of your body” (Lithuania, Health Policy Senior Researcher)
Doctor as guarantor of well-being | “When we introduced primary care, our vision was that there would need to be more prophylaxis, more prevention, more work with people in community, to have more healthy people. It was not only about providing treatment, because our older system was only focused on sick people…it was about taking care of healthy people; then of course if you are sick, you have to go to the hospital.” (Lithuania, Family Practice Manager)
Preventive and advisory function | “The key idea was to switch in medical care from a focus on diseases to a focus on patients and ensure a more holistic approach, with a lot of prevention and health advice.” (Lithuania, Lithuanian College of General Practitioners)
Expanded responsibilities / increase attractiveness of family medicine | “The idea is to give them more decisional attitude…to get better doctors into the primary care system because we thought that primary care is the key and when we organise this well then all the other things go smoothly and we can control them” (Estonia, Ministry of Health)
Centrality of doctor-patient relationship | “My vision is this: as a patient, I want to have a family doctor to whom I can talk about my problems, my feelings, and so on. There has to be a personal contact between the patient and the family doctor.” (Lithuania, Family Doctor)
### First Order Categories | Illustrative quote

#### A. IDEAL TYPE OF PROFESSIONAL LOGICS AND MODES OF LOGIC ELABORATION

<table>
<thead>
<tr>
<th>Category</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decentralisation</td>
<td>“But also there was a decentralisation movement in Lithuania, in general, and responsibilities for the organisation of healthcare delivery was attributed to the municipalities, so every municipality must decide, as stakeholders they had to decide what to do with the polyclinics and hospitals...and re-organise them, privatise them, they had to decide what to do with them. In some municipalities, you have more and more single- or group- family practices like private healthcare providers; in others less.” (Lithuania, State Patient Fund)</td>
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<td>Accountability for a patient list</td>
<td>“If you link the patient list to the practice, then the practice owner will become very powerful, and this was not the idea. Instead, two doctors who are in the same practice may have the same responsibilities towards the practices, but have separate responsibilities for their own lists of patients. They are more accountable for what they do clinically towards their patients.” (Estonia, World Health Organisation)</td>
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<td>Managerial responsibilities</td>
<td>“I think that this task has been fulfilled and that the family doctors took over very many responsibilities, and with the chance of private practice in a public system they could even make decisions on how to run the practice and how to use this money more effectively.” (Estonia, Tartu University)</td>
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<td>Individual responsibility for patient</td>
<td>“The idea was to increase actual responsibilities, because if you were a salaried doctor in a big system like a polyclinic you didn’t feel such responsibilities towards your patients. This is why we wanted to have the list system, so that the doctor is a personal doctor: every doctor knows that patient, and the patient knows the doctor.” (Estonia, Estonian Society of Family Doctors)</td>
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<td>Centrality of strong primary care organisations</td>
<td>“So the philosophy at that time was that primary care is the basis of our health systems and we have to develop it, and this is our priority. And we have to create strong primary care organisations to support that.” (Lithuania, State Patient Fund)</td>
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<td>Separation between primary and secondary care</td>
<td>“Another aspect of reform is that before, in the previous system, in the Semashko system, we had these big polyclinics where the primary care physicians, like therapists, paediatricians, worked together with all the specialists. So, during the reform, the majority of polyclinics disappeared in terms of mixture of primary and secondary care together; so the majority of polyclinics were just legally separated into two units, one for specialist care and one for primary care.” (Lithuania, State Patient Fund)</td>
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<td>Contracting mechanisms, independent organisations</td>
<td>“And also it was idea to create some financial incentives for doctors working at all levels including primary care, moving from this budget-financing we had in Soviet time with just fixed salaries for all employees in health sector. [...] The idea was try to link service delivery more directly to financial incentives, to create organisations that could contract with the insurance fund for their activity, and as a result assuring increase of efficiency in the health sector.” (Lithuania, Health Policy Senior Researcher)</td>
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<td>Focus on outpatient care</td>
<td>“Many problems in Soviet times were solved in hospitals, with inpatient care, not in primary healthcare institutions. Today this has progressively changed; it has lasted to some extent, but it has gradually changed towards outpatient care and more care provided in primary care centres to treat manageable problems. Even the public opinion is more and more favourable to outpatient institutions.” (Lithuania, Family Doctor)</td>
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<td>Assuring continuity and coordination of care</td>
<td>“Our idea was that primary care doctors should be the coordinators of the care: they refer, but they take back the information, and then they again refer when needed, to hospitals if needed, and then they follow up. They shouldn’t treat and diagnose too much, but they keep the responsibility for each case.” (Estonia, Ministry of Health)</td>
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<td>Managing patient lists</td>
<td>“This was the main difference for us defining or separating between group practices and polyclinic-type practices: doctors had to maintain their own lists, to maintain their own responsibility for a group of individuals. In polyclinics you came to work in the morning and you didn’t know who you will see, and you actually shared the whole list of patients with other 10 or 15 doctors; you don’t have this personal relationship with your patients.” (Estonia, Health Policy Senior Researcher)</td>
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<td>Grafting/Appending</td>
<td>“The starting point for both countries was exactly the same [the Soviet model]. The difference was that Estonia did a very clean-cut, comprehensive reform, and I think in Lithuania they just did a piecemeal...they didn’t really reform, but the new forms of provision emerged and they coexisted with the others, and you have a more plural system.” (The World Bank)</td>
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<td><strong>A. IDEAL TYPE OF PROFESSIONAL LOGICS AND MODES OF LOGIC ELABORATION</strong></td>
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<tr>
<td>Complement</td>
<td>&quot;This is also the new role that we wished for, that the family doctor was also the advisor...because — far from that! — we don’t say that family doctors can answer all the healthcare-related questions. No. Specialised medicine has its own role. But not the whole population should go to specialists, only in some selected cases.&quot; (Estonia, Tartu University)</td>
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<td>&quot;But after some years, the hospital reform was also implemented and hospitals become like private companies and started to look at financial resources and other resources in a more economical way. And doctors also in hospitals started to think much more similarly to family doctors, World Health Organisation had already thought five years ago about efficiency, quality, patient care and so on. So, in my mind, they started to come closer to each other and mix the way of thinking.&quot; (Estonia, World Health Organisation)</td>
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<td>&quot;in Tartu, at the heart of the family medicine reform actually, because the University Chair of Family Medicine was implemented in the University and so on, in Tartu Clinic the paediatricians could start collaborating with family doctors and they found their own areas or niece for working and they were not really afraid of the family doctors, because they knew that they knew more about children and had their stuff to teach family doctors much more about taking care of children their own. And as I told you one day the family doctors and other specialties started collaborating.&quot; (Estonia, Tartu University)</td>
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<td>&quot;And actually we did reform in parallel also all the other levels of service: after primary care, we started with emergency services and we did also the Hospital Master Plan. So the whole system was kind of described and measured and clear for us...how the patient should get in and what happens afterwards. So this was technical correction, [the system was] ordering [itself]. And then we thought that...in 1999 we started to legislate all this. So we knew already what had happened for 2 years, how we could do and how we couldn’t do and we started writing the law, but it took a bit more time, I think in 2000, and even 2001 or 2002, but we started in 1999 so I had quite clear vision.&quot; (Estonia, Ministry of Social Affairs)</td>
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<td>&quot;And if we think about why the family medicine reform has been successful since 1998 it is because the whole package was created and changed. Not only ownership, or legislation, or some regulations, but also the financing was shaped in the way to create incentives, and it was agreed at the policy-making level, and of course it was advised by foreign consultants as well.&quot; (Estonia, World Health Organisation)</td>
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<td>Coexistence</td>
<td>&quot;I believe our system is only one. Of course if we compare it with Estonia, they were more radical, they just forced all GPs to become private. We were not so radical, but probably that doesn’t mean that we have two parallel systems.&quot; (Lithuania, State Patient Fund)</td>
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<td>&quot;There were several waves in our reform process. At the beginning it was decentralisation and clear general practice without specialists. We didn’t achieve this because of resistance in Vilnius, especially in Vilnius, from these big polyclinics. But then [...] we separated GPs and specialised care. And another vision was to create centres for specialist care in towns and to decentralise these family practices, but it happened that we now have a mixture. [...] Ideally, the idea was from the beginning — but we didn’t do this — [to have] groups of GPs, not teams of specialists instead of family doctors, but groups of GPs, who should work in general practice. There are maybe some, but it is not mandatory.&quot; (Lithuania, Ministry of Health)</td>
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<td>Changing relationships with service users</td>
<td>&quot;Really we are on the point that we promoted family medicine and it’s really our future, but on the other hand the relationship between the GPs and the specialists is very difficult and there is not an easy solution.&quot; (Lithuania, State Patient Fund)</td>
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<td>“The evaluation was done just on this Kaunas project. For the others it was more or less the political will that helped to choose which was better and which was not. And actually Lithuania has chosen [to give] a lot of independence to the municipalities in organising primary care the way they like.” (Lithuania, Mykolas Romeris University)</td>
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<td>“There are 2/3, who were retrained and were previously cardiologists, paediatricians or other specialist doctors. So for them it was really broadening their area and changing their mind-sets. So, in that sense it was a huge change in the mentality and for the population to really understand that this was now one doctor to whom you could talk. And that’s what I mentioned before was the kind of quote from the 90s that “the doctor has got a couple of weeks training and now what is the difference?”, but actually there is a difference but it comes in the long run. So doctors had to change in their cultural environment, the patients had to understand the new environment. So in that sense that was the major shift.” (Estonia, World Health Organisation)</td>
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<tr>
<td>A. IDEAL TYPE OF PROFESSIONAL LOGICS AND MODES OF LOGIC ELABORATION</td>
<td>“I think the creation of the system of GPs — because we have more than 70% inhabitants who are under GPs and we didn’t have it at all [before the reform] — has changed also the culture of people. They don’t go to specialists directly; and if they have good GPs, of course they receive many services; they don’t need to go to polyclinics.” (Lithuania, Ministry of Health)</td>
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<td>Changing way of thinking about health</td>
<td>&quot;I think it has changed already some years ago, about 20 years ago, in line with what the WHO says...that health is not only, how to say, it doesn't mean that you don't have any diseases, but it means full well-being and full health. The concept of health means that you feel happy, you feel healthy and you can leave your life fully. We all work towards this goal.&quot; (Estonia, family doctor)</td>
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### B. PHASES OF THE PROCESS OF LOGIC ELABORATION

#### Motivating change

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<td>Doing something new</td>
<td>&quot;What I would add, maybe coming back to the history of the reform...maybe I would agree that it was really political decision to have something totally different from what was before. Before it was Semashko, now we have to have something different, and this difference was of course family medicine.&quot; (Lithuania, StatePatient Fund)</td>
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<td>&quot;...and the natural willingness, not just in healthcare, but overall in Estonia to do everything differently than it was during the Soviet time...That was a social reaction...so that was the background. And when now the World Bank stepped in with their nice blueprints that fell into very fertile ground. Because it was something very different and it also fitted very well with this entrepreneurial idea, again very prevalent in current Estonian social thinking.&quot; (Estonia, Research Institute)</td>
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<td>Resource constraints</td>
<td>&quot;Politicians wished to have a more effective healthcare...and, seeing how quickly Estonia was opening to the world, this meant the cost would rise to keep the system as it was...and so we really believed that well-established primary healthcare actually could keep costs down and keep the system organised.&quot; (Estonia, Tartu University)</td>
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<td>Theorisation void</td>
<td>&quot;And also the politicians within the Parliament were involved very much in issues regarding the economy and healthcare was not so important at that time...economic issues and privatisation of commercial fields were the first priorities, but healthcare was somewhere aside&quot; (Estonia, Primary care centre manager)</td>
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<td>Engaging in international discourses</td>
<td>&quot;The important idea was to strengthen the role of first contacts doctors, like family doctors, yeah, and improve the overall healthcare system. The idea was, as part of this change, to achieve maybe gains in efficiency, to reduce maybe number of visits to so-called specialists, to reduce admissions to hospitals, to make services faster maybe and the more oriented to prevention of diseases but not treatment, and so on...Let us say, type of reflection of talks prevailing on the international scale.&quot; (Lithuania, Independent Consultant)</td>
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<td>B. PHASES OF THE PROCESS OF LOGIC ELABORATION</td>
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<td>Reconstruction of role-identity</td>
<td>&quot;First among the specialists in Lithuania, we wrote the medical norm with the competences of the family doctors. It is a law. We tried to do that to keep [part of the] medical field under our competence. We didn’t wait for cardiologists, gynaecologists…they would have just divided the field among themselves and we would have been left with nothing! So we did that first and we wrote a lot, a lot, a lot…too much of course In 2005 we revised this medical competence norm and it is much less [extensive] now, much less. Of course it is not so medicalised, it is how to say more like a project, it looks at responsibilities, such as prevention and continuity, rehabilitation, management and so on...&quot; (Lithuania, Kaunas University)</td>
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<td>Definition of professional competences</td>
<td>&quot;We thought that maybe, at the start of the reform, we should give more details on what are the tasks of the family doctors. And even up to now I think the family doctors are the only ones who have this kind of very detailed description, a list of what the activities are. But it was necessary this time because just to understand, as I told you, the broader scope of the family doctors, because before they used only their pens, but then they also had all the equipment and they were trained to do more, so we wanted them to become doctors! (Estonia, Ministry of Social Affairs)</td>
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<td>Revisiting doctor/patient relationships</td>
<td>“When the reform started, for us the motivation was that having a “family doctor” meant that she was going to take care of all the family. […] we thought…that we all know that there are some genetically transmitted diseases, like the chronic illnesses transmitted from generation to generation…and in this case the family doctor would know a bit more about all family members’ health, conditions, relationships, social skills, health education and all these things. This was a very big motivation. […] I think she would be like a member of my family, if we are talking about the family doctors.” (Estonia, City Government)</td>
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**B. PHASES OF THE PROCESS OF LOGIC ELABORATION** | "The problem was that they [= the patients] did not always go to the right specialist and there are a lot of diseases for which you need different specialists. And they ended up with doctors saying “this is not my area so please go there” and nobody really cared about their, these diseases. Everybody did some episodical things and then the patients had to move…[...] People were shopping around, not knowing where to go and visiting a lot of doctors just to get to the right one. So it was also a waste of money. [...] And we thought we want to lead the patients through the system, that there should be somebody who directs the patient, and not so much [having] gatekeepers to control, but to lead the person through this complicated system.” (Estonia, Ministry of Social Affairs)

Use of practical knowledge to theorise | “And it was in 1991 that our first group of doctors entered retraining [in family medicine]. These were mostly experienced doctor already, half of them working in rural areas. So with their help actually we designed the first curriculum, because they were working as first-contact doctors, we must say, they were alone in rural areas, and they knew what they were lacking from the previous university education.” (Estonia, Tartu University)

Transmitting new identity to practitioners | "The first element was communication to the physicians. […] In general we started, if I am not mistaking, to train and change the doctors’ understanding.” (Lithuania, Ministry of Health)

Empowerment of professionals | “We did want to break up the polyclinics and we did want to take away the power from the policlinic head physicians and definitely it was a way to empower the doctors.” (Estonia, National Institute for Health Development)

Legitimising representatives of the new profession | “…for family doctors I think it was…I remember that I felt like ‘I am a very important person now!’ Yes. This was the feeling as a family doctor, that I am very important and that I have my own patients and money to manage and, you know this kind of thoughts.” (Estonia, City Government)

"I think the reform process in the early 90s, where family medicine was a specialty equally to cardiology, pneumology and so on, is important.” (Estonia, World Health Organisation)

*Creation of innovative organisational forms*
### B. PHASES OF THE PROCESS OF LOGIC ELABORATION

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<td>Physical breakout between new and old structures</td>
<td>“So we were trying to help all this [=increasing the number of GPs] through organisational or administrational instruments. Like, for example, we were trying to separate legally primary healthcare from secondary healthcare. We had those outpatient clinics, which were huge, with primary and secondary care together...we were trying to separate primary and secondary healthcare.” (Lithuania, Mykolas Romeris University)</td>
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<td>Enabling actual changes through formal structures</td>
<td>“But at the beginning [...] the doctors continued as salaried doctors. Although the private practice was allowed, only a few could establish their own contracts with the Health Insurance Fund, I think in ’94-'95. But then in 1997, when the Ministry took the lead, really the reform in healthcare organisation happened, because at that time there was already a considerable group of doctors in retraining, [...] and 1997-98 were the years of big changes in practical healthcare.” (Estonia, Tartu University)</td>
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<td>Endorsing new roles through new organisational forms</td>
<td>&quot;Another problem was to organise the everyday work of GPs, because we had centralised polyclinics, as we call them. And these international projects, the World Bank project and the EU PHARE project, [...] supported the creation of GP practices so that they really started to work.” (Lithuania, Ministry of Health)</td>
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<td>Legitimation of new role</td>
<td>“But in that situation, in polyclinics, family physicians don’t work as family physicians, because of the specialists; they just refer.” (Lithuania, Vilnius University)</td>
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<td>Trust on other new organisational forms</td>
<td>&quot;[...] in the ‘90s the family doctors were very proud: they wanted to have their own practice, they wanted to have their own patient list. If you compare this to the system where many of them [=the doctors] of the older generation practiced, now they could manage and be the doctors. The youngest saw also the possibility for business and other things, but they saw that...you know...I can manage my practice and my patients. [...] This would help the respect for the family doctors and the family doctors’ system.” (Estonia, World Health Organisation)</td>
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"Also the privatization process that went on in the country was no successful at all...and I am talking now not only about healthcare, but in the whole country...so the people lost trust. So I can understand why those politicians wouldn’t allow family doctors to do that [=to own private practices], because there was a lack of trust.” (Lithuania, Mykolas Romeris University)
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<td>Decentralisation of responsibilities</td>
<td>“Our Parliament adopted many important laws about healthcare systems in general, about healthcare institutions, about health insurance and so on. So these laws are talking about decentralization of primary healthcare and about responsibilities of municipalities. According to these laws and according to a special law on local governments, the responsibility for primary healthcare is on municipalities.” (Lithuania, City Government)</td>
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<td>Promoting independent decision-making</td>
<td>“Therefore, it was very important to have a separate system of financing for primary healthcare and separate it from the secondary care and hospitals, and it was achieved in that way that family doctors have their own contracts with the Health Insurance Fund. And in my opinion it was also very important for the specialty because it was like posing it as a condition that the specialty itself took decisions and doctors themselves felt stronger.” (Estonia, Tartu University)</td>
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<td>Creating incentives for increasing doctors’ responsibilities</td>
<td>“If I don’t feel the responsibilities, if I don’t think I am in control, I just refer to a specialist, especially if a patient expects to see a specialist for consultation; no problem, I refer. But in this case, the money for this consultation goes from the State patient Fund to the specialist and the specialist does my job. So there should be some system that could measure quality of care and monitor the volume of care. In this sense, if I do everything by myself as a family doctor, I should receive more money, compared to doctors in polyclinics, where they do not take care of patients, but just refer.” (Lithuania, Kaunas University)</td>
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<td>Link between decision-making models and organisational forms</td>
<td>“Around 1995, when I worked within the city government, my colleagues and I prepared a number of projects for the reform, also for the hospital reform. They aimed to separate primary care from the hospital. It was a project for decentralising healthcare. And after 1995, the municipalities could manage the structures, they became owners of the real estate, responsible for the real estate.” (Lithuania, Family Practice Manager)</td>
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<td>“I think the contract between this new entrepreneur and the Health Insurance company was the biggest change, because if you have a contract, you have a choice and you can decide yourself.” (Estonia, Estonian Society of Family Doctors)</td>
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<td>Strengthening identity through governance arrangements</td>
<td>“I think a real strength of the system, from the doctors’ point of view, was their independence. I think independence was a big motivation for them to become family doctors, to be part of the primary care system. It was because of the independence, because of the salary, because of…well… I think independence not only from the financial point of view, but also independence for taking decisions and making their own choices.” (Estonia, City Government)</td>
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<td>Enactment of new practices</td>
<td>“[…] if you do some reform the most important thing is to have people who support and who are able to perform those tasks. And therefore, as I said that we started with those active doctors, it was a great advantage for Estonia, because 60 active doctors after their training, after three years, started to be teachers for others who started the training as family doctors. In my opinion it is the most important thing, because if you have an empty field, there is nobody there and you cannot train others and also you cannot show what the work in family medicine is.” (Estonia, Tartu University)</td>
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<td>Enhancing specialists’ identity</td>
<td>&quot;And also from the side of secondary care we saw support, because these doctors mostly wished to get rid of the primary care work. And everyday patients coming with this and this complain… it’s better that the patients will be prepared already or somehow selected. This was the argument… and so that for example, a nose and throat doctor is mostly surgeon, not treating otitis media, for example. Of course there are some special groups for which it became an issue… For example, in Tallinn and the big polyclinics where somehow the primary healthcare and secondary care doctors in polyclinics were like competing, then these doctors were a bit different; but the leading specialists working in hospitals were for the idea to have family doctors, to have work that permits real specialist to their work. So this was the chance in the 1990s.” (Estonia, Tartu University)</td>
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<td>&quot;Usually family physicians can deal with most of the cases, they can handle the problems. And, if not, then it is already, let’s say, a selected decision and they are already selecting the patients for the specialists. The specialists also complain that family doctors send them too many patients without [conducting] any deeper investigations. They are also angry and say it is better for them if family doctors work better.” (Estonia, Estonian Society of Family Doctors)</td>
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<td>Peer recognition/legitimation</td>
<td>“Still there are some specialists, who actually don’t understand what are the family doctors’ role and tasks. But there are also many more who are very supporting and who consider family doctors as equal colleagues.” (Estonia, Family Doctor)</td>
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<td>Persistent resistance</td>
<td>“According to the ministry of health, in 2010 primary healthcare will be provided only by teams of family physicians with the assistance of dentists and psychiatrists. At the moment, a rather hard process of adaptation and recognition of a new speciality of family physician is ongoing” (Lithuanian Family Medicine News Network).</td>
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<td>Practice differentiation</td>
<td>“But we still, somehow continue to have in Vilnius and Kaunas those large, mixed polyclinics, all together, specialists and GPs. So this is also…This is mostly due to political reasons and very strong directors of such polyclinics, so this is one more aspect, maybe not so very important but still. But on the other hand, another trend I should say is that among those primary healthcare providers working independently from the secondary healthcare, especially private, they tend to have specialists back. So, to say like “back”…so they are ready to pay some money to the specialists from what they receive for primary care provision, but to have specialists sitting near. So this is again an interesting trend, maybe not so important.” (Lithuania, State Patient Fund)</td>
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<td>&quot;We were trying to analyse the role of primary healthcare doctors, actually GPs, and understand what they are doing, what procedures they are doing in primary care, and we compared that in 1999 and 2008. And we were taking recognised private and public institutions in Vilnius and Kaunas [...] Private institutions up to 2006 have made certain progress, from 86 to 87.1% increased their procedures. Public institutions were presenting some negative tendencies. So...the goal was that primary care doctors could take up those procedures from the specialists. But in public institutions they were not doing that, because a lot of those transitional period teams were working there and specialists as well [...] So that means that we have to analyse why, and one answer is that all specialists are sitting there and patients are aware of that and the financial incentive is not enough.” (Lithuania, Mykolas Romeris University)</td>
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<td>Reflection of approaches into practices</td>
<td>&quot;So, mainly in these polyclinics, these teams [consisting of] a district paediatrician, a district therapist, and assisted by a surgeon and a gynaecologist, are still practicing. So, but we think...how to say...it’s an old approach to primary care, one thing; and, another thing, the service is not sufficient. [It is] not the same as [that of] family physicians, if we just look at the medical competences, the simple medical competences. So they only look at the ear, at the eye, maybe do not make neurological tests; and [they are] not pursuing a holistic approach and continuity [of care]. No continuity, no holistic approach.&quot; (Lithuania, Lithuanian College of General Practitioners)</td>
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<td>&quot;In big cities we still have these big ambulatory care institutions, [where] there is a GP and a team, with a therapist, a surgeon and so on, and they are working additionally to this specialised, ambulatory care. [...] Maybe it’s expensive, yes, because you have the opportunity to send the patient just next door to the specialist and [there is] no need to go to other cities or in other parts of town.&quot; (Lithuania, Independent Consultant)</td>
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<td><strong>C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION</strong></td>
<td>Ability to synthesise conflicting positions</td>
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<tr>
<td>Cooperation andconcertedness</td>
<td>&quot;And it was really literally done as a parallel and cooperative process, so that were deadlines, meetings when both sides presented what they had been doing, we discussed, and then set new tasks and new deadlines…and this was it.&quot; (Estonia, National Institute for Health Development)</td>
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<td>Practical and pragmatic approach</td>
<td>&quot;We were satisfied with many things we did even in other areas. There was a pension reform that was done at the time I was in the Ministry, together with the opposition. We were a minority in the Parliament…and, in this way, some things are still working today, because they were done with the opposition.&quot; (Estonia, Health Protection Inspectorate)</td>
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<td>Ideological and political drivers</td>
<td>&quot;In many countries these things [=breaking up the polyclinics] have happened too, because of some like really political, ideological vision or agenda. In Estonia, these reforms in healthcare did not have any ideological agenda. It was rather searching for what would work. If our objectives are these, what would work? We are very pragmatic in Estonia in that sense.&quot; (Estonia, National Institute for Health Development)</td>
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<td>Entrepreneurial attitude</td>
<td>&quot;It was a political decision that we needed to change our system. And in primary healthcare we decided to try this model of the GPs.&quot; (Lithuania, State Patient Fund)</td>
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<td>Conservative attitude</td>
<td>&quot;Definitely this is the case in Estonia, because if you look at what Estonia has achieved, [there are] a lot of new innovations and the people are ready to accept new things more easily than other countries.&quot; (Estonia, Estonian Society of Family Doctors)</td>
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<td>&quot;If we compare us with the Estonians, I think that they have a better understanding of how to deal with pressures than we do in this country. Maybe it depends on historical traditions. Lithuania was a country which was part of a very big empire for a long time, some 500-700 years ago. And it was Catholic, of course, and in that we still feel more conservative. And after that, we formed a very big state with Poland. After that our country was occupied by Russia. [...] In our traditions we had this very big, strong [state] that could push others around.&quot; (Lithuania, Lithuanian Society of General Practitioners)</td>
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<td><strong>Internal and external awareness</strong></td>
<td>&quot;I think Estonia has succeeded a bit more [than the other Baltic States] in using the developed country’s knowledge and experience, applying it to our system and creating the vision of how the health system had to be developed. [...] people were travelling around Europe and maybe some other countries of the former Soviet Union. We used their experiences, but we applied them to our context, and we wished to become a developed and modern country, and at the same time to be liberal and open country.&quot; (Estonia, World Health Organisation)</td>
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<td><strong>Internal focus</strong></td>
<td>&quot;I think international organisations had their role, but the good thing was that Estonians were very keen to have this dialogue, they had their own ideas, and they wanted to debate about them…because what the WHO and others did in the ’90s was that they played the mirror-role, basically, it was possible to have a dialogue, because if you are trying to develop your reforms only within your own country you might forget something.&quot; (Estonia, World Health Organisation)</td>
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<td><strong>Radical approach</strong></td>
<td>&quot;Our first, very important document was the National Health Concept, which was signed by the Lithuanian Parliament in 1991. The draft was adopted by the Lithuanian Medical Association, officially. And this is the first paper where primary healthcare and family doctors was mentioned, the institutions. And according to this concept, other legal acts were prepared. So it was all internal. At the beginning I mentioned international organisations, institutions and projects which we implemented together, but they were implemented later, in the year 2000.&quot; (Lithuania, Ministry of Health)</td>
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<td><strong>Radical approach</strong></td>
<td>&quot;Lithuanian society is quite a close society in the sense that we are trying to keep the society as it is, not open. Maybe those living in Lithuania are a little bit afraid of competition […] that they would lose something. It is still a very close society and even to outsiders.&quot; (Lithuania, Lithuanian Institute of History)</td>
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<td><strong>Radical approach</strong></td>
<td>&quot;In Estonia there was a very clear hospital reform, because they changed the hospital legal status. They merged hospitals, which are now all autonomous. They have a very clear mandate, they provide only specialised care, and the hospital system is now an acute-care system. So you don't have hospitals that are kind of in between primary care and secondary care, so hospitals just provide acute care. The financing model is very clear, for both primary care and hospitals. So...that’s true not only about primary care, but it is a clean-cut reform approach that they apply to other parts of the health system as well.&quot; (The World Bank)</td>
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<tr>
<td>C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION</td>
<td>“In Estonia, they were more radical, they just forced all GPs to become private.” (Lithuania, State Patient Fund)</td>
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<td>Incremental approach</td>
<td>“We made this in a very moderate way, in a very smooth moderate way, with a lot of options, with a lot of pilots.” (Lithuania, Mykolas Romeris University)</td>
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<td>Rapid implementation</td>
<td>“It’s difficult to say something very certain on that, but my feeling is that our direction is to have more small providers and more private providers. But I am not sure about what will happen in big Vilnius polyclinics, in which we have primary and secondary care under one roof. I am not sure about them, maybe they will stay some 5 years or so, or even 10 years. So…but in fact, regarding the [transition period] teams... it is quite easy and clear because we have some documents which say that it was prohibited to contract with these teams if we hadn’t contracted with them in the past, [...] like a natural death of these teams.” (Lithuania, State Patient Fund)</td>
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<td>Sluggish implementation</td>
<td>“Of course if we plan some reforms or changes, nowadays we plan for 5 years or 10. But in the first years as an independent country we implemented all changes very rapidly, in one year. We weren’t used to it.” (Estonia, Ministry of Social Affairs)</td>
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<td>Creating of coherent vision</td>
<td>“I think we have had some continuity, we haven’t changed the general direction, but, the speed of the implementation was different in every period. At the beginning we were very quick, then we stopped for a while, and then again. And we went on like that.” (Lithuania, State Patient Fund)</td>
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<td>Flexibility to accept pluralistic perspectives</td>
<td>“When we were planning [the reform] in our Society of Family Doctors we had many discussions on what should be the role of family doctors... whether this was what we called the “lead doctor” and there could be other doctors in primary healthcare as well, who are not family doctors; or we should try to cover the whole field with family doctors. This was the opinion that was shared by the majority who felt that all our colleagues should be in the same system even if they were not all very happy with this leadership role...but for that purpose the reform was designed to have the possibility of a group practice, where someone within the group could take some more administrative tasks, permitting all the other colleagues to do maybe more clinical work. This was decided in this way.” (Estonia, Tartu University)</td>
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<td>Creation of alternative visions</td>
<td>&quot;It depends on the local politicians and the local management, because it was not forbidden, it’s better to say, to create one or another model...There was no clear definition of what a 'model' means for primary care and it was allowed to create different models&quot; (Lithuania, Ministry of Health)</td>
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<td>Convergence to one model</td>
<td>“Because what we didn’t do… what the other countries used to do is piloting too much…because you cannot really pilot something that is really small because you don’t get the real outcome. [...] I think most of the countries have done the reform and piloted one model, then piloted the other, then piloted a third one…Ok, in Tallinn we piloted these salaried and not salaried doctors models, but then we decided that if we reform we need to go over it all of us, otherwise it doesn’t work if we leave [some parts out].” (Estonia, Ministry of Social Affairs)</td>
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<td>Freedom of choice</td>
<td>&quot;Yes, we have not created a model for the university-towns or the capital-towns and another for our islands. So we implemented it in the whole system and then we looked at how to fit it into the geographical boarders or population or culture.&quot; (Estonia, World Health Organisation)</td>
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<td>Consistency of links between theorisation and practices</td>
<td>&quot;We are now in such a time when we have three people and two NGOs! So many of those NGOs and they don’t cooperate, they wouldn’t like to. So everybody is focused on their own issues...so this is like, I would say, adolescence in the development, when we had no freedom at all and now you would like to be as much free as you want, and you don’t look at the country's bigger picture. (Lithuania, Mykolas Romeris University)</td>
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<td>&quot;Some say a GP should refer to precisely one specialist, because he/she knows him, trust him. But no. Because of our democracy. The patient has to be able to choose.&quot; (Lithuania, Ministry of Health)</td>
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<td>&quot;And if we think about why the family medicine reform has been successful since 1998 it is because the whole package was created and changed. Not only ownership, or legislation, or some regulations, but also the financing was shaped in the way to create incentives, and it was agreed at the policy-making level, and of course it was advised by foreign consultants as well.&quot; (Estonia, World Health Organisation)</td>
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<td><strong>C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION</strong></td>
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<td>Providing tools to enact new roles</td>
<td>&quot;So I may say that the initial phase of reform was mostly to give doctors a better education and the idea that they can work in practice, to do more and to have more comprehensive healthcare.&quot; (Estonia, Tartu University)</td>
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<td>&quot;On paper we have a lot of very nice documents and maybe you know that our Health Program in the 1980s was one of the best in Europe. But the problem is that we are not implementing them [...] To decide and to do are two very different things. In Lithuania we are producing a lot of papers, but we have problems with the implementation.&quot; (Lithuania, Independent Consultant)</td>
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<td>&quot;There should be people in the system who understand the linkages, and there should be people who translate the 'value for money', the 'quality', the 'access', all these questions that we have as health policy specialists into the practical tools that the family doctors have. [...] And this is extremely difficult and this is the key [...] So somebody has to translate these concepts into the practical things for the family doctors, because we could dream but family doctors would never think in the same terminology of the policy makers, and they have to do different things.&quot; (Estonia, World Health Organisation)</td>
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<td>&quot;Also [it would be good] to enhance the independent work of doctors and nurses and to give real tools to municipalities on how they can manage these general practices, because a lot has been done in theory, according to laws, but not in reality. So we have to change many things.&quot; (Lithuania, Ministry of Health)</td>
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<td>Legitimacy of theorisers</td>
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<td>History of the universities</td>
<td>&quot;For example, to compare Lithuania with Latvia and, in particular, Estonia...they had universities at that time, in the XIX century. We had no university, and schools were Polish and Russian schools.&quot; (Lithuania, Lithuanian Institute of History)</td>
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<td>Socialisation centre</td>
<td>“And then in Estonia, the Centre of Postgraduate Education has always organised courses for doctors, on different topics, and it has been a tradition. So this was the only centre, the only medical faculty here, where doctors came to [attend] different courses. So we decided why not start providing these doctors what they need? But that time we did it a bit differently, so we planned the whole curriculum, not only for just one long common visit, but for a series of activities...to lead them, we thought at that time, to have the qualification of a family doctor.” (Estonia, Tartu University)</td>
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<td>Personalities</td>
<td>&quot;And having the credibility of the University really helped. And obviously it's not only that the university was involved; it's also about personalities and the Chair in Family Medicine was a very well respected professor. So everything came together.&quot; (The World Bank)</td>
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<td>Leadership roles</td>
<td>“I think in Lithuania academics do not want to recognise family doctors as specialists, as equal to the other specialists [...] The former Director of the Family Medicine Department had several professorships, in surgery, cardiology, [...] but he was not even a family doctor!” (Lithuania, Primary Care Centre Manager)</td>
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<td>Legitimation of the new profession in the academic community</td>
<td>“When the Department was opened, it signalled the acceptance of family medicine, because our Department was at the same level of all other Departments, no difference: if you have a professorship, you belong to the city council and you can diffuse our great ideas about family medicine also in those places. In some countries, up to now they don't have academics in family medicine and therefore the whole [idea of] family medicine in these countries encounters many difficulties, because other specialties have much power.” (Estonia, Tartu University)</td>
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<td>Homogeneity of vision</td>
<td>&quot;I think there were attempts to have another [centre] as well, but in this case, as normally the organisations would start fighting with each other, it was good that in these years it was like one voice speaking, taking care of all issues...and...[...] you can't have different opinions from within the same group.” (Estonia, Tartu University)</td>
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<td>C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION</td>
<td>&quot;There was a very close collaboration between the university and the Society of Family Doctors, [...] geographically, but also ideologically. [...] This is a continuation of a tradition in Estonia that the head of the professional association, never mind what specialty, is the head of the specialty at the University or has a professorship [...] And it is a tradition that the president of the association is also a leader in the specialty in the country. Therefore, we have always had a very good cooperation, and we will continue to have it.&quot; (Estonia, Tartu University)</td>
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<td>Internal threats</td>
<td>&quot;For example in primary care the strong group is the University because they were basically the main reform implementers in the early ‘90s, from that the Family Doctor Association was built up.&quot; (Estonia, World Health Organisation)</td>
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<td>Engagement of practitioners</td>
<td>&quot;(There is) no difference (between the two). Maybe one, the Vilnius association, was established in 2002, later, and like in opposition to the College of Family Physicians...the so-called Vilnius association and Kaunas association, so like in opposition. But the functions are the same. Now we collaborate, there are no problems at all.&quot; (Lithuania, Lithuanian College of General Practitioners)</td>
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<td>Conveying political commitment</td>
<td>&quot;And with their help together, I think about a year later after the courses started, we organised, we felt that this was something special that needs to be established...a Society of Family Doctors, we called it, Family Doctors, although at that time it was not yet a medical specialty in Estonia. And I think this first group of doctors it was the initiative, with which we found it fascinating to do something new and to do something differently.&quot; (Estonia, Tartu University)</td>
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<td>&quot;And it is also very clear to me that you needed high level commitment to the direction of the reform, and especially the World Bank Health Project in Estonia was very successful was that this project helped to keep the engagement, so we were actually external partners to Estonia even when the government changed or the minister changed. At last in more than 5 years...if you read now the project 8 memoirs every 6 months, they all start with policy discussion and kind of you engage from outside and you try to mange, providing better resources when something is needed...it’s not only about PHC, but it’s the same also about financing and hospital reforms, that helped the government to stay on track, even if there is a leader on the national level who is willing to do so. And in Estonia it was I think perhaps Lithuania never had this type of vision, or it didn't have that at the central level.&quot; (The World Bank)</td>
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<td>Allowing for local variations</td>
<td>&quot;It was a very small group of people, but they were open-minded, they had their own vision, they had the same way of thinking with the mainstream politicians, so I think they had much more power and windows to talk with politicians and all these people here.&quot; (Estonia, World Health Organisation)</td>
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<td>&quot;There are a lot of strategies and a lot of laws just to develop primary healthcare. The professional associations developed a lot of documents and the Parliament supported them, but in reality it is only on paper. [...] It depends on the politicians and the political will also at the local level...&quot; (Lithuania, City Government)</td>
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<td>“And before these reforms, polyclinics worked together with hospitals, they were one legal entity. So the reform separated them. Unfortunately, in bigger towns there was quite a big resistance, and now we still have big polyclinics in Vilnius, Kaunas, Klaipeda, Siauliai...our big cities. They were separated from hospitals, but it depends on the political will and on who wants to decentralise the family practices.” (Lithuania, Ministry of Health)</td>
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<td>Socialisation process</td>
<td>&quot;Apart from these structural changes to separate institutions for primary and secondary care and the financial incentives, there was the idea to implement retraining, intensive retraining of all doctors employed in outpatient care, to provide more knowledge and skills related to the activities related to the so-called family medicine or general practice.&quot; (Lithuania, Independent Consultant)</td>
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<td>Acquisition of technical competences</td>
<td>“During the Soviet period we didn’t have such kind of healthcare as primary healthcare. So we had to create everything and we started from human resources. It meant that our universities participated in the reform by educating physicians and nurses first of all; and I can’t tell you exactly, maybe in 1993, we reformed the training, [introducing] residency. So a special program for GPs was created and we started to educate doctors to become GPs. And together with that, we had another program for the retraining of paediatricians and internists, and also other doctors who wanted to become GPs. So the University taught them what family medicine is, what they have to do as family doctors, and so on. And they started a community of doctors [...] until we had enough GPs and stopped retraining them.” (Lithuania, Ministry of Health)</td>
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<td>Influence of role models</td>
<td>“And therefore, as I said that we started with those active doctors. It was a great advantage for Estonia, because 60 active doctors after their training, after three years, started to be teachers for others who started the training as family doctors. In my opinion it is the most important thing, because if you have an empty field, there is nobody there and you cannot train others and also you cannot show what the work in family medicine is. But we had these doctors who were really good and we were able to show in the whole Estonia how family doctors were working, they were like pilot.” (Estonia, Tartu University)</td>
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<td>&quot;For young people it seems that when they have good supervisors, then they choose more this profession. [...] We have to choose the supervisors more carefully, those who have more comprehensive work.&quot; (Estonia, Tartu University)</td>
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<td>“But the trainers were taken from the other specialties [...] We do this also now, but at that time we didn’t have any [other] possibilities because we didn’t have any family doctors. We just collaborated with some outpatient primary care units, who were friendly to us, and they, how to say, trained our doctors [...] But after that of course we started to use our already functioning family clinics, like family medicine institutions. And now we do mainly family medicine rotation in these clinics with family doctors.” (Lithuania, Kaunas University)</td>
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<td>Reciprocal learning</td>
<td>“And I think residency has a very good impact on the attitude of other doctors, because we can make direct contacts with these other doctors during residency. Residency is one factor, not the only one. Of course, there has been quite a lot of cooperation and negotiation with the other doctors to improve the health system and so on. I think it’s actually only a part of it, but certainly it has had its own impact. During residency I spent about one month almost in every department where specialists worked, so I got many contacts and I leaned from them and they learned from me, so they saw that probably family doctors are not the most stupid! It’s again from Soviet times, where students who did not have good grades became kind of general practitioners. Now it’s a little different.” (Estonia, family doctor)</td>
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<td>Gaining trust and legitimacy</td>
<td>&quot;...what the University did was that they created this new type of doctors, the family doctors, and they secured that they would have credibility as with new qualification.&quot; (The World Bank)</td>
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<td>Increasing cooperation between practitioners</td>
<td>&quot;But lately the family doctors have proven more that they are a necessity and many specialists of course have relationships with family doctors as equals. And residency helped this process.&quot; (Estonia, family doctor)</td>
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<td>C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION</td>
<td>&quot;But when they started to talk to each other and the specialists started to stop calling family doctors stupid, the family doctors were like &quot;ok, maybe we are stupid and we don’t ask the right questions, but what is the right question? Tell us!&quot; And then the cooperation started and some specialties like maybe cardiology and internal medicine, which is more general medicine and general practitioner like and helping people as a whole...they started to implement all these clinical guidelines and average for family doctors and so on. That’s how the cooperation started.&quot; (Estonia, World Health Organisation)</td>
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<td>Counter-theorisation</td>
<td>“The main ideologists of the Tallinn healthcare model were the managers of the polyclinics and the managers of hospitals...because the current system was insured budget, and it was like a resistance from this side and also from the paediatricians, because paediatricians thought that they would lose their job with regard to their outpatient work.” (Estonia, World Health Organisation)</td>
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<td>Resource-related power</td>
<td>“One objective was to separate primary and secondary, hospital care, and of course the managers of hospitals and big health centres were one of the key players and they were extremely against this reform. [...] They are and they were very skilled and clever and they knew that they would lose the power...how to say...over the primary care budget and over the primary care physicians, when we gave family doctors this gate-keeping function.” (Estonia, Ministry of Social Affairs)</td>
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<td>Patient-related power</td>
<td>&quot;So it was presented as a problem for the patients, just to cover the fact that specialists were afraid that patients would be taken away from them.&quot; (The World Bank)</td>
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<td>Decrease in service quality</td>
<td>&quot;If we say why we were against this reform, this time, maybe we were not sure that for the children the care would continue to be at the same level as it was before.&quot; (Estonia, City Government)</td>
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<td>Discrediting professional competence of</td>
<td>&quot;They always, from the very beginning, saw us like competitors...and...well, hard discussions went on from the very beginning about the competences of family doctors. &quot;Why family doctors? Is she better than a cardiologist in handling cardiac problems?&quot; It's not, I think, what should be discussed...it's different. These tasks are different in primary care. But until maybe 2000, we had very hard discussions and confrontations, and they tried to push us out of every medical field.&quot; (Lithuania, Lithuanian College of General Practitioners)</td>
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C. CONTEXTUAL FACTORS INFLUENCING LOGIC ELABORATION